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Homelessness, Housing, and Harm Reduction: Stable Housing for Homeless People with Substance Use Issues

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Homelessness, Housing, and Harm Reduction: Stable Housing for Homeless People with Substance Use Issues

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The Social Planning and Research Council of British Columbia (SPARC BC)

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Deborah Kraus
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Michael Goldberg

July, 2005

Executive Summary

Introduction

The purpose of this study was to investigate innovative housing programs for persons who are homeless or at risk of homelessness and who have issues associated with substance use (e.g. drugs, alcohol or other substances).

The research specifically examined which housing interventions and factors, including a harm reduction approach, best help homeless persons with addictions access and maintain stable housing.

Three research questions were addressed:

1. How effective are innovative or alternative residential housing programs for homeless persons dealing with substance use issues, especially programs that incorporate high-tolerance or harm reduction into a supported living environment?
 2. To what degree is secure and stable housing crucial in designing alternative addiction treatment models for homeless people and a factor fundamental to successful substance use treatment models?
 3. Do harm reduction strategies, as part of supportive housing, enhance the stability and longevity of housing tenure for persons who are homeless or at risk and who have substance use issues?
2. The literature is clear that effective treatment for homeless people with substance use issues requires “comprehensive, highly integrated, and client-centred services, as well as stable housing”.¹ Housing is essential both during and following treatment. The literature review also found growing evidence that supported housing is essential regardless of treatment. In the programs profiled in this report, safe and secure housing was identified as a key factor that makes it possible for residents/program participants to address their substance use issues and to become abstinent, reduce their substance use, or reduce the negative impacts of their use.
 3. The programs profiled in this report found that the participants had undergone a number of positive changes since they became involved. One of the most frequent changes noted was stable housing tenure. Using a harm reduction approach - which provided for flexibility and focused on the individual needs of each client - was identified as a key factor for success.

Harm reduction

Harm reduction is defined as an approach aimed at reducing the risks and harmful effects associated with substance use and addictive behaviours, for the person, the community and society as a whole, without requiring abstinence.

Answers to research questions

1. Based on a review of the literature and the programs profiled in this report, a harm reduction approach combined with supportive housing can be an effective way to address the needs of homeless people who are dealing with substance use issues.

This study makes a distinction between approaches that are primarily a “tolerance of consumption” and other approaches that take the concept of harm reduction to another level. In all thirteen of the case studies profiled in this report, the agencies work to actively engage their clients in making positive changes in their lives. Some of the approaches used include motivational

¹ Kraybill, Ken, Suzanne Zerger and National Health Care for the Homeless Council. 2003. *Providing Treatment for Homeless People with Substance Use Disorders, Case Studies of Six Programs*. National Health Care for the Homeless Council. p. 16 Available online at: www.nhchc.org.

interviewing (to help clients enhance their motivation to address their substance use issues), focusing on the strengths and capacities of each individual - rather than on their limitations, and providing the necessary support and information to help clients reduce their substance use or to use more safely. As stated by one agency, the approach is one of “persistence” rather than “insistence”.

Housing first

In this study, “housing first” is defined as the direct provision of permanent, independent housing to people who are homeless. Central to this idea is that clients will receive whatever individual services and assistance they need and want to maintain their housing choice. The housing is viewed primarily as a place to live, not to receive treatment.

Approach

The researchers undertook a literature review and profiled thirteen initiatives in Canada, the US and the UK. Twelve of these projects are providing housing and services to people who are homeless or at risk of homelessness and who use substances. A thirteenth program was in the planning stages. All the projects incorporate a harm reduction approach.

Eight of the programs provide housing in buildings dedicated to their target population or a similar clientele. Another program is planning to develop a new building to be dedicated to the target group. In the other four programs, the housing units are integrated within non-profit or private rental building that serves a mix of tenants (e.g. scattered sites), or the program provides a mix of options. In one of these programs, the sponsor agency purchased 22 condominium units and rents them to their clients.

Information for the case studies was obtained through interviews with service provider personnel most knowledgeable about the program. In addition, the researchers sought to obtain written documentation about the initiative such as annual reports, policies and evaluations, if available. The researchers also conducted face-to-face interviews with thirty-three individuals who were living in (or had lived in) housing provided by the case study agencies and/or were receiving services from these agencies. Interview guides were used for all the interviews.

Summary of findings

The programs described in the case studies are effective in addressing the needs of people who are homeless and have substance use issues. All the agency key informants reported that their clients have undergone positive changes since becoming involved in the project. The most frequent changes noted were around housing stabilisation, substance use, physical and mental health, and income. The agency key informants also reported that some of their clients were participating in employment training, while others had returned to school. In addition, some clients were able to develop social networks and/or re-establish contact with their families.

When asked what they thought were the most effective services they provided, almost all the agency key informants identified housing. Housing provided the safety and security that made it possible for people to begin to reduce their substance use. Housing also provided a base for the residents to form friendships, get to know themselves, develop and establish their own networks, and become connected to the community.

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

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

The information provided by the agency key informants is supported by what the residents/program participants had to say. When asked about the factors most responsible for the changes in their lives, the most frequent response was housing - having a place to live. Participants also discussed how the support they received from the case study agency was responsible for the changes in their lives. Participants indicated that they value staff who are friendly, caring, supportive, responsive, helpful and compassionate. They want to be treated with respect, and “like a person”. They identified a

need for staff to be well-trained and knowledgeable about their issues. They also stated that experience is important - experience working with the target population and also real-life experience.

When discussing what was important to them in terms of their housing, participants indicated that they want affordable housing in quiet neighbourhoods away from drug dealing but accessible to public transportation, amenities and services. It is clear that a range of housing options is necessary to meet the needs of the target group. While some individuals may prefer the anonymity and strictly “landlord-tenant” relationship that occurs with scattered site housing, others may prefer the camaraderie, group activities and sense of community that is available in dedicated buildings.

While both agency key informants and residents/program participants discussed the importance of housing and support, it is the *combination* that holds the key to success. There had been times in their lives when the residents/program participants had been housed, but without success. Most housing providers would never house them again. What makes the case study initiatives documented in this report so compelling is their degree of success in helping the participants to turn their lives around.

The changes are especially remarkable, given how little demand is placed on clients to engage in programs or transform themselves. However, the relationship between staff and their clients is not hands off. While participation in services is always voluntary, staff work to engage clients and encourage their participation in service planning, external treatment and service use. Perhaps the element of choice is another key to success. As suggested by a key informant, “giving clients the treatment they want may allow them to select the treatment they need.”

At the same time, the study shows that no single model or approach will meet the needs of all homeless people.

Conclusions

Perhaps the most significant issue that emerges from this study is the degree of success that can be achieved with the housing first approach. The case studies in this report show that most people who are homeless, even if they have substance use issues and concurrent disorders, can be successfully housed directly from the street if they are given the right supports when they want them. If the goal is to end homelessness, the results of this study make it clear that for many people who are homeless, a “housing first” approach would make this possible.

The term “hard-to-house” should be put to rest. The interviews show that homeless people with complex needs can be housed successfully, as long as they have the right kind of support that meets their needs. The participants were clear about what is important to them. They want to be treated with respect. They don't want to be treated as a number. It is also important to consider their strengths. One participant pointed out that the people in her building are “vibrant and wonderful. It is important to recognize this”.

What is especially significant in the findings from these case studies is that if solutions can be found for this population - those with complex needs and who have the longest history of living on the streets - then perhaps key elements that distinguish the case studies, such as housing first or a client-centred approach, can be applied to address the needs of other people who are homeless - people who are newer to homelessness and who are not confronted by the multitude of problems that persons described in this report deal with on a daily basis.

Recommendations

Housing First

Many countries use a continuum approach to address homelessness. This continuum includes homelessness prevention services, emergency shelter, outreach, transitional housing, and support services (such as addictions counselling and employment training). While there is need for a range of housing options and services to address homelessness, this research paper recommends that **policies and programs for addressing homelessness should be expanded to allow for a housing first approach so that people who are homeless can have direct access to permanent housing, with support as needed and wanted.**

This report further recommends that **policies and programs should be based on the principle of “putting the client at the centre”**. This means providing people who are homeless with choices about their housing. It also means questioning whether the distinction between “permanent” and “transitional” housing continues to be useful, if there are any reasons for housing programs to impose time limits regarding a resident's length of stay, and if so, under what circumstances.

Harm reduction

There is increasing awareness of the concept of harm reduction, yet it is not widely understood. This report recommends **greater education and information about harm reduction and how it can work**. The researchers believe that a better understanding of the approach and its positive impacts will mitigate some of the misinterpretation and negative perceptions. As more policy makers are informed about the potential for harm reduction to achieve positive outcomes, this approach should receive greater support and acceptance.

Questions for further research

A number of questions emerged from this research that merit further study. These include:

- What are the advantages and disadvantages of dedicated housing compared to a scattered sites approach, and under what circumstances will it be more advantageous to choose one approach over the other?
- What are some of the best ways to help people who have been homeless develop social networks and become integrated into the community?
- What are some successful strategies for dealing with the co-existence of residents who are abstinent (particularly those who are newly abstinent) with those who aren't?

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Appendix A:	Case Studies
Appendix B:	Interviews with Residents/Individuals using the Programs Provided by the Case Study Agencies
Appendix C:	A Review of the Literature
Appendix D:	Methodology

Introduction

Purpose

The purpose of this study was to investigate innovative or alternative residential or housing programs for persons who are homeless or at risk of homelessness and who have issues associated with substance use (e.g. drugs, alcohol or other substances).

Specific objectives were to answer questions as to which housing interventions and which factors best help homeless persons who are substance users access and maintain stable housing. The project sponsors identified the following specific research questions:

1. How effective are innovative or alternative residential housing programs for homeless persons dealing with substance use issues, especially programs that incorporate high-tolerance or harm reduction into a supported living environment?
2. To what degree is secure and stable housing crucial in designing alternative addiction treatment models for homeless people and a factor fundamental to successful substance use treatment models?
3. Do harm reduction strategies, as part of supportive housing, enhance the stability and longevity of housing tenure for persons who are homeless or at risk and who have substance use issues?

One of the goals for this study was to learn more about programs that incorporate a harm reduction approach. However, this term was not defined at the outset. Rather, defining harm reduction was seen as a desired outcome of the research—to learn more about how harm reduction in the context of housing—has been defined in the literature and among practitioners in the field.

Method and Approach

The methods used to gather the information for this research project involved:

- Reviewing the relevant literature (see Appendix C);
- Preparing case studies to document 13 programs and services that incorporate or are planning to incorporate a harm reduction approach (see Appendix A); and
- Conducting interviews with people living in housing or using services provided by the agencies participating in the case studies (see Appendix B).

A brief description of the methods is provided below. A more detailed description of the methodology and approach is in Appendix D.

Literature review

The researchers undertook a review of the literature from Canada, the U.S., U.K. and Europe, focusing on materials published since 1990. The literature review provides an overview of harm reduction, the connection between substance use and homelessness, intervention strategies for people who are homeless and who use substances, and harm reduction approaches in the context of housing. (See Appendix C for the complete literature review.)

Case studies

The researchers documented 12 programs that are providing housing and services to people who are homeless or at risk of homelessness and who use substances and that incorporate a harm reduction approach. A 13th documented program was in the planning stages.

All of the information for the case studies was obtained through interviews with service provider personnel most knowledgeable about the program. In addition, the researchers sought to obtain written documentation about the initiative, such as annual reports, policies, and evaluations, if available. Interview guides were used for all interviews. These guides were modified depending on whether the project had operated for a period of time or was in the planning stages. The interview guides are included in Appendix D.

The following criteria were used as a basis for selecting which initiatives would be documented as case studies (further details are in Appendix D):

- **Harm Reduction**—Must use a "harm reduction" approach
- **Client Group**—Projects covering a range of clients who are homeless
- **Types of substances**—Projects covering a range of substances used
- **Type of housing offered**—Projects covering a range of housing options
- **Innovation**—Projects doing something that is unique.

Priority was given to Canadian initiatives.

Table 1 shows the name and location of the case studies included in this report.

Table 1 - Name and location of case studies documented in this report

Canadian (on-site interviews)	<ol style="list-style-type: none"> 1. Princess Rooms, Vancouver 2. Eva's Satellite, Toronto 3. Canadian Mental Health Association (CMHA), Ottawa 4. Ottawa Inner City Health Project (OICHP), Ottawa 5. Services à la Communauté (CDC), Montréal 6. Chambreclerc II, Montréal
U.S. (on-site interviews)	<ol style="list-style-type: none"> 7. Lyon Building, Seattle 8. Supportive Housing and Managed Care Pilot, Minneapolis (SHMCP) 9. Anishnabe Wakiagun, Minneapolis 10. Pathways to Housing, New York
United Kingdom Projects (telephone interviews)	<ol style="list-style-type: none"> 11. Heavy Drinkers Project, Manchester 12. In Partnership Project, Manchester
Planned Project (telephone interview)	<ol style="list-style-type: none"> 13. Situation Appropriate Supportive Housing (SASH), Halifax

Interviews with residents/people using services

The researchers conducted face-to-face interviews with three individuals from each of the 10 projects where on-site interviews took place. Additional interviews were conducted with three residents of another initiative that the researchers had planned to document as a case study but could not as the facility was no longer in operation.¹ The purpose of the interviews was to hear from the residents and individuals using the services about what they like most and least about their housing, the kind of services and activities they are involved in, what their life was like before they became involved in the program, how their lives changed since becoming involved in the program, and suggestions for other organizations interested in undertaking a similar project.

Limitations of the research

One of the difficulties that this research confronted, as do similar projects that examine existing initiatives, is that of availability and comparability of data. It is clear that most projects are very stretched in delivering their services and do not have the resources or the capacity to undertake outcome studies. However, this is a critical element that would allow better learning from what has been put into place and better targeting and design of new projects. The lack of systematic outcome measures also makes it difficult to recommend one approach over another.

One of the goals of the study at its outset was to examine the transferability of the results to programs that target the subject population. This proved to be difficult for two reasons. The first is that no one model appears to best serve all the needs of this population, rather there are various ways of providing housing and services, while using different combinations of approaches, that lead to success. The other reason for the difficulty in assessing transferability is related to the need for more research on outcomes and conditions for the outcomes. Until there is a better understanding of what works and why, it will be difficult to recommend one approach over another within the variety of approaches that can be considered.

¹ The researchers had originally intended to document the O'Neil Crack Cocaine Project, a former initiative of Seaton House in Toronto. Interviews were conducted, but it was subsequently decided that the researchers would not prepare a case study for this project because sufficient information about the project or rationale for its ending were not available. Nevertheless, it was decided that the input from the interviews with former residents should be retained.

Overview of the literature review

The literature review focused on materials in English and in French published in Canada, the United States and Europe since 1990. A number of issues emerged that proved to be important in guiding subsequent phases of this research. These include the application of the harm reduction philosophy as well as which approaches to housing provision are the most effective.

Harm reduction

The traditional approach to the treatment of addictions was based on abstinence, and relied heavily on a client's willingness to accept lifelong abstinence as a goal. However, during the 1980s, there was a growing sense that this zero-tolerance approach did not work well for many homeless persons. Studies in the US found that 12-step programs, which account for more than 90 per cent of all alcohol and other drug treatment programs in the U.S., had a success rate of between five and 39 per cent and that 80 per cent of clients failed to complete traditional treatments.² There was a growing belief that the zero-tolerance approach to drugs and alcohol was a barrier that prevented many users from seeking/accessing programs and services.

These findings are consistent with a Toronto study that found substance users were reluctant to seek out conventional addiction treatment services, including 12-step programs, detoxification, and rehabilitation that require people to abstain from using drugs or alcohol.³

The American studies as well as that from Toronto found that while traditional services have been successful for some people, abstinence-

based programs have little chance of attracting or retaining people who are homeless.

In parallel to these observations about abstinence programs, the emergence of HIV/AIDS and the link to drug use through sharing of injection equipment brought the issue of drug use into the realm of public health, with impacts that went far beyond a small and marginalized population. Many countries began to take the public health-based perspective that the dangers of the spread of AIDS among drug users and from drug users to the general population posed a greater threat to health than the dangers of drug use itself. Many of these approaches began in Europe, including Switzerland where drug addiction is viewed as a temporary phase in an individual's life, and the Netherlands, where there is tolerance of "soft drugs."

The literature includes a variety of definitions of harm reduction that can be summed up as follows:

Harm reduction is an approach, strategy, set of interventions, policy or program aimed at reducing the risks and harmful effects associated with substance use, and addictive behaviours, for the person, the community and society as a whole, without requiring abstinence.

Although harm reduction does not require abstinence, it does not rule out abstinence in the longer term. In fact, harm reduction approaches are often the first step toward the eventual cessation of drug use. One of the main benefits of harm reduction is that it facilitates access to services. With a harm reduction approach, therapy/service is provided even

2 See for example Denning, Patt, Jeannie Little and Adina Glickman. 2004. *Over the Influence, The Harm Reduction Guide for Managing Drugs and Alcohol*. New York: The Guilford Press. Or Brocato, Jo and Eric E. Wagner. 2003. Harm Reduction: A Social Work Practice Model and Social Justice Agenda. *Health and Social Work*. 28(2): 117-125.

3 Steering Committee for the Study Project on Homelessness and Alternative Addiction Treatment. 1999. *From the Revolving Door to the Open Door. Final Report of the Study Project on Homelessness and Alternative Addiction Treatment*. Toronto: Steering Committee for the Study Project on Homelessness and Alternative Addiction Treatment

when people continue to use drugs and are unwilling to enter traditional substance abuse treatment programs. A harm reduction approach can enable access to services such as safe housing, health care, psychological help, and safer means of drug use.

A key element of harm reduction is to provide a “client-centred” approach to working with people “where they are” rather than “where they should be” as dictated by treatment providers. With this approach, clients are allowed to set their own goals while receiving support and assistance.

Harm reduction also embodies the concept of “low threshold,” which means removing traditional barriers to treatment that insist on a commitment to abstinence as a requirement of admission and as the only acceptable goal. Examples of “low threshold” approaches to accessing services might include street-outreach, drop-in centres or information groups that allow people who are actively using drugs to take part in treatment activities on site, as well as “wet” shelters or housing that does not require abstinence.

Some researchers have noted that harm reduction programs are more likely to attract active drug users, to motivate them to begin to make changes in their behaviour, to retain these individuals longer in treatment, and to minimize attrition and dropout rates.

Housing provision

It is clear from the literature that effective treatment for homeless people with substance use issues requires “comprehensive, highly integrated, and client-centred services, as well as stable housing.”⁴ Housing has been identified as a cornerstone in providing treatment, and as

essential following treatment. There is also growing evidence that supported housing is essential regardless of treatment. The literature also points to the need for a full range of housing options, including alcohol and drug-free housing, and supportive housing that may be “wet,” “damp” or “dry,” transitional or permanent.⁵

The predominant and more traditional approach to housing homeless individuals who consume substances and/or have mental health issues has been an approach that follows a “continuum of care.” Individuals are expected to become more engaged in abstinence as they move along the continuum. The “continuum of care” typically begins with outreach as a first step that encourages clients to accept a referral for programs such as drop-in centres, shelters and safe havens with an objective that clients become “housing ready.” The next stage in the continuum would be housing, often some form of transitional housing. Support services are usually provided to help the residents move toward independence and self sufficiency. It is expected that clients will ‘advance’ to more independent, less supervised and less restrictive settings as they master the appropriate skills required for housing readiness.⁶

4 Kraybill, Ken, Suzanne Zerger and National Health Care for the Homeless Council. 2003. *Providing Treatment for Homeless People with Substance Use Disorders, Case Studies of Six Programs*. National Health Care for the Homeless Council. p. 16 Available online at: www.nhchc.org.

5 *ibid* page 21

6 Refers to standards and expectations of housing providers before independent housing is offered. Expectations can include psychiatric treatment, sobriety and life skills such as cooking.

The other approach that is revealed in the literature is one where housing is seen as a critical factor in stabilizing substance use, rather than a consequence or reward for control or abstinence. In the “housing first” approach, housing is viewed primarily as a place to live, not to receive treatment. Central to this idea is that consumers will receive whatever individual services and assistance they need to maintain their housing choice. Proponents of this model emphasize that it facilitates normal community roles, social integration, and increased independence and control for the client.

A well-documented example of this approach is Pathways to Housing in New York (profiled as a case study in this report), which offers immediate access to permanent independent apartments. Housing is not connected to treatment. Consumers who are active substance users are not excluded from housing and consumers who relapse while housed are considered in need of treatment, not eviction to a more supervised setting. Support services are provided through a multi-disciplinary Assertive Community Treatment (ACT) team⁷. These services address housing issues, money

management, vocational rehabilitation, mental health and substance abuse treatment, and other issues. The majority of services are provided to tenants in their homes and communities and staff is available 24 hours a day, seven days a week.

Evaluations of the Pathways program demonstrate that homeless individuals who use substances and have histories of psychiatric hospitalization can remain stably housed in independent apartments with support services.

Other issues, not dealt with explicitly in the literature review, but that may be important are questions of location of projects. For example, there are strong indications that moving persons away from sources of drugs and the drug consumption milieu may be desirable if not essential to the development of new capacities and relationships. NIMBY (Not In My Back Yard)⁸ can be another factor in the development of new projects.

7 In this report, ACT is defined as a model of case management where a multi-disciplinary team of professionals is responsible for providing services to clients. Caseloads are small, typically a 1:10 ratio. Most services are delivered on an outreach basis, and there is usually 24 hour coverage. Intensive case management is similar to ACT. Intensive Case Management also provides outreach services, lower caseload ratios and coverage outside of regular working hours. The main difference from ACT is that Intensive Case Management services are not delivered by a multi-disciplinary team of professionals.

8 An acronym used to denote opposition by local communities to the introduction of facilities or housing for certain populations. Refer to the CMHC website <http://www.cmhc-schl.gc.ca/en/imquaf/ho/index.cfm>, for information on the “Train the Trainer” workshop, *Gaining Community Support for Affordable Housing and Homelessness Services*, produced through a partnership between the Canada Mortgage and Housing Corporation (CMHC) and the Government of Canada’s National Secretariat on Homelessness (NSH). This workshop and associated workshop materials are designed to provide municipalities and related affordable housing and homelessness service providers with tools, capacity and best practices to overcome “Not in My Backyard” (NIMBY) opposition as it relates to affordable housing and homelessness services.

Overview of case studies

About the people

All the case study programs described in this report provide housing to a segment of the homeless population that existing studies have characterized as being least able to achieve stable housing. Most of the people served have been homeless for many years—living on the street, staying temporarily with friends, and in and out of emergency shelters. Most have complex health needs, including mental illness, substance use issues, or concurrent disorders (both mental illness and substance use issues). In addition, they may also have HIV/AIDS, FAS/FAE, physical disabilities, developmental delays, acquired brain injuries, histories of trauma, and other medical conditions. Often their behaviours make it difficult for them to access or maintain housing.

The client group that is served by the projects and programs that were profiled has sometimes been referred to as “hard to house” or “hardest-to-house.” But, as some individuals who participated in the interviews have stated, perhaps the problem hasn’t been with the individuals but with the lack of appropriate housing and services suitable to their needs.

Almost all the projects documented are considered by many to be the “service of last resort.” For example, clients in one project have been turned away from other programs because of active substance use, refusal to participate in psychiatric programs, histories of violence or incarceration,

and behavioural problems. In another, residents have not only been refused services by many agencies in their city; some of the individuals were reported to have been banned even from crack houses.

Not only is this group the most persistently homeless, but this is the group that also consumes a disproportionate share of homelessness services. In 1999, the findings of the Toronto Mayor’s Homelessness Action Task Force⁹ sounded the alarm about persons who were chronically homeless. Analysis of nine years of shelter data in Toronto found that while the chronically homeless population constituted only 17 per cent of the cases, they occupied 46 per cent of the bed nights between 1988 and 1996.¹⁰ As the case studies illustrate, this population often has serious health and mental health problems that accompany or are the result of the substance abuse and the years of homelessness. This leads them to use more expensive services, such as hospital emergency departments, because they are not in a stable situation and are unable to gain access to more cost-effective and preventive services.

As shown in Table 2, most of the programs are targeted primarily to single adults. Two are targeted to youth (Eva’s Satellite and In Partnership), and two serve both families with children and single adults (Canadian Mental Health Association and Supportive Housing and Managed Care Pilot). One program in the U.S. is targeted to American Indian adults.

9 Mayor’s Homelessness Action Task Force. 1999. *Taking Responsibility for Homelessness: An Action Plan for Toronto*. Toronto: City of Toronto.

10 Springer, Joseph H., James Mars and Melissa Dennison. 1998. *A Profile of the Toronto Homeless Population. A Study for the Homelessness Action Task Force*. In Background Papers Volume 2. Toronto. City of Toronto.

Table 2 - Type of clients served by each case study

Project	Type of clients
Canadian	
1. Princess Rooms, Vancouver	<ul style="list-style-type: none"> • Single adults—men and women • Chronically homeless with high rates of repeat shelter use, complex health needs, challenging behaviours, and histories of evictions. • Most have a mental health diagnosis, substance use issues and a concurrent disorder
2. Eva's Satellite, Toronto	<ul style="list-style-type: none"> • Youth (16—24) • Homeless • Most are actively using drugs and/or alcohol and are unable to access mainstream, abstinence-based youth shelters
3. Canadian Mental Health Association, Ottawa	<ul style="list-style-type: none"> • Most are single men and women • Some families with children • Homeless or at risk • Serious mental illness and, in many instances, substance use issues (i.e. concurrent disorders)
4. Ottawa Inner City Health Project, Ottawa	<ul style="list-style-type: none"> • Single adults—mostly men • Chronically homeless • Complex health needs and challenging behaviours. All have physical needs related to substance use and mental health issues.
5. Services à la Communauté (CDC), Montréal	<ul style="list-style-type: none"> • Single adults—men and women • Homeless • Substance abuse issues
6. Chambreclerc II, Montréal	<ul style="list-style-type: none"> • Single adults—men and women • Chronically homeless • Mental illness and a substance abuse disorder
U.S.	
7. Lyon Building, Seattle	<ul style="list-style-type: none"> • Single adults—men and women • Homeless • Have two of the following three diagnoses: HIV/AIDS, mental illness and substance use issues
8. Supportive Housing and Managed Care Pilot (SHMCP), Minneapolis	<ul style="list-style-type: none"> • Families with children • Single men and women • Long histories of homelessness and high service utilization • Homelessness is exacerbated by other issues such as medical problems, mental illness, chemical dependency, and histories of trauma
9. Anishnabe Wakiagun, Minneapolis	<ul style="list-style-type: none"> • Single adults—men and women—mostly American Indians • Formerly homeless, mostly from the streets or detox facilities • Most are affected by late-stage chronic alcoholism
10. Pathways to Housing, New York	<ul style="list-style-type: none"> • Single adults—men and women • Chronically homeless persons with mental illness • 90 per cent have a substance abuse disorder

Project	Type of clients
United Kingdom Projects	
11. Heavy Drinkers Project, Manchester	<ul style="list-style-type: none"> • Single adults—men and women • Many are homeless and have long histories of unsettled accommodation • Long-term heavy drinkers
12. In Partnership Project, Manchester	<ul style="list-style-type: none"> • Youth—single women (16–25) • Most have had very chaotic lives • Substance use issues Planned Project
13. Situation Appropriate Supportive Housing (SASH), Halifax	<ul style="list-style-type: none"> • Single adults—men and women • Homeless • Experience significant impairment because of a mental illness and co-occurring substance use issues

About the housing

Most (eight) of the programs are providing permanent housing (see Table 3). One provides transitional housing—with no maximum length of stay (Princess Rooms) and one provides transitional housing with a maximum stay of two years (In Partnership). One project provides emergency shelter—with no maximum length of stay (Eva’s Satellite).¹¹ The Ottawa Inner City Health Project serves individuals in a full range of housing options, from short-term to permanent. In Halifax, the SASH project is planning to provide a mix of transitional housing (no maximum length of stay) and emergency accommodation.

Nine of the programs provide (or will provide) housing in buildings dedicated to their target population or a similar clientele. In the other

four programs, the housing units are integrated within non-profit or private rental buildings that serve a mix of tenants (e.g., scattered sites), or the program provides a mix of options. For example, the Canadian Mental Health Association includes 22 condominium units, among the 80 provided, that were purchased and are rented to clients.

Most of the housing is located in buildings owned or operated by non-profit housing sponsors (either the sponsor agency or other non-profit housing providers). Three programs have relationships with private landlords who make units available to their clients (Canadian Mental Health Association, Supportive Housing and Managed Care pilot, and Pathways to Housing).

¹¹ While most emergency accommodation has a maximum length of stay, this facility is nevertheless considered an emergency shelter. It provides shared/communal living, has rules about when the residents may be on-site, and has curfews.

Table 3 - Type of housing provided in each case study					
Project	Type of housing	Type of unit	Number units	Type of provider	Scattered Site vs. Dedicated¹²
Canadian					
1. Princess Rooms, Vancouver	Transitional. No maximum length of stay.	Private bedroom with kitchenette. Shared bathroom	45	Non-profit	Dedicated
2. Eva's Satellite, Toronto	Shelter. No maximum length of stay	Shared	30	Non-profit	Dedicated
3. Canadian Mental Health Association (CMHA), Ottawa	Permanent	Most are self-contained	80	Non-profit Private rental Condos ¹³	Mostly scattered sites
4. Ottawa Inner City Health Project (OICHP), Ottawa	Full range from short-term to permanent	Mix of options: Shared and self-contained	No fixed number	Non-profit	Dedicated and scattered sites
5. Services à la Communauté (CDC), Montréal	Permanent	Mix of options: Shared and self-contained	No fixed number	Non-profit	Dedicated
6. Chambréclerc II, Montréal	Permanent	Private bedrooms. Shared kitchens and bathrooms	24 rooms	Non-profit	Dedicated
U.S.					
7. Lyon Building, Seattle	Permanent	Self-contained	64 units	Non-profit	Dedicated
8. Supportive Housing and Managed Care Pilot (SHMCP), Minneapolis	Permanent	Self-contained	144 households served	Mostly private rental; some non-profit	Mostly scattered sites
9. Anishnabe Wakiagun, Minneapolis	Permanent	Private bedroom. Share bathrooms. Facility provides meals	40 rooms	Non-profit	Dedicated
10. Pathways to Housing, New York	Permanent	Self-contained	500 tenants	Private	Scattered sites
United Kingdom					
11. Heavy Drinkers Project, Manchester	Permanent	Mix of options: Shared and self-contained	36 places	Non-profit	Dedicated
12. In Partnership Project, Manchester	Transitional—2 year maximum	Self-contained	17 units	Non-profit	Dedicated
Planned					
13. Situation Appropriate Supportive Housing (SASH), Halifax	Transitional (no maximum length of stay) Emergency units	Transitional are self-contained. Emergency units have private bed/bathrooms	25 units	Non-profit	Dedicated

¹² The entire building is dedicated to the target population or a similar clientele.

¹³ Owned by the program sponsor, CMHA, and rented to their clients.

About the services

Types of services

The clients of case study agencies have access to a range of services. All the case study agencies provide assistance to help their clients access medical, mental health and substance use services. Most agencies also help clients manage their income and provide assistance with life skills. Many agencies offer programs for social and recreational opportunities. Many agencies that provide housing in dedicated buildings help residents manage their medications, and also provide meal programs. These services were generally not available to clients who lived in scattered-site housing units. Other programs that were offered by one or more case study agencies included help to find permanent housing, a needle exchange, children's services, help with legal issues, spiritual activities, and confidence raising/assertiveness training.

Some of the above-noted services are available on-site, while others are available in the community. In addition, some services that are provided on-site by one agency may be available off-site with another agency.

Model of service delivery

When asked about the approach that is used to deliver and coordinate services, eight of the 13 case study agencies stated that they are using (or plan to use) a model of case management (see Table 4). This generally means that each resident is assigned to one staff person who is their primary contact and who is responsible for:

- Addressing immediate and basic client needs; and
- Connecting clients with existing services in the community.

Four case study agencies stated that their clients have access to the Assertive Community Treatment (ACT) model of case management—or a modified version of ACT. At Pathways to Housing, clients have access to ACT services, which includes a team of social workers, nurses, psychiatrists, and vocational and substance abuse counsellors who are available seven days a week, 24 hours a day. The team also includes a housing specialist to coordinate housing services.

The Canadian Mental Health Association offers short and long-term intensive case management. Case management services are available until 10 p.m. 365 days a year. These services are delivered according to clients' needs, and where the client chooses. The Lyon Building in Seattle describes its model of service delivery as one of "community support case management." This approach has three components: case management from agencies that refer residents to the Lyon Building; on-site clinical support services provided by Lyon Building staff; and a flexible residential program designed to promote housing success. The goal is to coordinate community support services to meet the needs of the clients in order to promote their highest level of stabilization in the community.

In addition to a model of case management, the SASH project is planning to introduce a community development approach, which would aim to involve tenants in creating a community within the building.

Some of the case studies did not have a specific name for their approach to providing services. Nevertheless, staff work closely with residents to help them achieve housing stability. For

example, with the Heavy Drinkers Project, staff is on-site 24 hours a day. They support residents to access services available off-site, but also work with each resident on-site to develop life skills, address substance use issues, and discuss needs and aspirations. Several other case study agencies also provide 24-hour on-site staffing, including the Princess Rooms, Lyon Building, and Anishnabe Wakiagun.

Table 4 - Model of service delivery used in each case study

Project	Model of service delivery	Harm reduction approach and substance use
Canadian		
1. Princess Rooms, Vancouver	Modified version of ACT/intensive case management. 24 hour on-site staffing. Also incorporates motivational interviewing, ¹⁴ the strengths model (which focuses on clients' resources and abilities), psycho-social rehabilitation, stage-wise case management, comprehensiveness, life skills and social skills.	Uses harm reduction as a set of beliefs, principles and strategies to help residents minimize the harms associated with high-risk behaviours. This includes helping residents move to less harmful substances and reduce their use. Triage also supports residents wishing to enter substance use treatment.
2. Eva's Satellite, Toronto	Focuses on respecting the individual dignity and self-determination of all clients, making client-driven referrals and decisions, explaining decisions to clients with clarity and respect, maintaining client confidentiality, and providing appropriate services and programs.	Approach involves developing an honest and trusting relationship with each youth, engaging with the youth and supporting them to take one step at a time, and informing youth of ways to stay healthier and reduce the harms associated with their lifestyle and substance use. The goals are to help clients stay safer and healthier by making useful choices for themselves.
3. Canadian Mental Health Association (CMHA), Ottawa	Short-and long-term intensive case management available until 10 p.m. 365 days/year. Services are flexible and portable—they follow clients wherever they live. Intensity varies according to the client. Incorporated motivational interviewing. Delivered where the client wants—at home or on the street.	Encourages clients to reduce their use or move to less harmful substances.

¹⁴ "Motivational Interviewing is...a popular method of intervention within the field of drugs and alcohol. It is considered by many to be an effective tool for working with people with "compulsive" or "addictive" behaviour. Motivational Interviewing is a client centred approach that strategically directs clients to examine, explore, and resolve the ambivalence they have about their behaviour... (It) works on the assumption that people have implicit attachments to the behaviours they engage in..." www.smmgp.demon.co.uk/html/articles/art004.htm

Project	Model of service delivery	Harm reduction approach and substance use
4. Ottawa Inner City Health Project (OICHP), Ottawa	Services offered are on multiple levels—the first is health care—the primary goal of OICHP. Includes whatever elements are needed to stabilize and improve the health of the client, which can range from offering safe alcohol to treatment of medical conditions. Other services are based on the goals of the client. Partner agencies can be included to help meet these goals. Long-term support for those with severe or persistent mental illness is available through Canadian Mental Health Association or the ACT programs.	Harm reduction implies that it's not merely management of one problem (e.g. in way that a disease like diabetes would be treated) but takes the broader context into account and includes other behaviours that create harm in the lives of people. The approach is based on getting people to invest in the idea that their lives can be different. Reducing consumption of substances is a goal only if the client identifies it as such.
5. Services à la Communauté (CDC), Montréal	Varies by project. Most buildings have permanent staff but rely on community and public agencies for services such as health.	The focus is “empowerment” with an emphasis on the strengths and capacities of the person rather than the substances that they consume.
6. Chambreclerc II, Montréal	A range of services is offered, some in the project itself (e.g. recreation activities, common meals) while others are part of the network of services in the downtown area (e.g. health services). Work is done on an individual level between staff and clients. Staff is present an average of 21 hours/day.	Approach is to have residents begin to recognize the impact of their consumption and help them to find ways to reduce the problems related to the consumption. Harm reduction is understood as: reduce consumption, change consumption habits (e.g. move away from hard drugs, safe disposal of used syringes) or ensure that there is not an increase in use. The process is understood to be a long-term project with likely relapses and difficulties.
U.S.		
7. Lyon Building, Seattle	Community support case management. Three components: Case management from referring provider agencies; on-site clinical support services; and a flexible residential program designed to promote housing success. Motivational interviewing is used to help tenants address their substance use issues. ¹⁵ 24 hour on-site staffing.	The goal is to help tenants reduce the harmful effects associated with substance use and foster a relationship where staff and tenants can work together to establish “therapeutic rapport” and develop strategies to reduce substance use. Staff deliver a consistent message to encourage tenants to make changes in their lives to reduce their use of substances, move to less harmful substances, or enter treatment. One of the staff mottos is “persistence rather than insistence.”

¹⁵ This approach is designed to help tenants address their ambivalence and explore options for changing their behaviours regarding substance use.

Project	Model of service delivery	Harm reduction approach and substance use
8. Supportive Housing and Managed Care Pilot (SHMCP), Minneapolis	<p>Case management. Services are flexible, creative and depend on each participant's goals. One provider team uses a modified version of ACT. Some provider teams hire staff from a variety of disciplines e.g. nursing, social work, psychology, or will assign staff as experts in a particular area, such as substance use, mental health or harm reduction.</p> <p>Depending on the individual or family, staff use techniques such as stages of change¹⁶ and motivational interviewing to engage participants to reduce harm in their lives.</p>	Participants are always encouraged to cut down on their use. Substance use is never condoned, but providers are sensitive to how difficult addiction is and how it is often intertwined with participants' mental and emotional health. Providers work closely with participants to make sure they understand how their use is harmful, not only to their health, but how it may impact their family, friendships, housing, and employment.
9. Anishnabe Wakiagun, Minneapolis	A case manager focuses largely on health and medical issues. Helps clients access the most appropriate services. Aspects of the program and services are specifically designed to reflect the values of Aboriginal people. Two staff are on duty at all times—24 hours/day.	Wakiagun residents may drink in their own rooms, but may not drink in any of the building's public spaces or outside on the grounds, and they are not permitted to drink with friends who come to visit. The use of drugs in the building can result in immediate discharge and Wakiagun does not permit possession, use or distribution of illegal drugs.
10. Pathways to Housing, New York	ACT team, made up of social workers, nurses, psychiatrists, and vocational and substance abuse counsellors who are available seven days a week, 24 hours/day. Clients can choose the frequency and type of services they receive. Team also includes a housing specialist to coordinate housing services. Housing and treatment are closely linked but separate. Clients may accept housing and refuse clinical services.	No requirement of sobriety or psychiatric treatment is imposed on clients, but support is offered by ACT teams. Relapses are normal and should be expected.

16 Stages of change are, "(F)undamental stages through which individuals typically progress when making behavioral changes: precontemplation, contemplation, action, and maintenance of change." <http://vhaaidsinfo.cio.med.va.gov/aidsctr/safer-sex/ss16.htm>

Project	Model of service delivery	Harm reduction approach and substance use
United Kingdom projects		
11. Heavy Drinkers Project, Manchester	The focus is on providing support to develop life skills, address alcohol issues, and discuss needs and aspirations. Staff act as coordinators for other services and are on site 24 hours/day. Work is also undertaken on supporting residents to access statutory services	Demands are not made for residents to stop or reduce their alcohol use. Instead residents are supported to address issues such as housing, health, social networks, family, and occupation. Residents are encouraged to look at the impact of alcohol use, move to other less harmful types of alcohol and, over time, reduce consumption.
12. In Partnership Project, Manchester	One-to-one or group work sessions. Services delivered by staff or external partners. The framework for support is the Structured Day Program that is tailor-made for each resident.	Approach is to help the residents move to safer use of substances (e.g. clean needles). The focus is not on rehabilitation and detox, but more on getting the women ready for this, if they desire.
Planned project		
13. Situation Appropriate Supportive Housing (SASH), Halifax	Plan to use case management approach where each resident will be assigned to one staff person as their primary contact and case manager. The strategy will focus on integrating health care and social service resources and doing “what works” at a particular time with a particular individual. As with its other buildings, MNPHA also plans to implement a community development approach. The goal is to have three staff on duty at all times—24 hours/day.	Plans to “accept people where they are at,” and to provide housing with very few demands. There will be no expectations that residents participate in recovery programs or take their medications if they don’t want to. MNPHA hopes that residents will want to engage in these activities, but will not require them to do so.

Table 4 shows the different ways in which services are provided to clients. While the level of intensity may vary, each program is similar, in that they are flexible and geared to focus on the needs of each individual client.

Findings from the case studies

Introduction to the findings

The 12 case studies of programs that are operating were examined to identify common elements, which have been organized into three topics:

- How and why harm reduction
- Putting harm reduction into practice—supports and services
- Housing

While the approaches stemming from adoption of harm reduction result in many common features in the projects, more differences emerge when housing is examined—based on whether the housing is permanent or not and whether the units are in a dedicated building or integrated within other buildings (e.g. scattered sites). The two components—a harm reduction approach and the type of housing offered—can be intertwined and housing can have an impact in the way that harm reduction is implemented.

It is important to note that most of the projects are relatively new—most are less than 15 years old, two are pilot projects, and four have been operational five years or less (although in a number of cases, for example, Chambreclerc and the Princess Rooms, they grew out of organizations that are much older). In many respects the projects illustrate the willingness, if not the necessity, to move beyond the traditional solutions for this client group—a cycle of street and shelters, with intermittent stops in hospitals, detox or rehabilitation services, and prisons.

Although the projects are relatively new, the key informants were able to provide us with information on how the projects impact on the lives of residents and what they felt were the reasons for

success. This information is provided following the presentation on the three main topic areas.

How and why harm reduction

The case studies and the adoption of a harm reduction approach

A number of case studies did not initially identify themselves as harm reduction (e.g. Anishnabe Wakiagun and the Lyon Building) although all the projects came to this approach based on pragmatism. For example, Anishnabe Wakiagun in Minneapolis, which serves a clientele that is almost exclusively American Indian, resulted from the observation of a high detox recidivism rate—half of the people who had been in detox more than 20 times were American Indians. A Task Force set up in the early 1990s to look at the issue of housing and homelessness for this group concluded that their needs were not being served and that the objective of the project should be to bring people off the street into a safe and monitored environment. Anishnabe Wakiagun has incorporated these observations into their eligibility criteria and, to be accepted into the program, a person must have 20 or more admissions to detox in the last three years or two or more attempts at chemical dependency treatment.

In Vancouver, Triage, the sponsoring agency of the Princess Rooms, had come to understand that their target population were active users. Similarly in Montréal, the Board of Directors of the first Chambreclerc project had worked with the clientele for years and knew that abstinence was not a realistic goal and that a harm reduction approach would be more effective. The Heavy Drinkers Project in the U.K. came about with the recognition that ‘dry’ accommodation is not suitable for everyone and the acknowledgments

that some people would never be able to stop drinking. In Montréal, the work of Dollard-Cormier is seen as being rooted in a pragmatic approach with the client group the necessity for which was reinforced with the advent of HIV/AIDS.

Projects also came about with the observation that services were lacking or there were shortcomings in what was being offered. For example, Eva's Satellite, a youth shelter in Toronto, had noted that youth were not likely to stop using drugs and alcohol and the insistence that they do so was having negative impacts. The Downtown Emergency Service Center (DESC), which manages the Lyon Building in Seattle, deals with persons for whom treatment programs have not worked—those for whom treatment programs are effective do not need DESC.

Adopting a harm reduction approach also has minimized, if not eliminated, some of the secondary impacts of abstinence based projects. For example, Eva's Satellite noted that if youth were unable to abstain, they were unable to access housing, resulting in a return to the street and further harm. In Ottawa, the creation of OICHP reflected community concerns about chronically homeless persons who were in terrible health and often caught in a double bind: their health was getting worse in the shelter system and in many instances they were unable to leave shelters because of health problems.

Because the projects deal with a clientele that has often been turned away from other services, many are the last recourse available and a number, such as Anishnabe Wakiagun, clearly state that they are preventing deaths. The DESC in Seattle intervened with a shelter to begin with as they saw that as a "death prevention" strategy, while the Princess Rooms in Vancouver sees one of its impacts as helping people live longer.

Legal Issues

Key informants were asked about legal issues and problems they may have with the police. Very few indicated that this was a problem. In many cases the agency had made efforts to develop a working relationship with the police. For example, in Eva's Satellite, many of the youth have a history of police involvement. Conflict had arisen in the past between police who would come to the shelter wanting to question a particular youth while staff were responsible for protecting the confidentiality of their residents. A protocol, outlining how police are to proceed in such instances has been developed and has improved the relationship. In the U.K., the In Partnership Project works closely with the police, including having a senior officer involved with the agency at a policy level.

When the Lyon Building was planned, the director of the sponsoring agency, DESC met with the city's legal staff and the county prosecutor to explain the mandate, goals and harm reduction strategy. Support was expressed as long as there was no drug dealing and the project did not create problems in the community: there have been no problems to date.

In other instances, projects are seen as stabilizing influences; for example the building that now houses Chambreclerc was notorious for drugs and drug dealing but is now seen as an asset to the neighbourhood.

In some projects where clients live in scattered units that are owned by non-profit organisations or by private landlords, for example Services à la Communauté (CDC) and CMHA-Ottawa Branch, there is no specific control of drug use and clients have the same rules and obligations as all tenants.

However, projects can find themselves in a grey zone when it comes to drug acquisition. For example, clients at OICHP may have permission to consume marijuana for medical reasons, but because there are no pot-buying clubs in Ottawa, it remains illegal to acquire. Triage, while it has not experienced any particular legal conflicts has had to deal with drug dealers and drug activity around the building. Security measures have been put into place to address this issue.

The implementation of a harm reduction approach

The case studies reveal common features in the application of a harm reduction approach. Some of the variation is the result of the housing type that is offered but also can stem from the expectations placed on residents.

All the projects start with the understanding that the clients are consuming drugs or alcohol and the objectives of the projects are to help the clients find safer alternatives or eventually decide to reduce or stop using altogether. In Eva's Satellite, staff work with the youth to discuss harms associated with their substance use and to help them minimize these harms; in the Heavy Drinkers Project, there is support for residents to move from harmful types of alcohol such as very strong cider to lager; in the Alcohol Management Program, where OICHP clients can go, house wine is served every hour during the day to help people move away from more harmful, (e.g. non-beverage) alcohol. There is also recognition that some clients may never become abstinent.

One of the common features of the projects is a holistic view of the person—consumption of drugs and alcohol is situated in a broader context, seen as one aspect of the person—often the consequence of other problems and a coping mechanism. Staff at Services à la Communauté

of Centre Dollard-Cormier, for example, state that it is not harm reduction that is the focus but rather “empowerment” with an emphasis on the strengths and capacities of the person rather than the substances that they consume. Partnership in Manchester, which grew out of work with young women who were survivors of abuse and dealing with a range of problems, does not focus on the use of substances but rather substance use is viewed as a coping mechanism. OICHP, in defining success, embraces a “social inclusion” model whereby success is framed by the clients’ goals and social participation. This holistic view of the person has led to some common perspectives and the adoption of similar instruments and strategies in many projects.

Putting harm reduction into practice—supports and services

Situating the individual at the centre of the intervention

The projects not only see the persons in their entirety, but place the residents/clients at the centre of the intervention. The phrase that was perhaps used the most often in describing approaches, rules or expectations for participants was “case-by-case.” The issue of substance use is generally one that is dealt with from a starting point assumption that the person will continue to consume, but can be encouraged to move to less harmful substances. For example, with OICHP, reduction of consumption is a goal only if the client identifies it as such. In Anishnabe Wakiagun, residents who become abstinent are handled on a case-by-case basis—while they are not required to leave, it may be suggested that they look for other housing if they have been sober for a year or more (although often the persons

themselves will want to move away from an environment where most are consuming). Almost all the projects used a case-by-case approach for situations of conflict between residents, temporary absences, and in the eviction process. For example, situations of conflict between residents in the Princess Rooms in Vancouver are handled on a case-by-case basis and the focus is placed on identifying and addressing the underlying causes of the conflict. In CMHA-Ottawa Branch a meeting with residents having difficulties may be organized or the person causing the conflict may be met with individually.

Temporary absence is often also dealt with on a case-by-case basis. For example, with OICHP, if someone is in hospital the space is usually saved for them if there is a reasonable expectation that they will be coming back. This typifies the approach in many projects.

Because eviction is the measure of last resort, almost all of the projects approach its possibility on a case-by-case basis. While behaviour that endangered staff and residents was not tolerated, almost all tried to find means to resolve issues before persons were sent away. In Pathway to Housing in New York, for example, outreach workers will intervene if there is a threat of eviction. CMHA - Ottawa Branch, like Pathways, has a role of mediating between landlords and tenants and avoiding eviction of their clients. Anishnabe Wakiagun, confronted with a situation that may lead to eviction (e.g. victimization), will have staff intervene to counsel about the consequences of residents' behaviour.

Importance of relationships between staff and clients

Nine of the case study agencies discussed the importance of creating *relationships* with their

clients. At the Princess Rooms, Triage has stated that its primary goal, and the foundation of its work, is to establish an open, non-judgmental relationship with each tenant. They believe that these relationships help to provide hope, optimism and real opportunities for recovery and moving beyond homelessness. The Lyon Building also believes that successful relationships between tenants and social service providers are crucial to long-term housing success. They have learned that clients accept a relationship with people they trust, but do not accept people telling them how to live their lives. At the Supportive Housing and Managed Care Pilot (SHMCP), Hearth Connection, the project sponsor, also believes that building a relationship of trust is essential to the effectiveness of case management and the pilot. One of the primary responsibilities of staff is to build healthy, trusting relationships with participants so that participants are comfortable sharing the intimate parts of their lives. This level of intimacy is seen as critical for service providers to be able to help participants face challenges, meet their goals, and learn how to advocate for themselves. SHMCP believes the participant's relationship with the provider is the linchpin of effective service delivery.

Case study agencies also pointed out the importance of flexibility and tolerance when dealing with clients, and that honest and open dialogue facilitates efforts to change behaviour. Good listening skills are also valued. At Anishnabe Wakiagun, all staff, including cooks and front desk staff, are trained to listen to residents describe their needs. They believe the most effective staff are good listeners who can make non-judgmental comments. Anishnabe Wakiagun cites their philosophy of service provision, which relies on treating residents with respect and building relationships between staff and residents, as one of the reasons why their

program has been successful.

The importance of treating clients with respect was also raised by staff at Eva's Satellite and Chambreclerc. As stated by the key informant at Chambreclerc, "The importance of a stable home, where people are treated with respect has an impact on residents. They no longer function in "survival mode" and begin to take control of their lives. They also have a sense of belonging and confidence in themselves."

On the other hand, it has been noted that sometimes it can be difficult for staff to achieve a balance between a close relationship and one that is professional. The key informant at In Partnership pointed out that staff have to work hard to maintain strictly professional relationships with the women. The relationships are very close and very tactile, with lots of hugging and comforting of residents. The Association has a set of guidelines which staff must follow so they do not get over-involved and are thus able to offer a fair service to all service users, but this is an area with which staff struggle.

Motivational interviewing

Many projects (e.g. CMHA-Ottawa Branch) use "motivational interviewing" to help clients see the impact of their use (i.e. defined as "a client centred approach that strategically directs clients to examine, explore, and resolve the ambivalence they have about their behaviour..."¹⁷). For example, in the Lyon Building the work is based on what the individual wants and staff present options and opportunities, while accepting that the decision belongs to the tenant. Staff at the Princess Rooms work with residents to enhance their motivation to participate in treatment, link with services, or make changes in their lives as

they choose. The staff believe that motivational interviewing can help avoid two traps: the trap of "anything goes" passivity that can creep into harm reduction programs, and the trap of service providers setting an implicit abstinence agenda for their client. While other projects did not use the term motivational interviewing, this was the de facto approach. For example, residents in the Heavy Drinkers Project are encouraged to look at the impact of alcohol use in their lives. At the OICHP the focus is having the client identify what things are creating harm and preventing them from living their lives as they wish, and then working on those issues.

Goal-setting and individual plans

One of the tools that was frequently used by projects was setting an individual plan. OICHP sets goals with clients and these can be very basic at the beginning, for example sleeping in a bed at night, showering periodically, eating, and not hurting others. Three goals are set on a weekly basis—one is always something that the client is already doing (e.g. getting up before noon, going down for one meal a day). Once there is success in meeting the goals for one week, the client gets into a pattern and the positive achievements are reinforced.

Other projects also used individualized plans. For example, staff from In Partnership in Manchester draw up a support plan with the resident that is basically a lifestyle plan, focusing on what is important to the resident rather than what the staff sees as important. It is recognized that the process can be slow and, as at OICHP, basic issues (e.g. sleep on a bed rather than on the floor) may need to be addressed initially. Small goals are set at the beginning (e.g. taking medication, getting a General Practitioner (GP)) and the women then move onto other goals (e.g. learning to cook).

17 See the Supportive Housing and Managed Care Pilot (SHMCP) case study in Appendix A.

There also could be variation in when the plan might begin (e.g., at the CMHA-Ottawa Branch this can occur when the client is still in the shelter situation) and in the content of the plan (e.g., the Heavy Drinkers Project encourages residents to agree to a drinking plan).

Minimal expectations

Most projects have minimal expectations of their residents. For example, Pathways to Housing has two requirements: people are expected to pay 30 per cent of their income on rent and to meet with a worker twice a month. Often some kind of regular contact with workers is expected but there seems to be flexibility around this requirement. For example, while the Heavy Drinkers Project expects residents to meet a support worker weekly, there is flexibility as long as meetings are held on a regular basis.

Residents of the Princess Rooms in Vancouver are not required to participate in any program or activity as a condition of their housing although staff do work with residents to enhance their motivation to participate in substance use or mental health treatment, take medications, link with other community services, or make other changes to their lives that they choose. In a similar fashion, Eva's residents are not forced to participate in programs: they can meet with caseworkers when they are ready and while the staff encourage the youth to take their medication they are not forced to do so. In fact, none of the projects, which often have a significant proportion of clients with mental health problems, require that residents take medication, although residents often are strongly encouraged to do so. For example, Chambreclerc in Montréal will try to meet with the client and discuss the possible consequences of not taking medication. Similarly, in Anishnabe Wakiagun if residents refuse to take their medication, staff will attempt to help

the residents understand the potential consequences and encourage them to take appropriate action.

Part of the process in which the projects engage residents revolve around building trust. For example, the Lyon Building staff see their work as “alliance building,” accepting that people will make their own decisions and will not believe the “wisdom” of the staff from the onset, but staff don't give up either. The approach is summarised in a staff motto: “persistence rather than insistence.” The harm reduction approach is seen as acknowledging that not everyone is ready or able to abstain from risky behaviours and that participants are more willing to trust their primary providers and open up about their lives over time.

Encouragement of other activities

Some projects put emphasis on clients undertaking activities or engaging with community organizations. For example, OICHP has found that social isolation contributes to the harm from substance use and because many are less welcome in the “regular world” they will spend more time with other addicts, on the streets, and lose social supports. Chambreclerc encourages residents to find support in the wider community as a way of encouraging social reinsertion.

In Services à la Communauté (CDC), which is rooted in community organizing and a collective response to social problems, clients are encouraged to participate and find their “voice.” The development of the newest project in which Services à la Communauté (CDC) was involved, Brin d'Elles, had potential residents involved in development and planning and many spoke of being “transformed” and “rediscovering that I exist and I'm still useful” through this process. Before construction, Anishnabe Wakiagun

consulted with people on the streets and held focus groups on the design of the building, wanting homeless persons to feel that they were active participants in the facility's development.

CMHA-Ottawa Branch has found that the scattered condo units have been especially successful and facilitate integration into the community by residents. (The issue of scattered units is discussed in the next section on housing.)

Rules

While emphasis is placed on a case-by-case approach and on flexibility, one area that seems to generate rules is that of guests—primarily, but not exclusively, in dedicated buildings. For example, at the Princess Rooms, only immediate family are allowed in the building, whereas Anishnabe Wakiagun has a maximum of two guests at specified times and guests who are seen as inappropriate or potentially dangerous can be refused entry.

Some projects have instituted rules about guests to protect the residents themselves. SHMCP has found that guests can be a significant problem since once a formerly homeless person is housed, their friends who may still be homeless will want to stay with them or the resident themselves, having found stability, may wish to “give back.” Having rules helps residents say “no.” Similarly at Chambreclerc, while there are no rules about having guests, vulnerable residents can use this as an excuse to refuse people they may not wish to receive or drug dealers who may be harassing them. At Pathways, participants have full control over their units, but because some can find themselves vulnerable to the influence of others, outreach workers will coach them on how to say “no”—even use Pathways program “rules” as an excuse to refuse guests.

In Partnership does not permit males on the site because prostitution is an issue for many of the women and they welcome being free from this in their home. Some of the housing provided to Services à la Communauté (CDC) clients has similar rules about women having clients come to their room or apartment, while other housing is in projects that do not disallow this as long as other tenants are not disturbed.

Another area where rules are imposed is that of consumption in common areas and sharing with guests. For example, residents in Anishnabe Wakiagun, Chambreclerc, the Lyon Building, and in Princess Rooms can all consume in their private spaces but not in common areas, whereas this is permitted in the Heavy Drinkers Project. In Chambreclerc and in the Heavy Drinkers Project residents are not permitted to consume with visitors either in private or in common areas.

The idea of forever or unconditional acceptance

A number of projects make explicit that they will never give up on a person. The Princess Rooms, for example, states that it has unconditional acceptance of residents' choices regarding substance use and high-risk behaviour. People evicted from Anishnabe Wakiagun can return at a later date, if they can present a good case for being allowed to do so.

At OICHP people are never told that this is their last chance because the program is one of last resort. They may be told that the program cannot provide services to them but that if the situation changes they can re-apply for admission. If they are asked to leave, this is often for a short period of time and is perceived more as “taking a break” rather than being barred. No one is barred but rather the term used is “relegated” and this is

never framed as punishment for, according to the Executive Director, “Sometimes the people in the greatest need are the most difficult.”

At Pathways the clients are promised that “we will house you forever” no matter what happens to them; even if they are put into prison or hospital they will be at the “top of the list” for housing.

Honesty and harm reduction

An important consequence of adopting a harm reduction approach is that clients are honest about use since they know that they will not be turned away because of it, permitting staff to deal with clients in an informed manner. In Partnership has found that the honesty from the women who do not worry about losing their accommodation because of drug use allows them to address issues. The Princess Rooms came to a harm reduction approach having noted that an overt agenda (i.e., abstinence) or a subtle expectation (e.g., An unwelcoming attitude and reluctance to fully engage with the user), impeded effective relationships and creation of useful service plans. The harm reduction approach has allowed them to build more honest relationships with their clients, and develop plans that clients want and are motivated to implement.

OICHP found the initial reaction of clients was disbelief that they would not eventually be turned away because of substance use. Clients’ experience had been that service providers would encourage them to be open about substance use and then exclude them for this. It took time for clients to trust the staff and the approach. Honesty about substance use at the Lyon Building allows staff to establish a “therapeutic rapport” with residents and develop strategies to reduce substance use.

Housing

Housing types

Agencies provided housing to their clients in a variety of ways. The majority of the projects are permanent housing, but not all of this is provided directly by the agencies. In some cases the agency has entered into agreements with non-profit housing providers, while others deal with housing in the private sector. What is distinctive about these arrangements is that the service providers spent time developing relationships with landlords to secure housing for their clients, and there is an expectation that if landlords experience a problem with a tenant they will contact the service agency to try to resolve the problem. The goal and expectation is that the landlords and service agencies will work together to help the tenants maintain their housing—rather than proceeding immediately with an eviction.

The case studies reveal a number of issues that are at the heart of approaches to dealing with persons who are hard to house, who have mental illnesses and/or who abuse substances. In some instances these issues are also at the core of current debates about best practices for dealing with homelessness itself—notably the use of dedicated buildings versus scattered sites and the “housing first” approach.

Housing choices

In a number of cases the organization, in working with its client group, came to the realization that housing was a major issue and consequently the organization would need to become involved in finding solutions. This is the case with OICHP that started with a focus on health issues but realised with time that more than health issues needed to be addressed—housing was the biggest issue.

CMHA-Ottawa Branch through its work with its clients found itself having to intervene because private landlords did not want to rent to this group—due to past history, because they did not present well in interviews, and because they might need help if they ran into difficulties. CMHA then began to intervene through arrangements made with both non-profit and private sector landlords.

Organizations also came to the realization that once housing issues were resolved the client could then move onto other issues. For example, SHMCP considers it easier and more beneficial to focus on root causes of harmful and risky behaviours when participants are housed than when they are on the street or in a shelter and struggling to survive. In the Lyon Building, it is expected that once tenants secure stable housing they can start to address other issues in their lives that may have led to housing instability in the past.

Part of the model developed by Pathways stemmed from the observation and feedback from homeless persons who did not want to live with others who also had mental illnesses: they preferred to live in housing and get treatment rather than living in treatment. Most wanted to live in their own apartments rather than in congregate settings.

The Princess Rooms also have a client group that is considered too hard to house by most supportive housing providers and private landlords. With the demonstration project, it is hoped to help individuals become more stable and “housing ready” for permanent housing. Other projects

such as Anishnabe Wakiagun, Chambreclerc, In Partnership, and the Lyon Building have been built or renovated specifically to meet the needs of the clientele that the organizations serve.

“Housing First”

Several case studies have adopted a “housing first” approach in providing housing for their clients.¹⁸ This term involves the direct provision of permanent and independent housing to people who are homeless. It is important to note that while the term is American in origin, Canadian projects have been using this approach for as long, if not longer, than agencies in the U.S. The housing is viewed primarily as a place to live, not to receive treatment. Central to this idea is that clients will receive whatever individual services and assistance they need and want to maintain their housing choice. Proponents of this model emphasize that it facilitates normal community roles, social integration, and increased independence and control for the client.

This contrasts with the “continuum of care” model. As described in the literature review (Appendix C), the decades of experience with the “continuum of care” model have shown that there are difficulties in engaging certain individuals (notably those with concurrent disorders¹⁹) in services; the inherent necessity that people change housing as they “progress” is stressful and can be counterproductive; many of the settings have institutional qualities; client choice or preference is ignored; skills learned for successful functioning at one type of residential setting are not necessarily transferable to other living situations; reaching the final step on the continuum (i.e. independent housing) can take

18 Canadian Mental Health Association, Ottawa, Lyon Building, Supportive Housing and Managed Care Pilot, and Pathways to Housing.

19 Concurrent disorders refers to the “combination of mental/emotional/psychiatric problems with the abuse of alcohol and/or other psychoactive drugs” (Health Canada, Centre for Addiction and Mental Health. 2002. *Best Practices. Concurrent Mental Health and Substance Use Disorders*. Ottawa: Health Canada).

a substantial amount of time; time limits for the various stages can seem arbitrary; and housing can be denied because people refuse treatment. One of the most visible “housing first” projects for individuals with mental illness and substance use disorders is Pathways in New York City. The director, in his outreach work with chronically homeless people with mental illness kept on hearing them asking for the same thing—a place to live. While specialized housing was being built, people resisted moving in because they did not want to live with others who also had mental illnesses and they wanted their own apartments. Furthermore, research in psychiatric rehabilitation indicated that the most effective place to teach skills required for a particular environment was in the actual setting. The project was set up based on the belief that if people with psychiatric symptoms can survive on the street, they can manage their own apartments and a strong belief that housing is a basic right. Finally, the “housing first” approach is considered by Pathways to be compatible with harm reduction—events such as relapses or consumption/abstinence have an impact on the whole community in congregate settings, making it harder for an individual to follow their own path and rhythm.

An almost parallel process occurred in Ottawa with CMHA. A manager working at CMHA was particularly inspired by an approach advocated by Paul Carling, from the Centre for Community Change International in Vermont, which proposed that people should be housed without any assessment of whether they were “ready” or not. Client surveys undertaken by CMHA during this period reinforced this vision: when asked what they wanted, most clients stated that it was independent living in an anonymous, non-stigmatized setting—not in a designated building. CMHA maintains that the best place for clients to learn to live in permanent, independent units is in such a setting.

In a similar way, SHMCP in Minneapolis, which also has a “housing first” approach believes that you cannot determine housing readiness until the individual is actually assessed in housing and has a chance to live independently. A “housing first” approach was adopted because they were unable to establish adequate criteria about who is “housing ready” and because in some cases moving people out of shelters and off the street became essential to the individual’s health and safety.

The projects that offer permanent housing, even if they do not call themselves “housing first,” are de facto such, since they all take individuals who have often been refused housing elsewhere (both in the private and non-profit sector), are often living in shelters or on the street, and find themselves having to slowly help individuals stabilize in their housing situation.

Dedicated and scattered site

Three projects offer housing in scattered sites: Pathways, CMHA, and SHMCP. While Services à la Communauté (CDC) and OICHP clients live in various housing projects, most are dedicated buildings operated by non-profit housing organizations. Pathways works with private sector landlords and does not rent more than 10–15 per cent of the units in any one building. The two models of housing provision (i.e. dedicated buildings and scattered sites) are briefly examined in this section in an attempt to tease out differences and potential benefits and disadvantages of each. Other issues that are related were discussed above, primarily in the section about rules. Many of the rules about consumption in common areas and about guests are applied in dedicated buildings. Such rules are not concerned with the need to control the behaviour of the individuals themselves but are concerned about the impact that such behaviours can have on others with whom they share the space.

Abstinence

A few projects found that the compatibility of residents who continue to consume and those who become abstinent can become an issue. In Partnership found that abstinence was difficult since the women are then surrounded by others who are using. In Services à la Communauté (CDC), a situation arose in one of the partner buildings where a certain number of residents became abstinent and became intolerant of others who continued to consume, which developed into a crisis that eventually embroiled the management and board.

Separation of housing and services

The ability to separate housing from support services is to some extent an outgrowth of the two models of housing provision—dedicated buildings and scattered sites. In Pathways, while housing and treatment are closely linked, they are considered separate and clients may accept housing and refuse clinical services without impact on their housing. At SHMCP, services are not linked to housing either. A person may move from housing and still continue to be served. It should be noted, however, that this approach is not related exclusively to scattered site projects, but is incorporated in many of the other projects (e.g., Services à la Communauté (CDC), OICHP). The Lyon Building, however takes a different perspective on this, preferring an integrated approach whereby staff have dual responsibility for delivery of services and property management. They want all staff to get to know the tenants as well as possible and develop effective approaches to working with them, feeling that this gives them a better sense of residents' situations and needs.

NIMBY

In a literature review in 1998, Novac and Quance found that “[t]he development of separate or special housing is more likely to meet with community resistance and less likely to facilitate resident participation in community life than integrated and conventional housing” and that this “stigma may serve to exclude residents from the regular social exchanges that occur among community residents.”²⁰

In a number of projects, NIMBY did appear to be an issue. For example, Anishnabe Wakiagun attributes a one-and-a-half to two-year delay in development of the facility because of problems with the neighbourhood, although once it was operational, objections diminished. Eva's, currently in the process of relocating the shelter, is confronting resistance from neighbours. The Lyon Building also has confronted difficulties with a neighbour who objected to clients loitering on the sidewalks in an alley and around the building. However, both the Lyon Building and In Partnership averted much potential negative reaction from neighbours by undertaking outreach activities, such as meetings and letters to local community residents.

Social isolation and social integration

While not explicitly discussed in the context of the case studies, in two instances these issues were touched upon. Pathways found that many of their clients do not know how to use their days when they move into their own independent apartment: organising social activities for them (e.g. movies, outings) becomes important. On the other hand, CMHA's experience with the purchase of 22 scattered condo units was reported to be highly successful with the advantage of not concentrating the clientele in one building, making integration into the community much easier.

20 Novac, Sylvia and Mary Anne Quance 1998 *Back to Community: An Assessment of Supportive Housing in Toronto, Report of the Mayor's Homelessness Action Task Force*, Background Papers Volume I, Toronto

The impact on residents' lives

Case studies varied greatly in terms of data on outcomes, evaluations, and assessment of impact. In some cases, the projects were too recent to draw solid conclusions about impact. However, all key informants did note that clients had undergone some changes since becoming involved in the project. The most frequent changes noted were around housing stabilization, substance use, physical and mental health and other changes, such as increased income. These changes are especially interesting, given how little demand is placed on clients to engage in programs or transform themselves, perhaps confirming the position expressed by a Pathways key informant, that “giving clients the treatment that they want may allow them to select treatment they need.”

Definitions of success

For many, if not most of the projects, one measure of success was housing stabilization. For example, Anishnabe Wakiagun defines success as having the tenant remain housed and not going back onto the street, while SHMCP defines success as stabilizing participants in decent affordable housing but also includes improvement to mental and physical health as well as general well-being and a reduction in substance use. DESC measures success for the Lyon Building by the length of time tenants remain housed, particularly when compared to their tenants' histories prior to moving into the Lyon Building. Services à la Communauté (CDC) looks for greater housing stability, changes to physical and mental health, but also seeks to have residents develop a sense of belonging and social involvement—to begin to see that they are not alone but that others share the same difficulties.

In Partnership acknowledges that the definition of success is different for each woman—for some this may be to go into detox or rehabilitation for others success is just to stay alive. Similarly OICHP sees the definition of success as a moving target. Initially the focus was providing health care that was comparable to the Canadian standard at an accessible cost (achieved during the pilot phase) and it has now evolved to a “social inclusion” model whereby success is defined by the clients' goals, social participation and with emphasis on much broader outcomes. At the same time, OICHP recognizes that the changes to clients' lives can be incremental and the long-term goal is getting clients back into “the mainstream.”

Impact on housing stabilization

A number of projects have monitored and produced data that evaluates the impact of their project on housing stabilization. Pathways has undertaken some of the most extensive research, including a two-year study that randomly assigned participants either to Pathways or to “continuum of care” programs. This study found that persons assigned to Pathways were housed earlier and spent more time stably housed. Research also has demonstrated that Pathways has a retention rate of clients between 80 to 88 per cent. Between 1993 and 1997, for example, 88 per cent of clients remained in their housing, compared to 47 per cent of those who went through the New York City treatment system.

SHMCP, since it is a pilot project, was evaluated in years two and three. The evaluations reveal that 66 per cent of single adults have stayed in their housing, while the proportion for families is higher, at 70 per cent. Families also are beginning to exit the program because they don't need the services anymore (although this does not

necessarily mean that they leave the housing). CMHA is currently completing an evaluation and preliminary results indicate stabilization of the housing situation for the vast majority of their clients.

Other projects monitor length of stay. For example, almost half (48 per cent) of the residents of the Heavy Drinkers Project have been there for more than two years, with an additional 14 per cent living there between one and two years. In the Lyon Building the average length of stay is three years and over 35 per cent have stayed four years or longer. Of those who have moved out, more than 60 per cent went to an adequate housing situation.

Other projects have noted the impact of housing stabilization. For example In Partnership has found that living in stable accommodation for more than a few weeks at a time has a major impact on residents' lives, allowing them to access other services and improve their health and well-being. Chambreclerc notes that a stable home where people are treated with respect has an impact on residents and that no longer functioning in "survival mode" enables residents to begin to take control of their lives and to get a sense of belonging and confidence in themselves.

Impact on substance use

The harm reduction model does not intend to end substance abuse but rather reduce the harm that stems from use or encourage people to consume less harmful substances. As OICHP noted, reducing consumption of substances is a goal only if the client identifies it as such and many clients do not initially regard consumption as a problem. Instead the focus is having the client identify what things are creating harm and preventing them from living their lives as

they wish. Nonetheless, a survey of OICHP clients undertaken in 2002, found that 78 per cent reported reduction in substance use as a result of participation in the program.

Case study agencies often monitor or note substance use of residents. Key informants to this study have observed an impact of their interventions on substance use by residents. For example, studies have revealed no differences in substance use between Pathways clients and those in traditional continuum services while preliminary results of the CMHA evaluation seems to indicate that clients reduce substance use. SHMCP has found that the project has led to participants becoming more willing to discuss their use and look at alternatives.

Other projects have noted a reduction in consumption (e.g., Chambreclerc and In Partnership), more controlled use (e.g., Services à la Communauté (CDC)), decrease in the severity of the impact of use (e.g., Lyon Building), safer use (e.g., In Partnership and Eva's Satellite) or reduced risk behaviours (e.g., OICHP). A number have also noted that residents participate in minimisation programs. For example, 83 per cent of residents in the Heavy Drinkers Project are currently taking part in harm minimization programs (i.e., structured support to reduce drinking or minimize harm). About 10 per cent of the residents left the Princess Rooms to enter a substance use recovery program.

Impact on physical health

Health was an area where there appears to be major improvements. OICHP for example, indicated that for 113 clients (January to March 2004), 95 complied with recommended medical care; 90 attended to their own personal health needs; and 103 made appropriate use of health care resources. Furthermore, 91 had successful treatment for the condition for which they

were admitted; 96 had primary health care needs and screening for infectious diseases addressed; and 96 established a relationship with health care providers needed to address their health needs on an ongoing basis. In a 2002 survey of clients, 100 per cent agreed or strongly agreed with the statement “My health has improved since becoming a client of the Ottawa Inner City Health Project,” including clients in the Hospice setting who reported feeling better as their needs for housing, food, health care and pain management were addressed.

A number of projects found that clients became less prone to use more expensive medical services. For example, a 2003 report on Anishnabe Wakiagun found that while the decline in the number of emergency room visits was not significant there was a significant decline in median medical costs due to residents having medical conditions requiring less expensive care. Anishnabe Wakiagun residents were reported to keep themselves cleaner than when they lived on the street and they usually gained weight. Similarly, persons assigned to Pathways spent fewer days hospitalized over the 24-month period. An evaluation of SHMCP, on the other hand, found increased use of primary care doctors, dentists and psychologists, whereas in the past participants had received all their medical care from emergency rooms for routine medical care.

Regular attention to physical health, teeth and eyes has been noted as an impact by Chambréclerc while the Princess Rooms found that links with physical health services increased 25 per cent.

Improved health was very noticeable and one of the major changes for In Partnership residents: the women get rid of infections and infestations, eat better, their skin improves, and they deal with sexual health issues in part through a sexually transmitted infections clinic available on site. Services à la Communauté (CDC) attributes improvement

in health to residential stability: people eat regularly and get sleep. Furthermore, reduced consumption often leads to increased income and better nutrition. However, stabilization also can lead to the emergence of health problems that may have been neglected in the past.

Impact on mental health

As in physical health, stabilization of the housing situation and the support of the projects seem to have a positive impact on mental health. For example, SHMCP found that participants are more likely to now have regular psychiatric appointments and that about 30 per cent are on medication administered by staff and 12 per cent set up their medications while staff observe the self-administration of their medications.

Chambréclerc notes an improvement in mental health, including fewer hospital stays and those that occur are shorter. This is due in part to residents taking their medication, but also to a better understanding of their illness. Three-quarters of the residents of the Lyon building have been found to reduce their use of crisis services within six months after moving into the building while Princess Rooms, in comparing the use of services at intake with current usages, found an increase of seven per cent in the links with mental health services.

On the other hand, Anishnabe Wakiagun has found that mental health issues of some residents become more apparent once they are stabilized and help is available in the facility.

In Partnership found that many of the mental health problems are situational (e.g., depression or stress) and that stabilizing the housing situation helps to a large extent as does having a better diet and access to a GP (i.e., who can then prescribe anti-depressants).

Other impacts

Key informants were asked about other changes in the lives of their residents. Many noted improved income, due to access to income support programs (e.g., Anishnabe Wakiagun, In Partnership, Lyon Building, Princess Rooms) as well as because of reduced consumption (e.g., Services à la Communauté (CDC), In Partnership). In some instances, residents have participated in employment training (e.g., SHMCP with 15 per cent of participants enrolled in some type of school and In Partnership where some residents have gone on to college) although some projects noted that employment could be difficult for some because of age, abilities, instability, and police records (e.g., Services à la Communauté (CDC), In Partnership). One of the challenges raised by In Partnership was that many of the young women earn so much as street workers that it is hard to have them accept much lower incomes from other employment. They also found that needing to consume several times a day was incompatible with holding down a job.

Some residents were able to develop social networks or re-establish contact with family. For example, in SHMCP a number of participants who did not have regular visits with their children before enrolling in the program did so now, while others have reconnected with siblings or family. Anecdotal evidence of CMHA residents points to family reconnection, including parents gaining access or custody of children because they are now housed. However, for residents of In Partnership, family reconnection can be a problem for women who have lived through incest but some current residents visit parents over weekends and younger residents have moved back with their parents.

Other impacts included residents taking control of their lives and developing a sense of belonging and confidence in themselves (Chambreclerc). Similarly, when asked, more than three quarters (77 per cent) of tenants of the Lyon Building reported feeling more in control of their own lives since moving in to the project and an overwhelming majority (83 per cent) reported an overall improved quality of life compared to the past.

A survey of 15 residents in the Princess Rooms in 2003 found that most reported that their lives had changed for the better since moving into the project and included benefits such as “the will to live” and motivation to get on with life, carry on relationships, and further their education.

Reasons for success

Key informants from the case studies were asked what they thought were the most effective services that they provided. Almost all identified housing. For example Anishnabe Wakiagun, noted “A bed to sleep in, in a room where the resident can lock the door” while the Services à la Communauté (CDC) informant stated that housing was essential to provide minimal security for people to begin to reduce consumption and that it also was the basis of friendships, of knowing oneself, and of developing and becoming connected to networks. CMHA in Ottawa states that it is not just a matter of providing housing—but good quality housing.

Most projects also noted the harm reduction approach and the flexibility in dealing with residents. For example, SHMCP attributed its success to being participant-driven, flexible and the intensive case management that is based on a trusting and respectful relationship. Princess Rooms also attributes its success to their client-

centred model, which focuses on strengths, harm reduction, rehabilitation, motivation, and the development of relationships with their clients. The Heavy Drinkers project noted the importance of a flexible and individually tailored approach to each resident and incident, while In Partnership found that dealing with issues on a case-by-case basis and considering all aspects of the situation rather than adopting a system such as “three strikes and you are out” was an important factor in success.

Many projects mentioned the critical role of staff and the structure of support. For example CMHA noted the level of support that is provided—particularly availability in the evenings and on weekends as well as multidisciplinary services. Anishnabe Wakiagun found that the way in which staff has come to accept and practice its philosophy of service provision and treating residents with respect were important factors. Key informants for the Lyon Building believed that reasons for the success include 24/7 staffing by human service professionals who know the tenants and work with them and also the approach and attitude of respect and hopefulness of staff that attracts tenants to services that they did not at first desire.

Collaboration between agencies was important as well and noted by OICHP, SHMCP, In Partnership and the Lyon Building. Others noted stable funding and a size that does not engender an institutional atmosphere (Anishnabe Wakiagun), no time frame for support (SHMCP) and the support of housing providers including private landlords (SHMCP, CMHA). Both SHMCP and Services à la Communauté (CDC) noted resident involvement in community activities. For SHMCP, this was assisting participants in finding ways to give back to the community and connecting them with community groups and programs, while Services à la Communauté (CDC) found that giving clients the opportunity to participate at all levels and giving them a voice was critical to success. Chambreclerc noted the importance of social activities such as collective meals.

Finally, Pathways attributes part of its success to the fact that it’s simply a cheaper means to provide services; it is estimated that the cost of emergency hospital services, prisons, shelters and other services for people with mental illness and living on the street costs the government about \$40,500/person/year. The cost of Pathways is about \$22,000 a year—much of this already allotted through government benefits programs.

Interviews with residents/individuals using the programs

Participants' backgrounds

The researchers conducted face-to-face interviews with 33 individuals, three from each of the projects. Thirty of the participants were residents or individuals receiving services from the ten active projects where on-site interviews took place. Three additional interviews were conducted with individuals who had lived in a project that was subsequently not documented as a case study.²¹

Some participants lived in housing that was owned and operated by the case study agency, and also received services provided by these agencies.²² Others lived in housing owned and operated by private landlords or non-profit societies. Participants in this housing received support from the case study agencies. In fact, the case study agencies had helped the participants secure their housing and provided ongoing support to help them maintain it.²³ All the participants in the interviews had been homeless or living in very unstable housing situations prior to becoming involved in the program. Some had been homeless for a few years before becoming involved with the case study agency, and all had substance use issues, except for one who had a serious mental illness. Some participants also had mental health issues or physical health problems.

Current housing

The interviews demonstrate that the participants were able to be housed successfully as a result of the work by the case study agencies. About one-third of all the participants (12) had been housed for less than one year, but more than one-third (13) had been housed for two years or more. Ten of the 24 individuals in permanent housing had been in their housing for two years or more, and five of them had been housed for four to six years.

Most of the participants were satisfied with their housing. Twenty indicated that they were very satisfied and nine were satisfied. As one participant said, "At last I'm home." Another participant said, "It's the best thing that ever happened to me." Only four indicated that they were not satisfied.

Impact of housing/program

Most of the participants had made positive changes in their lives since becoming involved with the case study agency. For example:

- Most (23) reported that their health had improved; one participant commented that he can sleep with "both eyes shut."
- Most (23) reported that they were feeling better about life; "I feel good about myself. I look forward to another day and to years to come."

21 These were residents of the O'Neil Crack Cocaine Project, a former initiative of Seaton House in Toronto. It was decided to include the information from the interviews with the three former residents even though the project itself was not documented as a case study.

22 These include participants living in the Princess Rooms, Eva's Satellite, Seaton House, Chambréclerc, Lyon Building, Anishnabe Wakiagun and tenants renting condominium units owned by the Canadian Mental Health Association.

23 These include individuals receiving services from the Ottawa Inner City Health Project, Dollard Cormier, the Supportive Housing and Managed Care Pilot, Pathways to Housing and Canadian Mental Health Association (renting units from private landlords and non-profit housing societies).

- Most (22) reported that they were using less drugs or alcohol or had stopped using these substances altogether—18 were using less and four had stopped; “Today drugs are second, not first.”
- More than half (18) were in touch with members of their family
- Half the participants (17) talked about having friends

Most participants did not report positive changes in terms of their incomes. Seven said that they were better off. They had more disposable income because of a higher income or were paying less rent. Seven reported that their income was more “regular,” and seven said that their incomes had not changed. Four participants said that they had less income compared to a previous time in their lives when they were employed and another four participants noted that their incomes were not enough.

Activities

Many participants reported that their daily activities involved attending to their health, accessing services in the community and participating in programs offered by the case study agency. A few volunteered their time at community programs, and a few were employed on a part-time or temporary basis.

Factors responsible for changes

When asked about the factors most responsible for the changes in their lives, the most frequent responses were housing and support.

Ten participants commented that simply having a place to live had been responsible for the changes

in their lives.

Participants had a great deal to say about the nature of the support they received from the case study agencies. The quality of their relationships with agency staff seemed to be of the utmost importance. Several participants talked about the warm, close and personal relationships they had with staff or their case managers. Others talked about the program or case study agency as a whole. As one participant said, “This organization helped me connect with who I really am and the kid I used to be. They see me as a work in progress—from jail to school.” Another said, “Continue doing this kind of work—there are lots of young people who are sick on the street—they commit suicide.”

Prior experience with treatment programs

More than half the participants had been through a treatment program before becoming involved with the case study agency, but all were using again when they became involved with the case study agency. Six participants said that they found the treatment program helpful. Three participants who had gone to a treatment program had used the facility as a place to stay, or to “get out of the cold” rather than to receive treatment for their substance use. Another participant said he went to treatment, “but only if beaten up and he ended up in hospital or detox.” He wouldn’t go into treatment until he got hurt and needed a place to heal. Some who went to a treatment program said that they didn’t like it. Others said that they weren’t ready to give up drugs or stop drinking at the time.

Current drug use

Most participants (22) reported that they were using less drugs or alcohol or had stopped using these substances altogether—18 were using less and four had stopped. There seemed to be a correlation between how people felt and their drug use. One participant said he used drugs to make him feel happy. Others said that they were feeling better (because of the program) and therefore needed to use less drugs. And the less drugs they used, the better they felt. This finding seems to indicate that participants were feeling better as a result of their involvement with the case study agency, and this helped create the conditions necessary for them to be interested in reducing or stopping their drug use.

Goals for the future

Participants identified several goals when asked about the kind of changes, if any, they would like to see for themselves over the next year. Participants who were living in a shelter said that they wanted to get their own place. A few others also wanted to move. For example, one person who was sharing a bathroom and kitchen said she would like to have her own place “and then never move again.” Another said he wanted to move to a different area where people aren’t using drugs or alcohol. Other goals mentioned by participants included getting a job, going back to school, getting off or staying off drugs, improving their mental health and improving relationships with their families,

Participants’ recommendations

Participants were asked if they had any words of wisdom or advice for any other organization that might be interested in doing a similar project to

the one like their case study agency. They were also asked to provide more comments about what features of the program they thought should be different and what should definitely stay the same. In reviewing the comments, the following themes emerge about what is important to the participants.

Staff

Eighteen participants discussed what was important to them in terms of staffing. They valued staff who were friendly, caring, supportive, responsive, helpful, compassionate and patient. They appreciated staff who helped them with practical things and were responsive to addressing maintenance issues. They also appreciated staff who they felt cared about them. Participants appreciated being treated “like a person.” As one participant said, “the personal touch is so important.” Participants also want to be treated with respect. They appreciated staff who were non-judgmental and accepting.

Participants also identified a need for staff to be well-trained—to understand about the nature of mental illness, addictions, different kinds of drugs (and how they affect you). They also believed that staff should be knowledgeable about harm reduction. One participant said it was important to have staff who can “talk to you when you are coming down from crack because they know what they are doing.”

Participants also felt that experience is important. This includes experience working with the target population and also real-life experience. One participant said he feels much more comfortable talking with staff who have life experience similar to his—rather than “green college kids.” He wants to hear from a peer rather than someone who is “book smart.” Another participant also said he thinks it is good to have staff who went

through the abuse themselves. By being sober, they can show the residents it can be done. At the Anishanable Wakiagun projet in the U.S., participants said that for programs serving Native Americans, other Native Americans should be employed as staff who have first-hand knowlegde of the issues that residents have faced.

Participants also said that there should always be someone on call. They appreciated staff being available 24/7. Participants wanted staff to be available when needed and wanted.

Housing

Sixteen participants discussed what was important to them in terms of their housing. They identified a need for rents to be affordable and for housing to be located in quiet neighbourhoods away from drug dealing but accessible to public transportation, amenities and services. Privacy was identified as an issue. It was noted that sharing can be problematic—particularly sharing a bedroom or bathroom. On the other hand, two participants mentioned tendencies to isolation and one person acknowledged that maybe she needed other people around.

One participant expressed a preference for scattered sites. He didn't think people should be grouped together. Another expressed a preference for an apartment-like building where residents can bring guests. On the other hand, some participants liked the sense of community that can be achieved in dedicated projects.

A need was also identified for housing options for people who don't use alcohol and drugs. Some participants who had stopped using drugs and/or alcohol identified a need for housing options that were "away" from these influences. The quality of housing is also important. Participants would like buildings to be clean and well-maintained. A preference was expressed for smaller buildings (serving 20–25 people). One participant, who

had been shown two different apartments, said that she appreciated being given a choice.

Discussion

The interviews helped to illustrate that the people served by the case study agencies are individuals. They have different interests, goals, needs and preferences. At the same time, they have many things in common. They want to be treated with respect and want decent, affordable housing in a good location. Some participants were living in scattered site housing. The researchers do not know whether participants living in dedicated buildings would have preferred this approach, where there are no rules about guests and people with the same issues are not all grouped together in one place. On the other hand, some participants clearly enjoyed the sense of community in a dedicated building. They appreciated the opportunities to socialize, the community meals and the fact that help was right there if they needed it. A few participants identified tendencies towards isolation and loneliness, and while these issues could be addressed in scattered site housing, these individuals might be happier living in a dedicated building. The issues of social networks, social isolation and social integration require further research.

Conclusions

Answers to research questions

One of the goals of this study was to answer specific questions about the effectiveness of housing programs for homeless people who are dealing with substance use issues. The particular focus was on housing programs that incorporate a harm reduction approach in a supported living environment. The two outcomes of interest were housing stability and the role of housing in designing alternative treatment programs for substance use.

In response to the research questions, this report found that:

1. Based on a review of the literature and the programs profiled in this report, a harm reduction approach combined with supportive housing can be an effective way to address the needs of homeless people who are dealing with substance use issues.
2. The literature is clear that effective treatment for homeless people with substance use issues requires “comprehensive, highly integrated, and client-centred services, as well as stable housing.”²⁴ Housing is essential both during and following treatment. The literature review also found growing evidence that supported housing is essential regardless of treatment. In the programs profiled in this report, safe and secure housing was identified as a key factor that made it possible for residents/program participants to address their substance use issues and to become abstinent, reduce their substance use or reduce the negative impacts of their use.
3. The programs profiled in this report found that the participants had undergone a number of positive changes since they became involved. One of the most frequent changes noted was stable housing tenure. Using a harm reduction approach—which provided for flexibility and focusing on the individual needs of each client—was identified as a key factor for success.

Findings

The programs described in the case studies are effective in addressing the needs of people who are homeless and have substance use issues. All the agency key informants reported that their clients had undergone positive changes since becoming involved in the project. The most frequent changes noted were around housing stabilization, substance use, physical and mental health, and income. The agency key informants also reported that some of their clients were participating in employment training, while others had returned to school. In addition, some clients were able to develop social networks and/or re-establish contact with their families.

The information from the agencies is supported by the interviews with residents/program participants. Ten of the 24 individuals in permanent housing had been in their housing for two years or more. Five of them had been in their housing for four to six years. Most of the participants also reported better health, feeling better about life, and less substance use (four had stopped using altogether). More than half the participants were in touch with members of their family and half the participants talked about having friends.

²⁴ Kraybill, Ken, Suzanne Zerger and National Health Care for the Homeless Council. 2003. *Providing Treatment for Homeless People with Substance Use Disorders, Case Studies of Six Programs*. National Health Care for the Homeless Council. p. 16 Available online at: www.nhchc.org.

Many participants reported that their daily activities involved attending to their health, accessing services in the community and participating in programs offered by the case study agency. A few volunteered their time at community programs and a few were employed on a part-time or temporary basis. Most participants did not report positive changes in terms of their incomes. Seven said that they were better off and another seven reported that their income was more “regular.” However, several participants also noted that their incomes were not enough.

When asked what they thought were the most effective services they provided, almost all the agency key informants identified housing. Housing provided the safety and security that made it possible for people to begin to reduce their substance use. Housing also provided a base for the residents to form friendships, get to know themselves, to develop and establish their own networks and to become connected to the community.

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

- A harm reduction approach—which provides the context for flexibility and a “client-centred” approach in working with program participants/residents;
- Flexible and intensive case management—based on a trusting and respectful relationship, including a relationship that helps provide hope, optimism and real opportunities for moving beyond homelessness;
- A high level of support—particularly being available in the evenings and on weekends;
- The role of staff—their approach, attitude of helpfulness and way in which they treat participants with respect;

- Collaboration among agencies—particularly between the housing and service providers;
- Connections with community services—to help participants get involved in community activities and be able to contribute to the community;
- Social activities for the program participants/residents—including communal meals; and
- Stable funding.

Again, the information provided by the agency key informants is supported by what the residents/program participants had to say. When asked about the factors most responsible for the changes in their lives, the most frequent response was housing—having a place to live. Participants also discussed how the support they received from the case study agency was responsible for the changes in their lives. Participants indicated that they valued staff who were friendly, caring, supportive, responsive, helpful and compassionate. They wanted to be treated with respect, and “like a person.” They identified a need for staff to be well-trained and knowledgeable about their issues. They also felt that experience is important. This included experience working with the target population and also real-life experience.

When discussing what was important to them in terms of their housing, participants indicated that they wanted affordable housing in quiet neighbourhoods away from drug dealing but accessible to public transportation, amenities and services. It is clear that a range of housing options is necessary to meet the needs of the target group. While some individuals may prefer the anonymity and strictly “landlord-tenant” relationship that occurs with scattered site housing, others may prefer the camaraderie, group activities and sense of community that is available in dedicated buildings.

While both agency key informants and residents/program participants discussed the importance of housing and support, it is the *combination* that holds the key to success. There had been times in their lives when the residents/program participants had been housed, but without success. Most housing providers would never house them again. What makes the case study initiatives documented in this report so compelling is their degree of success in helping the participants to turn their lives around.

The changes are especially remarkable, given how little *demand* is placed on clients to engage in programs or transform themselves. However, as noted by staff at the Lyon Building and Princess Rooms, the relationship between staff and their clients is not hands-off. While participation in services is always voluntary, staff work to engage clients and encourage their participation in service planning, external treatment and service use. Perhaps the element of choice is another key to success. As suggested by a Pathways' key informant, "giving clients the treatment they want may allow them to select the treatment they need." At the same time, this study shows that no single model or approach will meet the needs of all homeless people.

The term "hard-to-house" should be put to rest. The interviews show that homeless people with complex needs can be housed successfully, as long as they have the right kind of support that meets their needs. The participants were clear about what is important to them. They want to be treated with respect. They don't want to be treated as a number. It is also important to consider their strengths. One participant pointed out that the people in her building are "vibrant and wonderful. It is important to recognize this."

Perhaps what is especially significant in the findings from these case studies is that if solutions can be found for this population—those with complex needs and who have the longest history of living on the streets—then perhaps key elements that distinguish the case studies, such as housing first or a client-centred approach, can be applied to address the needs of other people who are homeless—people who are newer to homelessness and who are not confronted by the multitude of problems that persons described in this report deal with on a daily basis.

Policy considerations and recommendations.

Perhaps the most significant issue that emerges from this study is the degree of success that can be achieved with the "housing first" approach. The case studies in this report show that people who are homeless, even if they have substance use issues and concurrent disorders can be successfully housed directly from the street if they are given the right supports when they want them. If the goal is to end homelessness, the results of this study make it clear that, for many people who are homeless, a "housing first" approach would make this possible.

Many countries use a continuum approach to address homelessness. This continuum includes homelessness prevention services, emergency shelter, outreach, transitional housing, and support services (such as addictions counselling and employment training). While there is a need for a range of housing options and services to address homelessness, this research paper recommends that policies and programs for addressing homelessness should be expanded to allow for a "housing first" approach so that

people who are homeless can have direct access to permanent housing, with support as needed and wanted.

This report also recommends that policies and programs be based on the principle of “putting the client at the centre.” This means providing people who are homeless with choices about their housing. It also means questioning whether the distinction between “permanent” and “transitional” housing continues to be useful, if there are any reasons for housing programs to impose time limits regarding a resident’s length of stay, and if so, under what circumstances.

Another issue that has an impact on policy is the acceptability of the harm reduction approach and a lack of understanding on the part of some policy makers and communities about what this constitutes. As pointed out in the report, there was some confusion when the researchers first set out to identify potential projects about what harm reduction really means. This report makes a distinction between approaches that are primarily a “tolerance of consumption” and other approaches that take

the concept of harm reduction to another level. In all 13 of the case studies in this report, the agencies work to actively engage their clients in making positive changes in their lives. Some of the approaches used include motivational interviewing (to help clients enhance their motivation to address their substance use issues), focusing on the strengths and capacities of each individual—rather than on limitations, and providing the necessary support and information to help clients reduce their substance use or to use more safely. As stated by one agency, the approach is one of “persistence” rather than “insistence.”

The researchers were told that the concept of harm reduction can be strongly opposed, and misunderstood. This report recommends greater education and information about harm reduction and how it can work. The researchers believe that a better understanding of the approach and its positive impacts would mitigate some of the misinterpretation and negative perceptions. As more policy makers are informed about the potential for harm reduction to achieve positive outcomes, this approach should receive greater support and acceptance.

Further research

The findings from this study raise a number of questions that merit further study.

- Questions about the advantages and disadvantages of dedicated and scattered sites are raised in this study, although this was not a particular focus of the work. A more systematic assessment of the two models should be undertaken. Potential questions could include:
 - What factors should be considered when deciding which approach to use?
 - Under what circumstances will it be more advantageous to choose one approach over the other, considering the particular client group to be served, and the local housing market?
 - Would use of scattered sites be a way to avoid problems of NIMBY?
 - Do residents of scattered units integrate more easily into the local community compared to residents living in dedicated buildings?
 - Are residents of dedicated buildings less prone to isolation because a community is created in the building?
- Related to the question of creating community in dedicated buildings and integration of residents into local communities are questions about how to facilitate the creation of social networks. Potential questions include:
 - What kinds of strategies or activities are most successful in helping people who have been homeless develop social networks and become integrated into the community?
 - How do formerly homeless persons establish new friendships? Do they maintain links to people they might have known on the street or to people they knew before becoming homeless?
- The co-existence of residents who were abstinent and those who continued to consume was an issue that was raised in a few projects and by residents in their interviews. More information and research into this issue and methods to deal with this would be of benefit to projects that house this population, including for example, projects housing couples where one person may consume while the other does not.

Glossary

ACT - Assertive Community Treatment—a model of case management where a multi-disciplinary team of professionals is responsible for providing services to clients. Caseloads are small, (typically a 1:10 ratio). Most services are delivered on an outreach basis and there is usually 24-hour coverage.

CDC - Centre Dollard Cormier—a public facility offering specialized services for substance abuse and excessive gambling on the island of Montréal.

Chronic homelessness—A prolonged state of homelessness (as opposed to *episodic* homelessness where persons move in and out homelessness or *temporary/transitional* homelessness whereby homelessness happens once and never re-occurs).

Client-centred—an approach to working with people “where they are” rather than “where they should be.” With this approach, clients are allowed to set their own goals while receiving support and assistance.

CMHA—Canadian Mental Health Association.

Concurrent disorders—co-occurring mental /emotional/psychiatric problems and substance (i.e., of alcohol and/or other drugs) use disorders. Sometimes called “dual diagnosis.”

Continuum—Called a *continuum of supports* in Canada and continuum of care in the US (also the *staircase model* in Sweden), this approach conceptualizes the move from homelessness to stability as a series of stages starting with outreach and moving through a range of programs such as drop-in centres, shelters and safe havens, residential programs and various forms of housing in increasingly more independent and less-supervised settings.

DESC—Downtown Emergency Service Center—a non-profit organization in Seattle, Washington that is one of the largest multi-service agencies serving homeless adults in the Pacific Northwest. Responsible for operating the Lyon Building.

FAS/FAE—Fetal Alcohol Syndrome/Fetal Alcohol Effects.

Harm reduction—an approach aimed at reducing the risks and harmful effects associated with substance use, and addictive behaviours, for the person, the community and society as a whole, without requiring abstinence.

“Housing first”—the direct provision of permanent, independent housing to people who are homeless. Central to this idea is that clients will receive whatever individual services and assistance they need and want to maintain their housing choice. The housing is viewed primarily as a place to live, not to receive treatment.

Housing readiness—Refers to standards and expectations of housing providers before independent housing is offered. Expectations can include psychiatric treatment, sobriety and life skills such as cooking.

Intensive case management—Similar to ACT. This model also provides outreach services, lower caseload ratios and coverage outside of regular working hours. The main difference from ACT is that services are not delivered by a multi-disciplinary team of professionals.

Low-threshold—a concept that refers to removing traditional barriers to programs and services to make it as easy as possible for as many clients as possible to participate. This could include removing barriers to treatment that insist on a commitment to abstinence as a requirement of admission and as the only acceptable goal/outcome.

Motivational interviewing—a client centred approach that strategically directs clients to examine, explore, and resolve the ambivalence they have about their behaviour and to develop motivation to overcome their ambivalence through the process of articulating and pursuing their own personal goals.

NIMBY: Not In My Back Yard—An acronym used to denote opposition by local communities to the introduction of facilities deemed undesirable (e.g., waste storage facilities) or housing for certain populations (e.g., homeless persons). Perceived negative impacts on the community that can be cited include physical effects (e.g., loss of open space or increase in traffic) as well as financial implications (e.g., decrease in property values).

OICHP—Ottawa Inner City Health Project—Started in 2001 as a two-year pilot project to work in partnership with a number of organizations in Ottawa that offered homelessness services. The goal was to provide health care and improve quality of life for persons who are chronically homeless.

SASH—Situation Appropriate Supportive Housing—A project in the planning stages in Halifax to provide transitional housing and emergency shelter to single homeless individuals who have a mental illness and co-occurring substance use issues.

SCPI—Supporting Communities Partnership Initiative—the centerpiece of the Canadian National Homelessness Initiative, it funds projects that support priority areas which are identified through a community planning process.

SHMCP—Supportive Housing and Managed Care Pilot, Minneapolis—a demonstration project sponsored by Hearth Connection in Minnesota to address homelessness.

Transitional housing—Time-limited housing (e.g., two to three years) often with support services and the expectation that the residents will move on to independent and permanent housing.

Appendix A – Case Studies

Case Studies

- Chambrclerc II
- Canadian Mental Health Association—Ottawa Branch
- Services à la Communauté Centre Dollard—Cormier
- Eva's Satellite: Sponsored by Eva's Initiatives
- Situation Appropriate Supportive Housing (SASH): Metro Non-Profit Housing Association
- Supportive Housing and Managed Care Pilot: Sponsored by Hearth Connection
- Heavy Drinkers Project Sponsor: Manchester Methodist Housing Association
- In Partnership Sponsor: Manchester Methodist Housing Association
- The Lyon Building: Developed by AIDS Housing of Washington, and operated by the Downtown Emergency Service Center
- Ottawa Inner City Health Project
- Pathways to Housing
- Princess Rooms Transitional Housing Demonstration Project: Sponsored by Triage Emergency Services and Care Society
- Anishinabe Wakiagun: Operated by the American Indian Community Development Corporation

INNOVATIVE SUPPORTIVE HOUSING THROUGH A HARM REDUCTION APPROACH FOR SUBSTANCE USERS

Case studies



Montréal, Quebec

Chambreclerc II

Background

This case study has been prepared based on an interview with staff from Chambreclerc and documents that they provided.

The Sponsor

Chambreclerc II consists of 24 units (shared bathrooms and kitchens) targeting homeless persons with mental health problems that are often accompanied by substance abuse. These are persons who have been homeless for long periods of time and have known little stability in their adult lives.

Program Goals and History

Chambreclerc was incorporated as a not-for-profit organization in 1987. The first residents were housed in early 1991 in two rooming houses (17 rooms) built in the Milton Parc project in Montréal, and funded by the federal and provincial governments. This initial project was strongly linked with the St. James United church, located in the downtown area, that has been running a drop-in centre with a large clientele consisting of homeless persons with mental health problems.

The first rooming house project was set up with minimal support but in many instances members of the Board of Directors found themselves intervening on a regular basis with residents who had mental health and/or substance use problems.

Project at a Glance

Sponsor Name

Chambreclerc II

Goals

- Rehabilitation
- Better quality of life
- Help people to learn to live with their disease
- Harm reduction (i.e. stabilization or reduction in use)
- Social reinsertion

Target Population

Chronically homeless persons with mental illness and a substance abuse disorder

Housing Tenure

Permanent housing

Number of Suites

24 rooms

Factors for Success

- Staff
- Security and respect
- Activities related to food and food preparation that lead to better nutrition (e.g. community meals and collective kitchens)
- Social activities
- Residents taking prescribed medication
- Flexibility

Location

Montréal, Quebec

Project Start Date

2002

The fact that there were very few resources for persons with concurrent disorders in Montréal presented a major difficulty. Often services for those with mental health problems will exclude people if they find out that there is substance use, even if abuse is not an issue. As a consequence persons with concurrent disorders are likely to have been on the street for years and many have “burned” all of their bridges—some even excluded from crack houses.

Recognizing that the first rooming house project could not accommodate this clientele, the Board of Directors began to reflect on what could be done to meet the needs. Having worked with this clientele for years, the Board of Directors of Chambreclerc knew that a harm reduction approach, with no expectation of abstinence, would be more effective.

The project goals include

- rehabilitation—at the most basic level, help clients deal with issues of hygiene, cleanliness and living with others
- bringing people to a better quality of life—towards autonomy and stability
- helping people to learn to live with their disease
- harm reduction: reduce consumption, change consumption habits (e.g. move away from hard drugs, safe disposal of used syringes) or ensure that there is not an increase in use
- move towards finding support in the larger community—i.e. social reinsertion

Program Description

Chambreclerc is a 24-unit project in the downtown area. Kitchens and bathrooms are shared and common rooms are provided for the residents. There is a mix of males and females and the staff is bilingual—accommodating both an English and French clientele. In 2003, Chambreclerc was able to house 32 people. Staff is present, on average, 21 hours a day. Both group and individual activities and services are offered. While residents are not required to take their medication, they are strongly encouraged to do so and these can be administered by staff, if requested. If residents refuse medication, efforts are made to discuss and explain the possible consequences. For example, there is one resident who is schizophrenic and refuses medication, but because he is functioning relatively well, this does not represent a major issue. On the other hand, another resident whose condition has been very unstable for over 20 years has stabilized in part because he took his medication. However, the resident needs to be reminded that he is not “cured,” as he’d wish to believe, but rather the “cure” is related to the medication which must be continued to stay that way.

A range of services is offered, some in the project itself (for example, recreation activities, common meals) while others are part of the network of services in the downtown area (for example, health services). Reintegration into society is an important goal of the project—accomplished both through in-house activities and by using services and activities available in the community.

The People

The residents are both men and women, most with concurrent disorders. In 2003, of the 32 persons housed, 26 were men and 6 were women, ranging in age from 24 to 68, with an average of 43 years. The average length of time spent homeless is 8 years; the maximum is 30 years.

Administrators have found that people with concurrent disorders are easier to deal with than those experiencing only addiction problems, especially hard drugs. This latter group often does not want to collaborate and does not easily accept restrictions on consumption.

The Housing

The 24-room building has shared facilities (such as bathrooms and kitchens), designed as such to further break the isolation of residents. Rents vary from \$310 to \$360/month depending on the size of the room. The rent includes laundry facilities, cable, telephone, communal activities and cleaning supplies (for example, mops, brooms, cleaning products).

The building was occupied when purchased. It had been badly run, with drug dealing and violence occurring on the site. Nonetheless there were long-term residents and eight of them moved back in after renovations.

Access to Housing

Potential residents are referred to Chambreclerc by other agencies, including hospitals, a health and social services centre (Centre local de services communautaires—CLSC), and the network of homelessness services. However, there is flexibility in the referral process—people also can come to the project through self-referral and through word of mouth.

Eligibility Criteria

Potential residents must have a history of chronic/serious homelessness and either a concurrent disorder or mental illness, which require continuous support services within a flexible environment. Often these are people who would be eligible for mental health facilities, but because they consume or they do not want a situation with restrictive rules, these facilities are not suitable for them.

The process to be housed includes filling out an application form and having an interview with the selection committee, comprised of a Board member, the co-ordinator and a resident.

Degree of “Housing Readiness”

There is no expectation of “housing readiness”—most residents have come directly from the streets or shelters.

Program Expectations

Chambreclerc has a number of rules for residents

- Rents must be paid on the first of the month, without exception (unless there are administrative difficulties).
- All residents are expected to participate to monthly meetings, although this is applied in a flexible manner as some residents do not feel comfortable in group settings.
- Residents are not required to take their medication but are strongly encouraged to do so.
- Residents who are ready, may have a plan which specifies individual goals. This is applied with flexibility—the major goal is to get residents to engage in activities but the rhythm and capacity of each is respected. If people do not seem to be

participating, they will be reminded and encouraged to take part in those activities, but refusal to do so will be respected and perhaps the issue raised again in the future.

- Residents must be respectful of staff and other residents.
- Residents must participate in maintaining common spaces.

Program demand

There is no waiting list as such. Usually people need housing right away.

Harm Reduction and Substance Use

Substance Use

Ten of the current residents consume cocaine (both crack and injection), two consume alcohol, and eight marijuana (not exclusive consumption).

Policies and Approaches Relating to Substance Use and Abstinence

Use of substances

Consumption of drugs is tolerated in individual units but not in common spaces. Drug dealers are not allowed on the premises.

The approach is to have residents begin to recognize the impact of their consumption and help them find means to reduce the related problems. This is done on a case-by-case basis, with the understanding that this is a long-term project with likely relapses and difficulties.

Security measures

There are locks on the front door, as well as an intercom system and four cameras. The project office is located at the entrance with a window overlooking the main door.

Guests

Guests are allowed but they may be prohibited if there have been problems in the past. For example, some residents are vulnerable and unable to say “no” to people, even if they do not want these guests. In other cases, residents may be harassed by drug dealers. In these exceptional circumstances, it is easier for them to say that the rules of Chambreclerc do not permit guests.

Conflicts Among Residents

The rules governing Chambreclerc are discussed at the interview and are often brought up during resident meetings. Conflict between residents is dealt with on a case-by-case basis.

Temporary Absence

Residents who are hospitalized must be stabilized before returning to their unit. They are expected to reimburse the rent during their absence. The case will be evaluated if the absence lasts longer than a month. In one instance, someone was gone for four months, was able to come back to their unit, and reimbursed the rent owed over a three-month period.

Residents Who are Abstinent

Residents can continue to live in Chambreclerc if they become abstinent. However, as their needs change they will be helped in finding support outside the project and if necessary helped in finding another unit.

Role of Staff in Working with Residents

The role of staff is to support, listen and help the residents. It is important for staff to understand the clientele and the mission of Chambreclerc. Staff is present almost 24 hours a day (on average 21 out of 24 hours) and a

Services	Type of Service Availability	Service Provider	Are Services Available on Site (Yes/No)	Source of Funding: Public Private Charitable
Medical care	Physical Teeth Eyes Medication can be administered by staff	CLSC Dentists, optometrists, general practitioners in the community	No Yes	Public
Mental health		CLSC Community services Hospitals	No	Public
Substance use	Residents can be referred to rehabilitation, detox and harm reduction programs but very few request this.	Community services e.g. Dollard-Cormier or the Foster Pavilion for Drug Rehabilitation	No	Public
Employment assistance (training/finding work)	Rarely of interest to residents Chambreclerc can give referrals	Resources available in the community	No	Public
Money management	Part of ongoing services	Chambreclerc Community services Public curatorship	Yes	Charitable Public
Assistance with life skills, food, transportation, clothing etc.	Part of ongoing services	Chambreclerc Community services	Yes	Charitable Public
Social/recreational opportunities	Includes collective meals, social activities and resident meetings	Chambreclerc Community services	Yes	Charitable Public
Medication administration	Administration of prescription/medication	Chambreclerc	Yes	Charitable
Needle exchange	Safe disposal of needles in the Chambreclerc office (no distribution)	Chambreclerc (disposal)		Charitable
Assistance finding permanent housing	If requested	Chambreclerc	Yes	Charitable
Meal program	Collective meals collective kitchens	Chambreclerc Community services (i.e. soup kitchens,	food banks Yes	Charitable

log is kept for each period to keep everyone fully informed. Furthermore, a 15-minute debriefing period is set at each shift change. Staff meetings are held regularly.

Some residents get help from staff with regards to the maintenance of their unit, administration of money and medication. The staff will keep track of appointments, and, if needed, will accompany residents to various appointments or to do their shopping.

In some cases, a contract is signed between Chambreclerc and the resident, outlining obligations and responsibilities. (Currently this is being done with two residents.)

Legal Issues

Relations with the police are good as are those with the neighbours. The building was notorious (drugs, drug dealing, etc.) before Chambreclerc acquired it, so it is now seen as an asset to the neighbourhood.

Exits From Housing and/or Programs

Voluntary Move-outs

Residents can continue to live at Chambreclerc as long as they need it. Some may require greater support as they become less autonomous (for example, if their mental health deteriorates) and they will be helped in moving to more appropriate settings. Others will move onto more independent housing with fewer supports—a room or a studio apartment. Some find it hard to adapt to Chambreclerc and decide to go back to their previous situation.

Evictions

Residents can be evicted for stealing, physical or verbal aggression, or drug dealing. However, situations are dealt with on a case-by-case basis. Usually there will be a meeting with the residents and if they refuse to assume responsibility and work towards a solution, they will be asked to leave.

Services

Model of Service Delivery

Residents' money can be administered by Chambreclerc to guarantee that the cost for rent and food is covered if no other possibility exists (for example, administration by another community service). The work is done on an individual level, on a case-by-case basis between the staff and the clients.

Recreational and common activities, as well as the shared spaces help break the isolation of many of the residents.

Types of Services

Services offered on site include support and life skills (for example, cooking, maintaining an apartment). Residents can be given support in reconnecting with their families and to develop friendships. Residents are supported and are encouraged to use community resources to help them develop links and ties to the wider community (such as social reintegration).

Changes in Services

N/A

Connections With Community Programs/agencies

Chambreclerc is strongly linked with community services such as the homelessness team of the CLSC des Faubourgs (the local health and social services centre), shelters and local hospitals. It is a member of the Fédération des OSBL d'Habitation de Montréal (FOHM), the federation of non-profit housing organizations, as well as the Réseau d'aide aux personnes seules et itinérantes de Montréal (RAPSIM).

Staffing and Personnel Issues

Staff Burnout

Burnout has not been an issue. Support is given to staff through team meetings and individual support, if needed.

Policies for hiring formerly homeless individuals

Clients are not hired; most are too fragile.

Funding

The purchase and renovation of the building was funded through the Government of Canada, Supporting Communities Partnership Initiative (SCPI), which also provided funds for the first two months of operation. Furnishings were funded through the CLSC des Faubourgs and through SCPI funds. Because there is no mortgage on the property, the rental income can be used for support services. However this is not sufficient to cover all the costs; additional revenue comes from the EJLB Foundation. McGill University and Dawson College provide student social workers.

Annual Revenue:

Source of Revenue	Amount
Foundation (is to end in 2005)	\$100,000
Rent	\$98,000
Total	\$198,000

Costs	Amount
Support services (i.e. personnel)	\$120,000
Building cost (taxes, repairs, heating, etc.)	\$68,000
Unforeseen	\$10,000
Total	198,000

The project also received a one-time grant of \$43,000 from SCPI funds (for 2004/6) for the collective kitchen.

While \$120,000 has been allocated to personnel, this is far from ideal. Salaries are low, there are few benefits, and there has not been a salary increase in two years. The ideal amount for this budget item would be \$172,000.

Outcomes, Challenges and Factors for Success

The project is still relatively young but elements of success can be discerned. Residents have been stabilized, take their medication, and become involved in activities. They also begin to set goals and objective—a major shift in their lives.

Furthermore, the building which had been viewed as a nuisance (for example, petitions and complaints by neighbours, police raids, etc.) has changed and it is now an integrated component of the neighbourhood.

There are a number of challenges that confront Chambreclerc and its clients.

- helping people move on to other housing—there is a lack of suitable housing
- funding for support services

Impact of the Program on Residents

Because the project is still in its first years of operation, its impact has not been evaluated. However, some outcomes can be observed.

- The importance of a stable home, where people are treated with respect has an impact on residents. They no longer function in “survival mode” and begin to take control of their lives. They also have a sense of belonging and confidence in themselves.
- There is a reduction in consumption. People begin to recognize the importance of feeling well and the impact of housing, activities and food on this.
- Mental health has improved. There are fewer stays in hospitals, and the ones that occur are shorter. This is due in part to taking their medication, but also to a better understanding of their illness.
- Physical health has improved because of regular attention to physical health, teeth and eyes.
- There are fewer hospitalizations, less use of emergency health services, and less incarceration; however, use of primary health services has increased.

Resident Satisfaction

No formal assessment of resident satisfaction has been undertaken.

Reasons for Success

The project is seen as a “work in progress” that is being adjusted with time and experience. However, the model of giving people a framework with limits, while respecting their freedom of action seems to result in positive outcomes. Other factors important to the success include the presence of staff, the security and respect that is given to residents, common kitchens with collective meals as well as social activities. Finally, having residents take prescribed medication has been important to the success of the project.

Lessons Learned

Lessons from the project include:

- Flexibility and tolerance are important in dealing with the clients.
- Working with residents to make sure that prescribed medication is taken is important for people with concurrent disorders.
- Encourage people to take care of nutritional needs—common meals have been very successful in this respect.
- Staggering the intake of new residents, rather than having everyone arrive at the same time, worked well.
- Security cameras are important safety measures.
- Make as many elements available to help people stabilize—including going as far as providing a laundry, mops, brooms and household cleaning products to encourage good hygiene and cleanliness.

- Having people taking hard drugs live on the ground floor, near the project office, is very helpful—they can be monitored and intervention can be rapid if a problem occurs.

Publications

Canada Mortgage and Housing Corporation 2004 Housing Awards Winners—Best Practices in Affordable Housing: *Chambreclerc II: Stability and Support for Homeless People*
<http://www.cmhc.ca/en/prfias/gr/hap/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=72859>

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INNOVATIVE SUPPORTIVE HOUSING THROUGH A HARM REDUCTION APPROACH FOR SUBSTANCE USERS

Case studies



Ottawa, Ontario

Canadian Mental Health Association—Ottawa Branch

Background

This case study has been prepared based on an interview with staff from Canadian Mental Health Association (CMHA)—Ottawa Branch and documents that they provided.

The Sponsor

The CMHA—Ottawa Branch began in 1953 to plan and develop services for persons with mental health problems. Over 50 years, the work has expanded to encompass public education, support services and social action. The mission of CMHA—Ottawa Branch is to

- advocate and provide client-directed services and programs with and for people with mental health problems
- enhance, promote and maintain the mental health of individuals and communities through education and awareness

The Housing Outreach Program, developed in the late 1980s, focuses on persons who are homeless or those at risk of becoming so, to help them obtain or maintain housing of their choice.

Project at a Glance

Sponsor Name

CMHA—Ottawa Branch

Goals

- Provide stable housing for homeless persons and those at risk
- Community integration

Target Population

Homeless or at-risk persons with serious mental illness

Housing Tenure

Permanent housing

Number of Suites

- 25 units with private landlords (bachelor or 1-2 bedrooms)
- 21 units with CCOC, a non-profit housing agency
- 22 condominium units (1-3 bedrooms)

Factors for Success

- The commitment of the housing providers and landlords
- The quality of the condominiums and of the other units
- The level of support provided and its availability in the evenings and on weekends

Location

Ottawa, Ontario

Project Start Date

Late 1980s

Program Goals and History

The work of CMHA—Ottawa Branch with homelessness is rooted in outreach work in shelters in the 1980s. This work consists of engaging with the person (often in a shelter situation), finding housing for them and working on a plan around different aspects of their lives. The approach is one that is rooted in a harm reduction philosophy—persons are not forced to take medication or be abstinent to benefit from services.

Finding housing solutions for this clientele, often the most difficult to house because of mental health problems and, in many instances, substance abuse problems (such as concurrent disorders), was developed during this period. Treating concurrent disorders was especially problematic since the use of medication and alcohol/drugs was not accepted and the standard approach was sequential treatment rather than a more holistic approach. A CMHA manager was particularly inspired by the approach advocated by Paul Carling, expert on adults and youth with psychiatric disabilities, from Centre for Community Change International in Vermont. He proposed that people should be housed without any assessment of whether they were “ready” or not. This approach, what is now referred to as “housing first,” was adopted by CMHA.

Recognizing that their clients were having difficulty gaining access to housing on the private market, due to past history, because they did not present well in interviews, and because they might need help if they ran into difficulties, CMHA started to intervene through arrangements made with landlords. Through the late 1980s and early 1990s informal partnerships with landlords were developed and eventually these were

formalized into agreements signed by CMHA, the landlord and the tenant. Agreements also were made with non-profit housing agencies—primarily the Centretown Citizens Ottawa Corporation (CCOC), City Living and Ottawa-Carleton Housing.

In 2001, a planned project to build housing for this clientele fell through. Nonetheless the capital was still available and CMHA decided to proceed with the acquisition of 22 condominium units, scattered throughout the city. While not initially planned as such, this option has proven highly successful with the advantage of not concentrating the clientele in one building, making integration into the community much easier.

Program Description

Housing is one component of the services provided by CMHA—Ottawa Branch. The first stage is often outreach undertaken by CMHA workers, who are attached to different services in the community, including discharge planning in hospitals. Their goal is to take people off the street and provide stable housing. They engage persons, establish relationships based on trust, assess needs and whether the person is interested in housing. In ideal circumstances, a consent form will be signed by the client and CMHA to receive services, although there is room for verbal consent in cases where the client does not feel comfortable with this (for example, the client has paranoia).

This work with the client can include

- long-term community support that can be permanent
- assessment of the client’s skills, resources, strengths and weaknesses

- development of an individual service plan, including independent living plan and a crisis management plan
- links to community resources and mental health services
- advocacy

These services are flexible whereby the intensity can vary according to the client, and portable, following the client wherever they live. Clients can refer themselves or be referred by health professionals, family or community agencies.

The housing component of the work of CMHA is an extension of outreach work and is client-directed. Client surveys undertaken between 1988 and 1998 form the basis of the approach developed. When clients were asked what they wanted—most stated that it was independent living in an anonymous, non-stigmatized setting—that is, not in a designated building.

CMHA has developed a Special Referral Agreement with landlords that defines its role and the support that it offers to both the owner and, as long as desired, the resident. A number of agreements and letters of understanding are signed that outline obligations and conditions.

- The Special Referral Agreement (between CMHA, the landlord and the tenant) outlines the responsibilities of the landlord (for example, services, maintenance, eviction procedure), the responsibilities of the tenant (for example, rental payment, responsibility for cleanliness and repairs caused by “willful or negligent conduct,” care against freezing or clogging of pipes, etc.).

- The agreement identifies rental subsidies (for example, City of Ottawa).
- In a separate letter of understanding between CMHA and the tenant, the conditions of support services are outlined. This includes the role of CMHA as provider of the support services as well as the right of the client to dismiss the support worker and discontinue the services. If support services are discontinued, the letter makes it clear that the client continues with their tenancy agreement with the landlord. The letter also makes it clear that if support services were to end, CMHA will continue to provide advice and support to the landlord regarding any problems that may arise with the resident's tenancy.
- If the resident is to receive a rent supplement (for example, Ontario Ministry of Health) the resident signs a further agreement stipulating that if the agreement is discontinued, they will pay the full rent.
- CMHA can act as an intermediary between the landlord and the tenant, thereby averting potential problems. If a problem arises, CMHA can help landlords in suggesting methods to approach the tenant or proposing solutions that have worked in the past with this person (while respecting the privacy of the resident). A final option if the situation becomes difficult and the resident is no longer a client, is that CMHA can go back to and offer their services to the tenant.
- If an eviction process has begun, CMHA will continue to follow up. Often the fear of losing their housing pushes the tenant to accept services again.

Finally, some clients also participate in the Concurrent Disorders Project which offers

harm reduction treatment groups. Ten groups are in operation, including groups for specific clienteles such as seniors, youth and women. The project also has a training program for community agencies working with individuals with a concurrent disorder.

The People

Through the housing agreements and the condominiums, CMHA houses about 80 households; the majority are single persons—equally divided between men and women. Families with children have been accommodated in the condominiums, including single parents, who in some instances have regained custody or visitation rights to their children because they now have a home.

It is important to note that beyond direct provision of housing, CMHA also supports other clients. For example, in 2003, CMHA helped over 345 people maintain their permanent housing.

All clients have access to the resources of multidisciplinary services, delivered by a psychiatrist, nurses, occupational therapist, recreational therapist, and addictions specialists. Some of the clients have a formal diagnosis, while others do not (at least at intake). Between 40% and 60% have a concurrent disorder.

In many instances, CMHA clients are described as “hard to serve” or “difficult.” Often because of their mental health problems, sometimes combined with substance abuse, they have experienced difficulties—especially in maintaining housing—by definition CMHA is dealing with those persons who have the worst housing histories. Persons with personality disorders are found to be especially challenging.

The Housing

The quality of the housing that is offered to CMHA varies. The best and most desirable are the condominium units: they are a good size (1 to 3 bedrooms), in good condition and well-located. On the other hand, some of the private units are not in a great state of repair or are situated in less desirable locations. The cluster units (such as shared bathrooms) are perhaps the least desirable and have the greatest turnover rates. The issue of the quality of the housing is an important one for CMHA: experience has demonstrated that putting clients in very bad buildings (because of a lack of suitable housing, for example), inevitably sets people up for failure.

Depending on the program in place rent for the tenant can vary from \$325/month (the Ontario Works [social assistance program] maximum rent) to 30 per cent of gross income if the tenant is working (a rare occurrence). Rent supplements also are given by the City of Ottawa and the Ministry of Health. A total of 60 units are rent-g geared-to-income.

Part of the challenge for CMHA is balancing the needs of the clients, the landlords and the neighbours. This question of “fit” is an important factor for success. CMHA has a managerial role to ensure this “fit.” For example, in the condominium units, CHMA could be sued by the Board if it did not assume its responsibilities. By law, this responsibility includes notification to the other owners about the clients who are to occupy the units.

However, CMHA does not monitor behaviour nor intervene unless there are complaints. For example, problems related to drug dealing or prostitution are treated in the same way as they would be for any other tenant.

Services	Type of Service Availability	Service Provider	Are Services Available on Aite (Yes/No)	Source of Funding: Public Private Charitable
Medical care	Community resources			
Mental health	<ul style="list-style-type: none"> ■ 2 full-time nurses ■ 1 full-time psychiatrist ■ all front-line staff trained in mental health 	CMHA	According to the client's needs	Public
Substance use	<ul style="list-style-type: none"> ■ 2 concurrent disorder specialists ■ all front-line staff trained in concurrent disorders 	CMHA	According to the client's needs	Public
Employment assistance (training/finding work)	<ul style="list-style-type: none"> ■ 1 full-time specialized occupational therapist ■ undertaken by all front-line staff 	CMHA	According to the client's needs	Public
Money management	<ul style="list-style-type: none"> ■ undertaken by all front-line staff 	CMHA	According to the client's needs	Public
Assistance with life skills, food, transportation, clothing etc.	<ul style="list-style-type: none"> ■ undertaken by all front-line staff 	CMHA	According to the client's needs	Public
Social/recreational opportunities	<ul style="list-style-type: none"> ■ recreational therapist on staff ■ undertaken by all front-line staff 	CMHA	According to the client's needs	Public
Medication administration	N/A (in rare circumstances administered by the nursing staff)			
Needle exchange	N/A			
Assistance finding permanent housing	Outreach and Community Support workers	CMHA	According to the client's needs	Public
Meal program	N/A			

Access to Housing

Eligibility Criteria

The major factor to gain access to housing is the desire on the part of the client to be housed and to assume the responsibilities of a tenant.

Potential residents must be clients of the agency to qualify for the housing. The criteria for CMHA programs includes: either a diagnosis of severe mental illness or behaviours consistent with this; the condition must have existed for some time or be a severe first episode; and the condition must have a severe impact on the level of functioning.

Degree of “Housing Readiness”

CMHA has a “housing first” approach and maintains that the best place for clients to learn to live in permanent, independent units is in such a setting.

Program Expectations

The expectations of the client are the same as those for any other tenant, such as payment of rent, maintaining the apartment, etc. Clients are not obligated to have support services to maintain the housing.

Program Demand

CMHA does not maintain a waiting list for housing—this is not practical for homeless persons.

Harm Reduction and Substance Use

Substance Use

Between 40 per cent and 60 per cent of clients use substances. The drugs used by clients vary and include crack cocaine, heroin and prescription drugs while some clients are on methadone.

Policies and Approaches Relating to Substance Use and Abstinence

Use of Substances

CMHA encourages clients to reduce their use or to move to less harmful substances.

Motivational interviewing is used to help them see the impact of their use.

Security Measures

The security measures vary from building to building. No measures are in place specifically for CMHA clients.

Guests

Clients are full tenants with all the rights of tenants.

Conflicts Among Residents

Since most of the units are scattered, this is not an issue. If there is a conflict in the cluster units, this is treated on a case-by-case basis, using means such as meeting with the residents or with the individual who is causing difficulties to resolve the issues.

Temporary Absence

The agreement between the tenant and the landlord stipulates that the tenant will advise the landlord if they are absent for more than seven days. Since a lease has been signed, the tenant is protected by the *Tenant Protection Act* and as long as the rent is paid, they can maintain their unit.

In the case of hospitalization or incarceration, situations are resolved on a case-by-case basis.

Residents Who are Abstinent

Residents who are abstinent can continue to live in their units.

Role of Staff in Working with Residents

Legal issues

There is no specific control of drug use on the part of CMHA; clients have the same rules and obligations as all tenants under the Tenant Protection Act. CMHA staff is instructed to leave the apartment if illegal activities are going on—a policy to protect the worker (for example, if a dealer is there) and to avoid legal issues.

Exits from Housing and/or Programs

Voluntary Move-outs

Clients can move out. At times this is because they are unhappy about the housing, although efforts are made to try to find more suitable units.

Evictions

Clients can be evicted for threatening neighbours or for violence, as well as not respecting their responsibilities as a tenant (for example, not paying rent). The match between the client and the housing is key. Landlords cannot be expected to act as social workers; if the match is not a good one, the situation is ripe for failure. Measures are taken to avoid eviction, but in some cases this is inevitable.

Services

Model of Service Delivery

CMHA provides both short- and long-term intensive case management. The intensity of services varies according to need and can be weekly, monthly or more frequent.

Services are available until 10 p.m., 365 days a year and offered according to the client's needs—at their home, on the street, etc.

Changes in Services

The most important changes have been

- adding an extended hours capacity to the supports (evenings and weekends)
- a multidisciplinary approach (a psychiatrist, nurses, occupational therapist, recreational therapist, addictions training and treatment and some psychology services)
- the overall expansion from 1 outreach worker initially and about 6 community support workers to 19 outreach and 20 community support workers.

Connections With Community Programs/agencies

Other than the formal referral agreements with the housing providers and private landlords in the community, there are formal agreements for service with the following agencies:

- Union Mission for Men
- Shepherds of Good Hope
- Salvation Army Men's Hostel
- Salvation Army Men's Youth Hostel
- Women's Shelter
- Youth Services Bureau (YSB) Young Women's Shelter
- Centre 454

■ Ottawa Court House

There also are signed agreements for services with hospitals (for example, the Ottawa Hospital, the Montfort Hospital, the Queensway-Carleton Hospital and the Royal Ottawa Hospital) to provide hospital outreach services.

Informal connections are too numerous to mention, but include a wide variety of service providers, from community health centres to the police.

Staffing and Personnel Issues

Staff Burnout

Training of staff has proven to be key in helping prevent burnout. Supervision plays a key role as well. Furthermore, CMHA gives a generous vacation package (four weeks at the start) and is as flexible as possible in accommodating needs.

Policies for Hiring Formerly Homeless Individuals

Consumer experience is valued and if clients express an interest in working for CMHA, they are encouraged to get the required training so that they could be hired.

Funding

Annual Revenue*:

Source of Revenue	Amount
Foundation (is to end in 2005)	\$100,000
Rent	\$98,000
Total	\$198,000

Costs	Amount
Support services (i.e. personnel)	\$120,000
Building cost (taxes, repairs, heating, etc.)	\$68,000
Unforeseen	\$10,000
Total	198,000

*Year ending March 31, 2004 for all of CMHA-Ottawa Branch

Housing services costs (which include both a support component and actual housing provision) can be broken down in the following manner.

Frontline Support Services (Community Support and Outreach): \$5,472,088

Condominiums: \$66,536 revenue and \$104,808 expenses (there was a loss in the initial year due to vacancy loss and start-up costs, which will be rectified in subsequent years)

The Rent Supplement budget is part of the Frontline Support Services budget and is about \$170,000

Annual Revenue:

The project also received a one-time grant of \$43,000 from SCPI funds (for 2004/6) for the collective kitchen.

While \$120,000 has been allocated to personnel, this is far from ideal. Salaries are low, there are few benefits, and there has not been a salary increase in two years. The ideal amount for this budget item would be \$172,000.

Outcomes, Challenges and Factors for Success

The initial goal of the housing component was to offer clients permanent housing of their choice in the community. CMHA has accomplished this. Preliminary results of an evaluation¹ indicate that 90 per cent of clients of the housing outreach services, who have mental illness and were homeless, are still housed after nine months. The intensive case management appears to be an important component of this success, preliminary results indicate that clients experience fewer symptoms; they have lower rates of drug abuse, and better overall functioning, even in early stages of treatment.

Challenges confronting the work of CMHA include the lack of resources, which forces CMHA to establish priorities. A concern that stems from this is the desire to avoid “creaming off” those clients that have a better chance of being housed. The underlying concern is how to be fairer in the distribution of resources that are unfairly distributed at the onset.

However, CMHA has confronted previous challenges, including negotiation of legal agreements for rent supplement and concern about the impact of government withdrawal of funding. The involvement in condominiums is still at the learning stage, including responsibilities and liabilities of this form of ownership.

Impact of the Program on Residents

The preliminary results of the evaluation indicate stabilization of the housing situation for the vast majority of clients of the housing outreach program. It would appear that clients reduce substance use and have a higher quality of life. Anecdotal evidence also points to family reconnection, including parents gaining access to or custody of children because they are housed.

Resident Satisfaction

The turnover rate appears to be quite low. Residents of the condo units seem to be especially satisfied with their apartments.

Reasons for Success

The reasons for the success of the CMHA housing outreach are

- the commitment of the housing providers and the landlords
- the quality of the housing—especially the condominium units
- the level of support that is provided—particularly the availability during evenings and on weekends and the provision of multidisciplinary services.

Lessons Learned

Lessons from the project include:

- Make sure you can work with your housing partners. Find landlords who can offer units and are committed to working with your clients.
- Don't ignore private for-profit landlords. Some private landlords are real gems and are willing to go the extra mile.
- Communication with landlords is critical. It is essential that landlords let you know at the earliest possible time if a problem is emerging.
- More resources would be favourable.

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INNOVATIVE SUPPORTIVE HOUSING THROUGH A HARM REDUCTION APPROACH FOR SUBSTANCE USERS

Case studies



Montréal, Quebec

Services à la Communauté Centre Dollard-Cormier

Background

This case study of Services à la Communauté (Community Service Department), a division within the larger organization, Centre Dollard-Cormier (CDC), has been prepared based on an interview with a staff member from the Services à la Communauté (CDC), with additional written information that they provided.

The Sponsor

The Centre Dollard-Cormier was formed in 1997 when three centres (Alternatives, Dorémy-Montréal and Centre Préfontaine) dealing with alcoholism and drug abuse were merged. The three had specific mandates that continue to shape the services offered: Alternatives dealt with youth; Centre Préfontaine with the homeless population; and Dorémy-Montréal had a medical approach to substance abuse.

Funded by the Ministry of Health and Social Services, Dollard-Cormier, using a harm reduction approach, offers a wide range of services on the island of Montréal that include evaluation, emergency services (24/7), detox, a clinic for concurrent disorders (with the Louis-H. Lafontaine Hospital), and specialized services (youth, persons over 55 years old, persons who have been through the criminal justice system, people with mental health problems), as well as a program for persons with gambling problems. Dollard-Cormier deals with approximately 7,500 persons a year, and in 2003/2004, just over 3,000 of these were new clients. In 2003/2004, 7 per cent of the clients were the “entourage” (for example, friends and family) and 14 per cent of the clients required residential treatment. During this period, about two thirds of the Dollard-Cormier clients were men; 37 per cent were 25-39 years old and 16 per cent under 24; and 29 per cent consumed more than one substance and 24 per cent consumed alcohol only. The total budget of Dollard-Cormier is over \$17M and it employs almost 400 persons.

Project at a Glance

Sponsor Name

Services à la Communauté Centre Dollard-Cormier

Goals

The goals of Services à la Communauté (CDC) include housing with community support, democracy, defence of citizen rights, advocacy and social justice.

Target Population

Homeless persons with substance abuse problems

Housing Tenure

Permanent housing

Number of Suites

-

Factors for Success

- An approach that is rooted in a philosophy of empowerment
- A collective approach to solving problems and the participation of tenants
- Giving clients the opportunity to participate and giving them a voice
- Organisational flexibility and room to manoeuvre

Location

Montréal, Quebec

Project Start Date

1986

Program Goals and History

The work of Services à la Communauté (CDC) with homeless persons who have substance abuse problems stemmed from the Centre Préfontaine. It was formed in 1986 and the director of professional services was inspired by the approach to community organizing of people such as Alinsky. An example of the application of this approach by the Centre Préfontaine was setting up *L'itinéraire*, a homelessness monthly journal, written, produced, and sold by homeless persons in Montréal.

However, it quickly became clear that the major issue that had to be dealt with in working with this population was the state of homelessness itself. A key focus became helping people gain access to secure and adequate rooms in rooming houses—the most affordable source of housing for low-income singles at that time.

A first housing project was undertaken in 1987-8, in partnership with the City of Montréal and the Société d'habitation du Québec (SHQ) to renovate a rooming housing in the downtown area. All the tenants were clients of the Centre Préfontaine.

Between 1987 and 1990 a second project, one for women, was developed by establishing, with other organizations working in the milieu, the Réseau Habitation Femmes (RHF) a non-profit organization that has gone on to develop subsequent projects.

The approach to substance use grew out of a recognition that primary needs—such as housing and food—had an impact on substance use and that on a pragmatic level, a harm reduction approach would be more effective. This was further reinforced as the issue of HIV/AIDS became more prominent and measures to reduce the impact of behaviours were being developed and applied.

For the community organizer at Services à la Communauté (CDC) it's not even an approach of harm reduction, but rather one of “empowerment” emphasizing the strengths of the person and what they are capable of doing rather than on the substances that they are using.

The issue of substance abuse and harm reduction is situated in the larger context of community action. The general principles of the Centre Dollard-Cormier recognize that substance abuse is one of the major problems that affects Quebec society. Substance abuse can be found as a factor that is causal, associated, or consequential in many of the objectives that the government has set in health and well being—encompassing broad issues such as early school leaving, social isolation of the elderly, suicide and family violence. Substance abuse is then situated in a global context with a clientele targeted by the Centre Dollard-Cormier that is very large, and the recognition that rehabilitation requires a multitude of approaches, including community action.

Community action as defined by the Services à la Communauté (CDC) is the collective and interdependent response to social problems experienced by individuals. The means include developing community services, popular education, social and economic development, establishing new power relations that favour those who are victims of exclusion and oppression, and calling for social, economic and political changes that support greater social justice. The work encompasses not only individuals with problems of substance abuse but also marginalized groups and community and institutional organizations—always keeping the objective of giving power or elements of solutions back to the individuals and/or the communities themselves.

Program Description

One of the mandates of Services à la Communauté (CDC) is to work closely with partner organizations in Montréal to provide housing for its clients and to support other tenants who may live in the projects in which they become involved.

Services à la Communauté (CDC) often will enter into an agreement with partner organizations, specifying the overall goals of the project and the role of each organization. Thus the goals of the project could include

- develop collaborative means between the organizations to meet the needs of the specific clientele
- increase the number of social housing units for the clientele (for example, homeless women with substance abuse problems)
- offer the community necessary support so that the tenants can organize themselves, become integrated and develop a sense of belonging to their apartment and their neighbourhood.

The roles assumed by the partners are specified.

- Services à la Communauté (CDC) can be responsible for the community support and “social management.” The social management consists of supporting and helping the clients adapt to their apartment and get to know the neighbourhood, as well as dealing with all emergencies.
- Services à la Communauté (CDC) can participate on committees to select tenants.
- A partner organization that deals with housing may be responsible for supplying the apartments and ensuring the management of the units as well as all property-related emergencies.

- A governmental organization, for example, the public housing authority, might be part of the agreement as the source of housing subsidies to the tenants.

The agreement could specify the characteristics sought of the future tenants, which could include, autonomy, a sense of responsibility, a desire to have an apartment, a desire to move into the neighbourhood, a desire to stop substance use.

The partnership process and the approach that is centred on community action are well illustrated in an evaluation (Ducharme 2003) of the development of the most recent project in which Services à la Communauté (CDC) participated—Brin d’Elles. Over a period of one year, the planning committee for the project met 35 times, with additional simultaneous subcommittees meetings (for example, works, partnership and selection). The mandate of the planning committee included defining the needs of the tenants, the services necessary, the selection criteria, architectural needs, and the framework for the partnership. Not only were the partners in the project included (such as the Fonds dédié, the Women’s Y, Services à la Communauté (CDC), and RHF) but the committee also included women who were seeking a unit. Thus the philosophy of empowerment and integration of the potential tenants was incorporated from the outset. In all, ten potential tenants participated in the planning phase—four came to more than ten meetings and three came to all. Others participated more intensely in the subcommittees or in other activities such as presentations, site visits, etc.

The reasons given by the women for their participation varied but included a participant who was convalescing and thought this would be a good way to occupy her time while learning more about the community sector and women’s projects. Another was encouraged by a community worker who suggested that this would be a way to have her say, give her opinions, and get involved in something that she hadn’t known about before. For a third, this was a way to keep in touch with the Women’s Y, where she had lived for a period of time.

The evaluation of the Brin d’Elles project found that for many of the participants the initial reasons for their involvement in the planning committee were gaining access to a unit or to “kill time,” the impact went much further at the time of the evaluation. The reasons for involvement shifted to include “finding my strengths again,” “rediscovering that I exist and I’m still useful,” and, for a third, “for me, the apartment is not the essential aspect of this project: it’s really the teamwork and my involvement.” Another said, “I find that I’ve evolved enormously. I’m more and more involved. And in different things. Not only here, but I got involved in other things.”

When speaking of the impact of their involvement in the planning of the project, the women spoke of profound changes. “At the beginning, I didn’t speak very much. Now, I talk too much. I didn’t want to read, but now there’s no problem. I’m transformed.” “This has brought me lots of strength... You see everyone together that’s listening and you give your opinion and they respect your opinion. Often, it happened that I said things, you took note, and you said that it wasn’t crazy what I’d just said. As a result I felt that they were taking me seriously. This gave me lots of self-confidence.” (Ducharme 2003)¹

The People

The client group varies from project to project. Some projects are for women only, while others are for a mixed or an all-male clientele.

The Housing

Services à la Communauté (CDC) works closely with a number of organizations that provide housing such as the Fédération des OSBL d’habitation de Montréal (FOHM).

The type of housing varies from renovated rooming houses where tenants share kitchens and bathrooms, to studio apartments and one-bedroom units. The newest project is Brin d’Elles, completed in February 2003.

Réseau Habitation Femmes (RHF) This non-profit housing organization was founded in 1987 when organizations working with homeless women decided to deal with the lack of social housing for this group. Various organizations working with the women (day centres, shelters) and the Centre Préfontaine came together to set up the RHF. Two rooming houses in the downtown area were acquired and renovated in 1988. In 1994 RHF participated in the development of a project of seven studio apartments that was undertaken in partnership with other organizations including the City of Montréal public housing corporation. A second RHF project, comprising 23 units was completed in 1995-6. RHF is a partner in Projet Brin d’Elles (see below). A new project for women with children is being considered.

¹ Unofficial translation

The RHF client group are single women in situations of poverty, homelessness, drug addiction, alcoholism and mental health problems. The mission of RHF is to develop and manage social housing with community support using approaches rooted in feminism and empowerment. This housing has proven very important to the women. When applying for funding for a community space from SCPI, they were asked what social housing had brought to their lives, they answered “a door, a roof, a voice.”

Services à la Communauté (CDC) has worked with RHF since its institution and continues to give organizational support; tenants can be referred to services offered by the Centre Dollard-Cormier.

Villa Exprès pour toi is a non-profit housing organization that manages 29 studio apartments, for both men and women, many who have substance abuse problems. Services à la Communauté (CDC) was involved in developing the initial project and with the organization sporadically since the beginning.

Brin d'Elles Services à la Communauté (CDC), along with RHF, the Women's Y and the Fonds dédié à l'habitation communautaire (a non-profit group made up of representative of various organizations working with homelessness in Montréal), developed and built 22 one-bedroom social housing units for women. Special emphasis was put on soundproofing between units in this project, one of the issues that has caused problems between tenants in other projects. Funds also allowed purchase of furniture (for example, beds, tables) as well as major appliances. Seven units in the project are reserved for clients of Services à la Communauté (CDC). (Although, it should be noted that while other tenants may come through the other partner organizations, they also may be Centre Dollard-Cormier clients.)

Access to Housing

Eligibility Criteria

People can gain access to the housing both through “official” channels, that is through organizations that are part of the network of homelessness organizations in Montréal or partners in the housing projects. “Non-official” channels are through word of mouth or self-referral.

Each project has its own criteria and process for eligibility. Some may have selection committees that include tenants, while in other projects the choice is made by the community worker in the project or a Board committee.

Degree of “Housing Readiness”

Each project has its own specific criteria but they are similar in that there are no conditions about substance use or about housing readiness.

Tenants are expected to be capable of entering into a tenancy agreement—that is pay the rent and respect neighbours. Otherwise the attitude is “if there is a problem in the hallway or in common areas—that's our problem. What you do in your apartment is up to you.”

Program Expectations

Varies by project but generally there are no expectations of participation in programs or meetings with workers. Most of the tenants are in contact with a social worker or healthcare worker. If tenants are taking medication for mental health problems, they are encouraged to continue to do so, but there are no expectations that they be treated to qualify for the housing.

Program Demand

Some of the projects have waiting lists of up to a year. Other projects have lists that are updated or restarted at the beginning of each year.

Harm Reduction and Substance Use

Substance Use

Many of the tenants use alcohol. Cocaine and heroin seem to be the drugs of choice.

People with concurrent disorders present a particular difficulty—often organizations send the person back and forth between mental health and substance abuse services. Centre Dollard-Cormier, in partnership with the Louis-H. Lafontaine, a psychiatric hospital, runs a clinic that deals specifically with concurrent disorders: people can be encouraged but not forced to seek help.

Policies and Approaches Relating to Substance Use and Abstinence

Use of Substances

Since the tenants all have leases, they are free to do what they wish in their own unit. However, most of the housing projects do not allow substance use in common spaces.

Tenants are encouraged to reduce use. If substance abuse becomes very problematic, Dollard-Cormier can receive people in their 24-hour emergency facilities.

Security Measures

This varies by project but most have control access into the building and some have special emergency services.

Guests

This varies by project and size of the unit. None of the projects allow that the unit be shared on a permanent basis. Some projects have rules about women, who are working in the sex trade, having clients come to their room or apartment, while others will not disallow this as long as the other tenants are not disturbed.

Services	Type of Service Availability	Service Provider	Are Services Available on Site (Yes/No)	Source of Funding: Public Private Charitable
Medical care	These services are provided in the community.	CLSC Hospitals Community services	N	Public
Mental health	These services are provided in the community.	CLSC Hospitals Community services	N	Public
Substance use	Can be done through Dollard-Cormier services. Some hospitals also have specialized services.	Dollard-Cormier or others (e.g. St.Luc Hospital)	N	Public
Employment assistance (training/finding work)	These services are provided in the community.	Varies	N	Public
Money management	Varies according to the need of the person and the services and support offered in the project.	Varies	Varies by project	Public, charitable
Assistance with life skills, food, transportation, clothing etc.	Varies according to the need of the person and the services and support offered in the project.	Varies	Varies by project	Public
Social recreational opportunities	Varies—most projects have social activities and opportunities to become involved in the project (e.g. tenant committees).	Varies	Varies by project	Public
Medication administration	Varies according to the need of the person and the services and support offered in the project.	Varies	N	Public
Needle exchange	These services are provided in the community.		N	Public
Assistance finding permanent housing	N/A	N/A		
Meal program	Some projects have occasional community meals.			Public

Conflicts Among Residents

These are handled on a case-by-case basis and each project has its own means to resolve conflicts (such as bringing written complaints to the Board of Directors or to a management committee). Frequent causes of conflicts are too many comings and goings of a tenant, not locking the exterior doors when they leave, or tenants who get together and consume.

Temporary Absence

As long as the resident continues to pay the rent, they can come back to their unit.

Residents Who are Abstinent

There can be conflicts with tenants who have become abstinent. There is a case of this happening in a project where tenants who became sober tried to push their

neighbours to stop consuming as well. The tension reached crisis proportions that reached management and Board levels and took a number of years to resolve.

Role of Staff in Working with Residents

This varies by project.

Legal Issues

Drug dealing in the projects is not permitted. However if it occurs, there needs to be a complaint (on the part of other tenants or the worker) brought to the attention of police so that it can be dealt with.

Exits from Housing and/or Programs

Voluntary Move-outs

The rate of turnover varies by unit type—highest in the rooming houses where there are shared kitchens and bathrooms and lowest in the self-contained units. Most projects do not allow co-habitation, leading to people who wish to live with boyfriends or girlfriends to move out.

Evictions

This varies by project but can be caused by non-payment of rent (although attempts are made to resolve this first), or illegal activities, but problems such as complaints about having clients over will be dealt with by giving warnings first.

Services

Model of Service Delivery

This varies by project—most have permanent staff but rely on community and public agencies for services such as health.

Changes in Services

There have been no noticeable changes in the services.

Most Effective Services

Housing: there has to be minimal security for people to begin to reduce substance use. Housing also has an impact on people's lives—it is the basis of friendships, of knowing oneself, and of developing a sense of belonging.

Connections With Community Programs/agencies

The work of Dollard-Cormier rests on a partnership approach to develop and manage housing. Community and public agencies are key in delivering services such as health to tenants.

Staffing and Personnel Issues

The community development work is undertaken by one full-time organizer at Services à la Communauté (CDC) a 5-person division. Other divisions in Centre Dollard-Cormier deal with temporary housing such as foster families, social reinsertion (with semi-supervised apartments) and specialized housing (such as for persons with AIDS). The work of Services à la Communauté (CDC) is with permanent housing.

Staff Burnout

This varies by housing project.

Policies for Hiring Formerly Homeless individuals

This varies by housing project.

Funding

The Centre Dollard-Cormier is funded by the Ministry of Health and Social Services. Housing projects are generally funded by social housing programs. Currently in Quebec it is Accès-Logis. Some projects also receive funding through the Supporting Communities Partnership Initiative (SCPI) of the Federal government. For example, the Brin d'Elles project received funds from SCPI, Accès-Logis, and the Ministry of Health and Social Services as well as organizational support from the Women's Y, RHF and Services à la Communauté (CDC).

Funding for Services à la Communauté (CDC) is stable, while that for development of individual housing projects, is inadequate. This is especially the case for housing with community services—an essential component to help people stabilize and stay in their housing. Furthermore, there are rarely funds to help people settle into their unit (for example, furniture, dishes, etc.) if they are moving into an apartment for the first time. Maintenance costs are usually high as well, for example, most substance users are heavy smokers; when they move out the apartment needs to be repainted.

Annual Revenue*:

Source of Revenue	Amount
Public funds	\$16,659,182
Others	\$587,105
Total	\$17,246,287

Costs	Amount
Total	\$17,246,287

*Year ending March 31, 2004 for all of the Centre Dollard-Cormier.

Outcomes, Challenges and Factors for Success

Outcomes of the various interventions not only lead to greater housing stability and changes to physical and mental health, but tenants develop a sense of belonging and social involvement. As well a very important outcome is that people begin to realize that their problems are not unique—they are not alone, others share the same difficulties.

One of the major challenges confronting this work is the lack of recognition by government of community support in social housing. This has the effect of eliminating certain populations, those who are more “difficult” from most social housing. Furthermore, there is an overall lack of adequate funding for social housing—especially for low-income single and homeless persons. Often because the funds are insufficient the construction is of a lesser quality and buildings are situated in less desirable neighbourhoods.

Impact of the Program on Residents

Measures of Success	Outcomes
Residential stability (e.g. length of time housed)	There is an improvement in behaviour—for example people are less aggressive, leading to greater stability.
Reduced substance use and increased safety re use	Substance use is more controlled, even if it does not cease.
Improved mental health	Generally there is an improvement, especially when tenants become involved in the housing project (e.g. through committees).
Improved physical health	With residential stability, health usually improves. People eat regularly and get sleep. Reduced substance use often leads to increased income and better nutrition. Stabilization also can lead to the emergence of health problems that may have been neglected in the past.
Income	Reduced substance use often results in greater income for food, and consequentially improved nutrition. Most receive income assistance. Employment is difficult for some—because of age, abilities, and instability—although many do participate in employment reinsertion programs.

Resident Satisfaction

N/A

Reasons for Success

There are a number of reasons for the success of the approach.

- It is an approach that is rooted in a philosophy of empowerment.
- It provides a collective course to solving problems and the participation of tenants. This process gives them the means to gain control over themselves and the organizations.

- It gives clients the opportunity to participate at all levels and provides them a voice.
- On an organizational level, the flexibility and room to manoeuvre that Dollard-Cormier has given the community action has worked. The overall approach has always been supported.

Lessons Learned

- There has been an evolution in what is considered adequate housing for this population—moving from rooms with shared bathrooms and kitchens to self-contained apartments. The Brin d’Elles project is exemplary—extra funding allowed better quality of construction and included elements such as increased soundproofing between the units.

- It’s important to be open to partnerships—not only within the milieu of substance abuse but to a broad range of organizations and ways of doing things.

Publications

Centre Dollard-Cormier *Rapport Annuel 2003-2004* Montréal

Ducharme, Marie-Noëlle (2003) *Quand un plus un égale trois... Évaluation du partenariat lors de l’implantation de la Maison Brin d’Elles* Montréal : Fonds dédié à l’habitation communautaire, Partenaires - Centre Dollard-Cormier, Réseau habitation femmes, « Y » des femmes de Montréal

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INNOVATIVE SUPPORTIVE HOUSING THROUGH A HARM REDUCTION APPROACH FOR SUBSTANCE USERS

Case studies



Toronto, Ontario

Eva's Satellite: Sponsored by Eva's Initiatives

Background

This case study was prepared based on an interview with staff from Eva's Satellite and written material that they provided.

The Sponsor

Eva Smith was a community outreach worker and counselor who knew and understood people in despair, particularly youth. She helped create the North York Emergency Home for Youth, which opened in 1994 and was named Eva's Place in her honour. Eva's Satellite was established in 1997 in response to a pressing need to assist youth not well served by the traditional shelter system. A third initiative, Eva's Phoenix, was established in 2000 to bridge the gap between emergency shelters and independent living for youth. It aims to break the cycle of homelessness by providing housing, employment and life skills training to 50 homeless youth.

All three programs operate under the corporate structure of Eva's Initiatives (Eva's).

The Mission of Eva's is to work collaboratively with homeless and at-risk youth to actualize their potential to lead productive, self-sufficient and healthy lives. Eva's does this by providing safe shelter and a range of proactive and progressive services that aim to create long-term solutions.

¹ A concept that refers to removing traditional barriers to programs and services to make it as easy as possible for as many clients as possible to participate.

Project at a Glance

Sponsor Name

Eva's Initiatives

Goals

- Help youth minimize the harms associated with drug and alcohol use
- Establish low-threshold¹ programs and effective in-house services
- Help youth access existing services in the community
- Respond to needs of the whole client—as defined by the client

Target Population

Homeless youth (16-24 years old) who have difficulty accessing mainstream, abstinence-based youth shelters

Housing Tenure

Emergency shelter

Number of Beds

30

Factors for Success

- Harm reduction approach
- Low-threshold programs
- Clear house rules
- Doing what it takes to help youth remain at the shelter
- Committed staff
- Honest and trusting relationships with the youth
- Systematic development and implementation of programs

Location

Toronto, Ontario

Project Start Date

1997

Program Goals and History

In the late 1990s, Eva's Place was noticing that increasing numbers of youth seeking shelter were using drugs and alcohol. At the same time, the City of Toronto Mayor's Homeless Action Task Force identified a need for more shelter services for this population. Youth who were using drugs and alcohol were unable to access traditional youth shelters because they required abstinence. Youth who were using substances had no place to go for emergency accommodation. The City of Toronto asked Eva's if they would operate a shelter specifically for these youth.

The City provided a temporary location, and for the first two years, Eva's Satellite operated on a seasonal basis. Eva's Satellite then found another temporary home, where the shelter has been operating for the last five years. Eva's Satellite is planning to move its program to a new facility that is being developed by the City of Toronto specifically for Eva's Satellite. The building will provide 40-beds and space for programming. Services will be available 24 hours/day.

The goals of Eva's Satellite are to

- reach out to all homeless and at-risk youth who have difficulty accessing mainstream, abstinence-based youth shelters;
- operate from a harm reduction perspective, with the aim of promoting good health and helping residents minimize the harms associated with drug and alcohol use, and the lifestyle that often accompanies such use;

- work with youth to establish low-threshold programs and effective in-house services. This means trying to make it as easy as possible for as many clients as possible to access the programs and services;
- identify existing services in the community that would benefit their youth and work with agencies to facilitate access to these services;
- respond to the needs of the whole client, rather than just their substance use or their health or housing status, and respond to the needs of the client as defined by the client;
- solicit input from clients in the development of programs and services and in the decision-making process at Eva's Satellite.

Program Description

The people

Eva's Satellite serves youth who are homeless and 16 to 24 years old. In 2004, Eva's Satellite served 893 youth. Three quarters of all the clients were single males, and one quarter were single females. Half the clients were white Caucasian, 40 per cent were West Indian and African, 5 per cent Hispanic and 5 per cent South Asian. The above racial breakdown has been typical of Eva's Satellite since it opened.

As noted in the table 45 per cent of the individuals housed at Eva's Satellite had concurrent disorders, 38 per cent had a mental health issue, and 35 per cent had substance use issues.

Half the residents had no income, while 35 per cent received income assistance and 15 per cent received income from employment.

Types of Issues	Per cent of residents
Concurrent disorder (mental health and substance use)	45%
Substance use	35%
Mental health. No formal diagnosis or connection to a mental health team/services	28%
Mental illness. Formal diagnosis and/or connected to mental health team/services	10%
Behavioural issues	15%
Domestic violence	10%
Involvement in the criminal justice system	10%
HIV/AIDS	2%

The Housing

At its current location, Eva's Satellite provides beds for 30 individuals. One room has 10 beds specifically for female youth. Four rooms are available to serve 20 males. One of these rooms contains two beds, and the other rooms contain four-six beds. There are two washrooms available for all the youth, and three showers. There are no kitchen facilities. At present, all the food consumed at Eva's Satellite is prepared at Eva's Place.

The new building will provide 40 beds, with two beds per room. The living space will be dormitory style, and there will be more bathrooms. It is expected that males and females will sleep on separate floors. The building will also contain space for programs, a gym, weight room and a kitchen. Meals will no longer be brought in from Eva's Place, but will be prepared on site.

Youth who come to Eva's Satellite stay for varying periods of time. Some may stay on and off for a few weeks while others stay on and off for a few years. There is no maximum length of stay at Eva's Satellite, but youth cannot stay past the age of 24.

Access to Housing

Most of the youth hear about the shelter through "word of mouth." Youth can simply "show up at the door." Agencies that serve youth may also refer them to Eva's Satellite. The intake process involves staff conducting a risk assessment within 24 to 48 hours of each youth's arrival. Staff ask youth about their socio-demographic background, physical health, mental health and drug use (for example, the types of drugs they are using and how long they have been using them).

Staff will discuss with youth different options about how they might reduce the harms associated with their drug use. They will also explore the nature of the relationships the youth have with their families to see if there is a possibility of reconnecting them to their homes.

Eligibility Criteria

Youth must be homeless and 16 to 24 years old to be eligible to stay at Eva's Satellite. Most are actively using drugs and/or alcohol. If a youth who does not fit the eligibility criteria comes to Eva's Satellite, staff will refer them to a suitable shelter or agency and will provide them with the means to access these services (for example, bus/subway token).

While active use of drugs and/or alcohol is not a requirement to stay at Eva's Satellite, if a youth who was not using substances came to the shelter, staff would recommend that they go to an abstinence-based shelter—such as Eva's Place. Eva's Satellite would be concerned about having a youth who is not using substances stay with them for fear that if they are around other youth who are using, they might start.

Degree of "Housing Readiness"

Since Eva's Satellite is a shelter, the concept of "housing readiness" does not apply to them. However, many of the youth who come to Eva's Satellite do want their own place to live. A Community Support Worker works with the youth to help them achieve this goal. Youth are most likely to access shared housing or a housing co-op. Some youth go to a treatment facility before trying to access housing.

Program Expectations

Very few expectations are placed on the residents. Staff practice harm reduction, and their approach is "client-driven." This approach involves establishing rapport and a relationship with each youth, and working with them to help them achieve their goals.

Youth are expected to abide by house rules, which include participating in daily chores (for example, keeping the building clean), respecting the curfew, and refraining from verbal aggression or causing property damage.

While it is not required, the youth are encouraged to attend house meetings, and to participate in various programs, such as movie nights, discussion groups, recreational activities and going to the library.

Program Demand

Eva's Satellite does not maintain a waiting list for the shelter. Their occupancy rate for 2004 was 68 per cent, and year-to-date 2005 was 76 per cent. Eva's Satellite reports that sometimes youth will reserve a bed and not show up, or they may leave suddenly.

Harm Reduction and Substance Use

Eva's Satellite defines harm reduction as "staying safer and healthier by learning about and reducing the harms associated with risky behaviour" (for example, unprotected sex or the use of legal or illegal intoxicating substances).

Eva's Satellite tries to reduce the harms that comes with risky behaviour as follows.

Treating clients with respect. At Eva's Satellite, this means accepting clients for who they are, wherever they are at in their life and with their substance use. In particular, it means not judging how clients get high or have sex. It also means listening to clients and accepting that they can make their own decisions. In addition, it includes asking others in the community to treat clients with respect and working with clients to teach communities, schools and governments about who they are and what they need.

Giving clients the basics of life. This means giving clients a safe and clean place to sleep and nutritious food to eat.

Giving clients information. This includes giving clients accurate information, education and resources so they can increase control over their physical, mental and social health. The goal is to help clients stay safer and healthier and make useful choices for themselves, whether they choose to use the information or not. Eva's Satellite provides information about housing, employment, legal rights, welfare, where to get clean needles or crack

pipes, where to go for detox, where to get help if pregnant, how to have safer sex, and how to reconnect with their families.

Substance Use

Most of the youth at Eva's Satellite are actively using substances, such as crack, crystal meth, and prescription drugs, as well as marijuana and alcohol. Staff believe that increasing numbers of youth are using crack, crystal meth, and prescription drugs. Staff are finding more needles around the premises, which leads them to believe there is also an increase in intravenous drug use.²

All the various drugs alter the mood and behaviour of the users so that most of the youth have issues that need to be addressed by the staff.

In particular, staff find that crystal meth makes their clients become agitated and “stir crazy.” They want to come in and out of the house repeatedly. They become hyper and can't sleep. This behaviour can be disturbing to the other residents. Staff handle these situations by walking around with the youth—talking and listening to them.

Staff believe that a significant number of youth have concurrent disorders (mental health and substance use issues). However, because they are young, most do not have a formal diagnosis. If staff suspect a mental illness (such as schizophrenia), they try to help youth access mental health services, including a psychiatrist or psychologist, for assessment and treatment. This can be very labour-intensive. Youth with concurrent disorders are more vulnerable than others because they act “different” and may become a target for teasing.

Youth who are new to Canada, particularly if they are from countries experiencing war, may suffer from post-traumatic stress. It can be challenging to help these youth feel safe. Eva's Satellite also finds it difficult to serve youth who are transgendered because the current facility does not provide sufficient privacy.

Policies and Approaches Relating to Substance Use and Abstinence

Use of Substances

Eva's Satellite serves youth who are using drugs and/or alcohol, and who are under the influence of these substances. However, alcohol and drugs are not permitted anywhere on the property. If a youth comes to the shelter with a bottle of alcohol, they can turn it in for safekeeping, and the alcohol will be returned upon discharge, if they are of legal drinking age.

Security Measures

There is one point of entry to the building, which is kept locked. Youth must sign out when they leave the building.

Guests

Visitors and guests are not permitted inside due to the small size of the building.

Conflicts Among Residents

Eva's Satellite has rules and clear expectations for their residents. Notices about the rights and responsibilities of each resident are posted in the building. House meetings are held to discuss any issues or conflicts that may arise. Youth usually understand and appreciate that if they are disruptive, their behaviour affects the other residents. Eva's has a complaints process to address specific issues that may arise and provides mediation if a dispute develops between or among residents.

Temporary Absence

If a client is staying at the shelter and misses the curfew, Eva's may release that person's bed to someone else. Eva's would not want to leave a bed vacant, particularly if there is someone else in need. However, if the client returns to the shelter late, staff would probably let him/her sleep on the couch.

Residents Who are Abstinent

If youth are abstinent, it is not likely that they will seek services at Eva's Satellite. These youth would have other options, and would want to be in a different environment.

Prostitution

Some clients at Eva's Satellite are in the sex trade, but prostitution is not permitted on the property.

Role of Staff in Working with Residents

Staff at Eva's Satellite use a harm reduction approach that involves

- developing an honest and trusting relationship with each youth
- engaging with the youth, accepting where they are at in their lives, supporting youth to take one step at a time, and providing the necessary information and supports
- informing youth of ways to stay healthier and reduce the harms associated with drug and alcohol use
- helping youth to identify the harms associated with their lifestyle and to explore ways to minimize or eliminate these harms.

The goals are to help youth minimize the harms associated with drug and alcohol use, and the lifestyle that often accompanies such use; and make informed choices when forming a plan to minimize the harms associated with their substance use and lifestyle.

² Eva's Satellite is confident that youth are not using substances on the premises—but are probably using nearby.

At the current location, staff are available between 5:00 p.m. and 9:00 a.m. At 5:00 p.m., youth check in and are offered a meal. Harm reduction workers are available to talk with the youth about what they are doing and to discuss any issues of concern to the youth. They may take youth out to a recreational activity, such as a baseball game or movie.

Legal Issues

A significant number of youth who come to Eva's Satellite have a history of being involved with the police. In the past, there was conflict between the police and Eva's Satellite because the police would come to the shelter wanting to question a particular youth while staff were responsible for protecting the confidentiality of their residents.

In September 2004, the City facilitated the development of a protocol that outlines how the police and Eva's Satellite will proceed if the police are searching for a youth they suspect of committing a crime. The protocol provides that if police are looking for a youth, they must fill out a form that outlines the particular information they are seeking. This form demonstrates to Eva's Satellite that the police have a legitimate request, and have an active case number or warrant to show that the person they are seeking is "of extreme interest." The police usually want to know if the youth was staying at the shelter on a particular day. If the youth was at the shelter, the police can rule him/her out as a suspect.

If a matter is not urgent, the police can call the General Manager. The General Manager will review the form and investigate if the youth was a client who stayed at the shelter on a particular day. If the matter is urgent, and police have completed the necessary form, they may go directly to the shelter. Staff will invite the police into the shelter. The police will inform the staff that they

are looking for a particular youth and ask if the youth can be brought to them.

This arrangement has served to improve the relationship between Eva's Satellite and the police.

Exits from Housing and/or Programs

Voluntary move-outs

Residents who leave Eva's Satellite may move into more permanent housing, which they usually share with others. Some go back home, while others may go to another shelter. Some youth leave because they are incarcerated.

The most common reason for leaving is that the youth is ready to "move-on." Youth who reach the age of 24 years old are no longer eligible to stay at Eva's Satellite.

Evictions

If residents breach the same house rule three times in a row, they may be considered for discharge. If a resident is discharged, he/she must leave the shelter for a period of 24 hours. If a youth causes serious property damage, he/she may be asked to leave the house for 72 hours, if a youth injures another person, he/she may be asked to leave for an extended period of time. If a youth is discharged, staff would find them a bed somewhere else and provide bus/subway tokens to get there. Youth may return to Eva's Satellite following a discharge.

Very few youth are discharged or required to leave Eva's Satellite. Staff do everything they can to avert a problem, including talking with the youth and holding house meetings.

Services

Model of Service Delivery

Eva's Satellite operates its program and services using a harm reduction model. Staff are responsible for

- respecting the individual dignity and self-determination of all clients
- making client-driven referrals and decisions
- explaining decisions to clients with clarity and respect
- maintaining client confidentiality
- providing programs and services that do not reflect any bias toward a client's personal behaviours, experiences, choices or identity
- providing programs and services to everyone, as long as they fit the agency's age requirements and can reasonably comply with the agency's house rules

Types of Services

Staff at Eva's Satellite provide the following basic services:

- accurate information
- harm reduction education
- food (breakfast and supper on the premises, and a "brown bag" lunch to go)
- clothing (when available)
- toiletries
- short-term storage
- bedding
- condoms
- referrals
- workshops

Additional services are available as follows:

Medical services. Eva's Satellite is negotiating with the Shout Clinic to provide a nurse on site for half a day/week. At present, staff refer youth to the Shout Clinic or to community health centres. Youth do not require a health card to access these medical services Youth who have health care cards are encouraged to secure their own physician. Youth will also be referred to emergency health services, if necessary.

Mental health. New Outlook provides a worker to meet with the youth and provide counseling once a week, on site.

Substance use. All staff at Eva's Satellite work with the youth to discuss harms associated with their substance use and to help them minimize these harms. For example, they might discuss strategies that would minimize time lost from work because of difficulties getting up in the morning. Staff also help youth access treatment programs, if the youth is interested.³

Employment. Eva's Satellite is within a short walking distance of Youth Inc., an organization that provides employment services for youth. Clients from Eva's Satellite are encouraged to go there for services.

Life skills/money management.

Community support workers assist youth with budgeting, lifeskills, legal, immigration and housing issues. They will also help youth obtain furniture if they are moving into housing. A worker is available to meet with youth Sundays to Thursdays on site.

Community outreach. Eva's Satellite believes it has a responsibility to engage in street outreach throughout Toronto to bring programs and services to those who cannot or will not use the shelter, and to maintain ongoing engagement to find out how the shelter can be modified to best meet their needs. A new position was created for a community outreach worker (40 hours a week), to work with youth in the community. This includes youth who may be having difficulties at school or who may be in crisis. The community outreach worker also helps advocate for youth with the police, and accompanies the police on foot patrol.

Youth Service Workers. These staff are available from 5 p.m. to 9 a.m. every day. They are responsible for the house. Youth check in with them, and these staff explain the rules and expectations for staying at Eva's Satellite. They inform youth of the chores they will be responsible for, provide meals and immediate crisis intervention, and help youth explore issues around their substance use and ways to reduce harms associated with this use.

Harm Reduction Worker. Generally available Sundays to Thursdays from 1 p.m. to 9:00 p.m. Provides educational workshops on lifeskills and sexual health, and organizes "movie night." Also works with youth to develop and implement new programs that meet their needs. This includes finding out what programs the youth would like to see developed, and what factors would encourage youth to participate in these programs. Provides individual and group counseling, and case management, including intake, assessments and referrals. Works with youth to explore issues associated with substance use and may refer youth to treatment. Is responsible for interface with external agencies.

Community liaison. A community engagement worker works to forge partnerships with organizations that provide services and programs in the community to help facilitate access to these programs for their clients. These include programs at the local library, schools, community centers and the "Y".

Other programs and services. Eva's Satellite offers a variety of low-threshold programs. Low threshold means that there is no need for the youth to sign up in advance, or to attend if they do sign up. If they do show up for a program, they can leave when they want. They can attend a program if they are under the influence of drugs or alcohol, as long as they can function appropriately. Some of the programs include

- basketball two nights/week at a local community centre
- a drop-in program at the library twice/week
- access to the YMCA twice/week
- weekly sexual health workshops
- weekly movie nights (these are shown on site, and usually have an education component (for example, related to drugs or alcohol or another topic that will generate discussion))

One new project that has started is the Garden Project. Once a week, interested youth will get together on and offsite to design a rooftop garden for the new facility.

³ For example, Eva's Satellite entered into an arrangement with the Shout Clinic to help youth attend an abstinence-based treatment summer camp in the Laurentians (north of Montréal).

Most Effective Services

Eva's Satellite has been working to develop new programs in anticipation of moving to their new facility. They have held focus groups with youth to find out more about the kinds of programs they want. This process has served to increase the extent to which youth are participating in their programs, because the youth feel a sense of ownership. It is important that youth participate in the programs. Eva's Satellite has found that the best way to stabilize the youth who come to the shelter is to engage them and keep them interested in the programs.

Connections With Community Programs/agencies

Eva's Satellite has arrangements with several organizations (such as community centers, the Toronto Public Library, Youth Inc., the YMCA, City of Toronto Department of Parks and Recreation, The Works (a needle exchange program developed by the City of Toronto Public Health) and Evergreen (organizing the Garden Project) that provide services to their clients. In all cases, Eva's Satellite enters into a written agreement (Memorandum of Understanding) that outlines the roles and responsibilities of each party.

Staffing and Personnel Issues

Eva's Satellite has the following staff positions.

- 7 Youth Service Workers – available 5 p.m. – 9 a.m. They are responsible for the house. Youth check in with them, and these staff explain the rules, expectations, inform youth of their chores, provide food and immediate crisis intervention
- 1 Harm Reduction Worker
- 1 Community Outreach Worker
- 1 Community Support Worker
- 1 Residential Supervisor
- 1 Community Engagement Worker
- Half-time General Manager

Staff burnout

Staff burnout has not been identified as an issue. Most staff have been with Eva's Satellite since the program first began.

Policies for hiring formerly homeless individuals

Eva Satellite does not have any specific policies in place about hiring former homeless individuals or hiring persons with a history of substance use.

Funding

Eva's Satellite receives most of its funding from the City of Toronto. It also receives funding from charitable donations and the federal government through the Supporting Communities Partnership Initiative (SCPI).

Residents at Eva's Satellite do not pay any rent. They are not required or are expected to pay for anything.

The level of funding since start-up has not been an issue, and for the most part the funding has been stable. The per diem rate at the shelter is based on the number of residents, and the number of residents on any given night is usually about the same.

Source of Revenue	Amount
City of Toronto (Per diems)	598,199
Municipal funding (projects) ⁴	197,543
Fundraising	186,544
Total	\$982,286

Costs	Amount
Support services (i.e. personnel)	\$120,000
Building cost (taxes, repairs, heating, etc.)	\$68,000
Unforeseen	\$10,000
Total	198,000

⁴ Includes \$24,142 from a project that ended May 30/05.

Outcomes, Challenges and Factors for Success

Eva's Satellite defines success as being able to work with their clients over time and to provide them with the services they need to achieve stability in their lives. They believe they have been successful in engaging youth to participate in their programs and in developing new programs that meet their needs. Eva's Satellite believes their success will increase once they move to their new building where they will be able to build on their programs and services.

Impact of the Program on Residents

Eva's Satellite reports that their program has had the following outcomes and impacts on the residents.

Outcomes	Examples of Changes
Residential stability (e.g. length of time housed)	Eva's Satellite is not in the business of providing stable housing.
Substance use	Eva's Satellite has observed that some youth reduce their consumption of substances while at the shelter. What is more noticeable, however, is that youth generally reduce the harms associated with their drug use. They may change their drug of choice to one that is less harmful, may switch to less harmful combinations of substances, or change the way in which they use drugs to be more safe.
Physical health	Eva's Satellite focuses on health promotion, increasing awareness of health issues among their clients, and helping youth to stabilize their health. This may ultimately result in less demand for emergency services, but not in the short term. The youth at Eva's Satellite often have multiple health issues.
Mental health	Eva's Satellite helps youth with mental health issues access services from mental health professionals. For some youth, their mental health improves if their substance use decreases. For example, they may experience less depression.
Employment/income	Youth Inc. helps youth with their resumes. It is estimated that about 35-40% of the residents have jobs. Eva's Satellite believes that their program helps their clients gain the confidence they need to be able to keep their jobs.
Education/training	Youth are encouraged to attend school.
Personal networks (e.g. more contact with family, new friends)	Youth have access to a program that helps them explore issues associated with reconnecting to their families.

Resident Satisfaction

Eva's Satellite has not conducted resident satisfaction surveys.

Reasons for Success

Eva's Satellite believes the main reasons for the success of their program include the following.

1. Their harm reduction philosophy which involves accepting clients for who they are and "where they are at," providing basic necessities (such as food and shelter), and providing information to help clients make informed choices about their substance use and lifestyle.

2. Low-threshold programs and services that make it easy for youth to participate. This includes programs that do not require youth to sign up in advance, to attend if they do sign up, or to stay for the entire program. Youth can attend a program if they are under the influence of drugs or alcohol, as long as they can function appropriately.
3. The house rules that make it clear what is expected of the residents.
4. Doing what it takes to help youth remain at Eva's Satellite where they can become more stable. This includes Eva's Satellite's goal not to discharge any youth unless this becomes an absolute necessity.
5. Staff who are committed to working with the youth—using a harm reduction approach.
6. Relationship building with the youth to develop honest and trusting relationships.
7. The systematic way in which Eva's Satellite has approached the development and implementation of their programs and services, which includes obtaining input from the youth (for example, focus groups) to ensure the programs that will meet their needs.

Challenges

The main challenges that Eva's Satellite have faced include the following:

1. The physical facility, which has been inadequate to provide the full range of programs and services Eva's Satellite would like to offer. This issue will be addressed once Eva's Satellite moves into its new facility. (Construction is scheduled to begin in the fall of 2005).
2. Adequate resources—the ability to access sufficient funding to implement all the programs Eva's Satellite would like is an ongoing challenge.

3. Building the new facility—Eva's Satellite has faced considerable opposition. It is necessary to break the stereotype images the general public has about youth. The shelter is currently on a main street (Yonge Street). It will be located on a side street and will back onto businesses that have housing above the commercial space. The property owners tried to block approval for the new building. The project received approval from the City of Toronto's Committee of Adjustments, but then business owners in the area filed an appeal to the Ontario Municipal Board (OMB). The OMB dismissed the appeal in March 2005, which means the project may proceed. Eva's Satellite communicated frequently with the city councillor who has supported the development of the new building from the start.
4. Eva's Satellite notes that serving their target population can be a challenge in itself. For example
 - A significant number of youth have a mental health issue, but most are not receiving treatment.
 - It can be difficult to reason with a person about rules and treating others with respect if they are under the influence of drugs or alcohol.
 - Eva's Satellite is also finding that more and more youth have no legal status to be in Canada.
 - Most youth don't have health cards, which makes it difficult to refer them to appropriate medical treatment.
- Youth who are 16, 17 and 18 years old present some specific challenges. First, they are below the legal drinking, so alcohol use is against the law for them. Second, it may be appropriate for youth 16-18 to have a curfew, but in a facility that also serves older youth, this would not be practical. Finally, younger youth are more impressionable than older youth and are likely to be influenced by them. All these issues suggest that perhaps younger youth would be better served in their own facility.
5. Not many other organizations are doing the same type of work as Eva's Satellite, therefore, there is not a great deal of experience to draw upon, or to guide them.

Lessons Learned

1. Conduct research on different models and approaches to determine what you think will work best for your target population. Program development requires systematic design and implementation. Make sure to obtain input from the target "users." If you want youth to be attracted to your programs, to participate and to remain interested, they should be involved in the initial program design and development.
2. Think about how to address NIMBY issues. Make sure to obtain support from your local city counselor. Eva's Satellite does not support public education and information when planning to develop a new building. They recommend that you do as much work as possible, and answer questions only when asked.

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INNOVATIVE SUPPORTIVE HOUSING THROUGH A HARM REDUCTION APPROACH FOR SUBSTANCE USERS

Case studies



Halifax, Nova Scotia

Situation Appropriate Supportive Housing (SASH): Metro Non-Profit Housing Association

Background

This case study was prepared based on an interview with staff from the Metro Non-Profit Housing Association (MNPHA). Other sources of information included a pre-development study prepared for the Association¹ and MNPHA's website.²

The Sponsor

MNPHA is a private registered charitable organization. It was established in 1988 to assist single adults who have been homeless or at risk of homelessness to create and maintain their homes. MNPHA provides supported housing to approximately 60 tenants in Halifax and Dartmouth, N.S. They manage these homes in a participatory manner. In addition to providing housing, MNPHA operates a housing support drop-in centre to help single people in the community address their housing, finance and health issues.

Program Goals and History

MNPHA is seeking funding from the Supporting Communities Partnership Initiative (SCPI) to develop long-term transitional and emergency housing for single people who are homeless and not served by any other housing in the community. These are mostly individuals with severe mental illness and co-occurring substance use issues. In addition to the provision of housing, the Situation Appropriate Supportive Housing project (SASH), would provide support and healthcare services to individuals participating in the program.

Project at a Glance

Sponsor Name

Metro Non-Profit Housing Association

Goals

- Reduce the harms associated with living on the streets
- Provide supportive housing for people not served by other housing
- Operate with a developmental approach to enable residents to move to other supportive housing or independent living

Target Population

Homeless people who are single and have a mental illness and co-occurring substance use issues

Housing Tenure

Emergency and transitional housing

Number of Units

20 transitional and 5 emergency units

Factors for Success

N/A

Location

Halifax, Nova Scotia

Project Start Date

Aim to start construction in the summer, 2005

¹ Peter Ilves & Associates Inc. 2004. *Situation Appropriate Supportive Housing: A Pre-Development Study for a 25-Unit Crisis-Transitional Housing Partnership to Reduce Homelessness Among People Disabled by Mental Illness and Co-occurring Substance Use*. Prepared for the Metro Non-Profit Housing Association.

² <http://www3.ns.sympatico.ca/mnpha/index.html>

The main goal of this project is to reduce homelessness among individuals with mental illness and co-occurring substance use issues. Additional objectives are to

- reduce the harms associated with living on the streets
- provide supportive housing for people not served by other housing
- operate with a developmental approach to enable residents to move to other supportive housing or independent living

Project planners believe the facility, with its integrated support program, will reduce stays in shelters, psychiatric institutions and hospitals, utilization of emergency health services and police involvement. They also believe that the need for shelter, food and security should be addressed before focusing on mental health or substance use treatment.³

MNPHA identified a need for this type of project in 1998, and has been thinking about it ever since. Development work began in 2002. However, it was not until early in 2004 that MNPHA received sufficient funding to prepare a workable plan for this project.

The main impetus for this project is that existing housing projects are forced to turn the target population away because they don't have enough staff to accommodate them successfully. MNPHA has been seeing these individuals in their drop-in centre, and is aware that there is no housing for them. In addition, because of their behaviours, these people are often barred from shelters and are forced to sleep on the streets. The number of people in this situation has increased over the years.

Program Description

The People

The SASH program will be targeted to single men and women who are

- more than 22 years old
- homeless or at imminent risk of homelessness
- experience significant impairment in basic daily activities because of a mental illness and co-occurring substance use
- not adequately served by existing shelters or other housing options in the Halifax region

Often, the behaviours of these individuals make it difficult for them to maintain housing.

Most will be in receipt of income assistance, while a few will have no income and a few will be in receipt of pension income.

The Association decided to target this population because there is such a strong need. Housing options do not exist for them. In addition, it is very difficult for individuals with concurrent disorders to access treatment programs in Halifax. Furthermore, MNPHA has a history of working with this target group, and believes it has the skills and expertise necessary to deliver a successful program.

MNPHA notes that its target population is often referred to as “hard-to-house” or “hardest-to-house.” MNPHA does not accept that it is people who are hard-to-house. The real issue is the lack of housing that is appropriate for people's situations.

The Housing

MNPHA plans to develop a building that will include 20 units of transitional housing and five units for emergency shelter. The transitional housing units would be self-contained (for example, private bedroom, bathroom, and cooking facilities). There would be no fixed maximum length of stay, however, staff will be expected to help residents move to a more permanent form of housing. The emergency shelter units are expected to contain a private bathroom but no cooking facilities.

Access to Housing

MNPHA has a close working relationship with emergency shelter providers in Halifax. They expect the shelters will refer clients with challenging behaviours to their facility, and that Mental Health agencies will also refer clients. MNPHA will also accept applications from eligible clients who walk-in.

Eligibility Criteria

The housing to be developed by MNPHA is expected to be “the housing of last resort.” If applicants have other options, they will not be eligible. Applicants will also be denied housing if they will pose a danger to others.

Degree of “Housing Readiness”

N/A

Program Expectations

There will be no formal expectations for residents—other than that they do not pose a risk to others. Over the longer term, it is expected that residents will work with staff to ensure their units remain habitable.

³ Peter Ilves & Associates Inc. 2004. *Situation Appropriate Supportive Housing: A Pre-Development Study for a 25-Unit Crisis-Transitional Housing Partnership to Reduce Homelessness Among People Disabled by Mental Illness and Co-occurring Substance Use*. Prepared for the Metro Non-Profit Housing Association.

Program Demand

N/A

Harm Reduction and Substance Use

MNPHA plans to adopt a harm reduction approach. They define harm reduction as:

Various strategies and approaches for reducing the physical and social harms associated with risk-taking behaviour.

Harm reduction is about preventing disease, death, incarceration and isolation. It is about improving and saving lives. Harm reduction is about making dangerous behaviours less dangerous.⁴

MNPHA plans to “accept people where they are at,” and will provide housing with very few demands. There will be no expectations that residents participate in recovery programs or take their medications if they don’t want to. MNPHA hopes that residents will want to engage in these activities, but will not require them to do so.

MNPHA decided to adopt this approach because they recognize that for some people, this is the only kind of program that will keep them off the street. MNPHA tried to house this population in another one of their buildings where they have higher expectations for their tenants, but found that a more specialized approach is necessary for this population.

Policies and Approaches Relevant to Housing the Target Group

MNPHA plans to work with tenants in a participatory way to develop appropriate rules and policies.

Use of Substances in and Around the Building

What residents do in their own private space will be up to them. However, residents will not be permitted to use drugs and/or alcohol in common areas. The selling of drugs in and around the building will also be prohibited.

Security Measures

MNPHA is considering ways to design the building to promote safety and security. They also plan to have two or three staff available at all times, 24 hours a day. MNPHA has looked at buildings where staff are positioned to see everyone who enters and exits the building, and supports this approach. Other ideas being considered include negotiating a fast response protocol with the Mobile Crisis Intervention Service⁵, and a minimally disruptive response protocol with the Halifax police.

Guests/Visitors

Policies will be developed.

Sex Trade/Prostitution

Policies will be developed to prevent this activity within the building.

Conflict Resolution

Policies and procedures will be developed to promote conflict resolution.

Temporary Absences

MNPHA expect to help residents maintain their housing if they need to be absent for a certain period of time.

Residents Who are Abstinent

Staff will be expected to support residents who become or wish to become abstinent. Because residents will have their own private unit, MNPHA expects that residents would stay for a period of time—to achieve a degree of stability. Over time, however, staff would probably direct these residents to other housing options.

Legal Issues/Police

MPNHA has always had a positive working relationship with the police, and expects to be able to work with them if any issues arise with the project.

Exits from Housing and/or Programs

MNPHA expects that breaches in policies or rules that put staff or other tenants in danger will be grounds for an eviction. For example, leaving needles around would be cause for concern. However, staff will be expected to work with residents to address behaviours or actions that could lead to an eviction.

Services

Model of Service Delivery

MNPHA plans to introduce an outcomes-focused strategy based on integrating health care and social services resources. This approach involves doing “what works” at a particular time with a particular individual. The model for service delivery will most likely be one of case management, where each resident will be assigned to one staff person as their primary contact and case manager. These

⁴ Peter Ilves & Associates Inc. 2004. *Situation Appropriate Supportive Housing: A Pre-Development Study for a 25-Unit Crisis-Transitional Housing Partnership to Reduce Homelessness Among People Disabled by Mental Illness and Co-occurring Substance Use*. Prepared for the Metro Non-Profit Housing Association. Taken from the Harm Reduction Project. 2004. Mission statement. Salt Lake City, Utah. <http://www.ihrproject.org>

⁵ This is a service available through the Capital District Mental Health Program.

case managers (MNPFA staff) would be responsible for

- addressing immediate and basic client needs
- connecting residents with existing services in the community to meet social, legal, recreational and education/training needs
- providing support to the mental health liaison worker
- providing mental health, primary care, or specialist medical referrals and facilitating access to these services.

In addition, as with its other buildings, MNPFA plans to implement a community development approach. This approach aims to involve tenants in the organization and to create a community in each building. Activities can include social events (such as, eating together sometimes), shared tenant projects (such as garden/food bank), house meetings to discuss any housing management issues, tenant selection committees to have a say in choosing new tenants, tenant representation on the Board, and tenant participation as much as possible in the economy around the housing (such as hiring tenants when possible).

Types of Services

MNPFA plans to make the following services available to residents in their SASH project.

Medical care: MNPFA expects that their residents will have many physical health problems that will need to be addressed. They hope to make arrangements for a nurse practitioner to come to the building on a regular basis.

Mental health: Plans are underway for

- a mental health worker to be at the facility every day to consult with staff and tenants if they wish
- the Mobile Crisis Intervention Service to be on call

Substance use: MNPFA's own staff will be available to provide counseling for residents and to refer them to other resources (such as, drug treatment programs), if the resident is interested.

Employment assistance: MNPFA's own staff would help residents who are interested in seeking employment and will also refer them to other services located in the community. They will also work with residents on money management and other life skills issues.

Meals: SASH will have a central kitchen where staff can provide meals for residents in the emergency units and for other residents who don't want to cook for themselves.

The building will be designed to provide space for the provision of services onsite. MNPFA thinks this will be particularly important for the provision of medical care. MNPFA also wants this space to be used by mental health workers as a place to meet with their clients who live in the building. MNPFA believes that residents would prefer to meet their workers in a "neutral" location rather than in their own units.

Connections With Community Programs/agencies

Formal: With mental health programs

Informal: With methadone programs, emergency shelters and supportive housing providers

Staffing and Personnel Issues

MNPFA believes that at least three staff should be on duty at all times. However, this may not be feasible, and there may be shifts where only two staff will be on duty. MNPFA's preliminary operating budget for SASH provides for the following staff positions:

- Program Coordinator/Manager (1 FTE): On duty from 9 a.m. until 5 p.m.
- Residential counselors (14 FTE): Would be on site and ensure continuous coverage within the SASH building. These staff would be responsible for maintaining informal contact with residents, some level of homemaking services, food preparation, social events, money management, life skills and security.

In addition, current plans for the SASH building include dedicated services to be provided by the Capital District Mental Health (CDMH) program.

- A liaison worker (1FTE): Would reside on site and would be responsible for assessing and triaging residents' mental and physical health care needs and expediently and rationally accessing appropriate services for individuals. This person would be an integral member of the MNPFA support staff team and would maintain strong ties to various CDHA mental health and addictions services.
- Case managers (2 FTE): Would be assigned to work with specific tenants. They would be their link to the mental health system and would follow tenants as they moved out to more independent housing. Worker to client ratios would be up to 1:10.

6 FTE means Full Time Equivalent positions.

- Crisis intervention services (approximately 500 hours per year): MNPCHA is working with the Mobile Crisis Intervention Service to see if they can be “on call” at all times.

Staff Burnout

MNPCHA plans to develop policies and strategies to address the potential for staff burnout. One idea is to provide support during staff meetings, and to discuss how staff can draw boundaries for themselves. During the planning process many individuals expressed a strong interest in being able to be part of the staff complement for the new project, and they have not identified staff burnout as a potential issue.

Policies for Hiring Formerly Homeless Individuals

MNPCHA has a tradition of hiring their own tenants whenever possible—“people who have lived the life.” In addition, residents at SASH will have opportunities to earn money by helping with tasks such as meal preparation and maintenance.

Funding

MNPCHA is planning to secure funding from the Supporting Communities Partnership Initiative (SCPI) to offset most development costs. A below-market-rate property contribution, combined with development fee and tax concessions are also being sought from the Halifax Regional Municipality. Total development costs are estimated to be approximately \$2 to \$2.3 million.⁷

SASH Development and Implementation Cost Summary

Source of Revenue	Amount
SCPI	\$2,254,782
Halifax Regional Municipality	\$150,000
Total	\$2,254,78
Cost components	
Support services design and Implementation, Partnership development <ul style="list-style-type: none"> ■ Training of residential support workers ■ Management training ■ Partnership development 	\$19,888
Building development <ul style="list-style-type: none"> ■ Land acquisition ■ Construction costs ■ Financing costs 	\$2,122,530
Overall project management and implementation support <ul style="list-style-type: none"> ■ Overall project management services ■ Research and administrative support 	\$112,365
Total	\$2,254,78

SASH Estimated Operating Costs

Estimated Operating Costs	Amount
Residential support services (to provide in-house services to residents) <ul style="list-style-type: none"> ■ Residential counselors (14 FTE) ■ Program manager (1 FTE) ■ Administrative overhead and supplies ■ Resident meals ■ Rehabilitation and support - supplies and services 	\$503,860 \$59,000 \$23,850 \$135,000 \$18,000 \$739,710
Healthcare services (to provide mental health, addictions and primary care services to residents) <ul style="list-style-type: none"> ■ Liaison worker (1FTE) ■ Case managers (2FTE) ■ Crisis intervention services (approximately 500 hours per year) ■ Administrative overhead and supplies 	\$72,000 \$144,000 \$23,760 \$31,868 \$271,628
Facility costs (to operate and maintain the SASH facility/building) <ul style="list-style-type: none"> ■ Real estate taxes ■ Utilities ■ Repairs, maintenance and landscaping ■ Insurance, legal and contingency ■ Capital reserve 	\$16,250 \$26,000 \$19,500 \$12,500 \$3,713 \$77,963
Total	\$1,089,301
Per diem on total	\$119

Outcomes, Challenges and Factors for Success

MNPCHA is considering how it will define success for their program. They would like to be able to document changes in

- the incidence of homelessness
- the inappropriate use of the health system
- quality of life/feelings of well-being

In addition, they plan to track the following specific outcomes

- residential stability (for example, length of time housed)
- substance use
- mental health
- increased participation in employment, volunteer or other community activities
- income
- personal networks (for example, more contact with family, new friends)
- improved use of mental health services and primary health care

Community Response

Community groups are completely behind this initiative and have been calling for such a project for several years. The Harm Reduction Committee, created in October 2002 as a sub-committee of the Community Action on Homelessness Committee, was seeking an agency to take on the challenge. Service agencies and health centres are very positive about the project. There have been no negative comments, although a few government officials have expressed a philosophical disagreement with harm reduction.

⁷ Peter Ilves & Associates Inc. 2004. Situation Appropriate Supportive Housing: A Pre-Development Study for a 25-Unit Crisis-Transitional Housing Partnership to Reduce Homelessness Among People Disabled by Mental Illness and Co-occurring Substance Use. Prepared for the Metro Non-Profit Housing Association.

Reasons for Success

N/A

Contact Information

Challenges

The main challenge to implement this initiative has been getting sufficient and sustainable funding to operate the project and provide for ongoing staffing. It is easier to obtain capital funding.

Once the building is up and running, MNPHA believes it will be a challenge to work with the target population and keep them stably housed. They are concerned about the potential for staff burnout. A third challenge will be to keep the drug and street culture out of the building.

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Lessons Learned

N/A

INNOVATIVE SUPPORTIVE HOUSING THROUGH A HARM REDUCTION APPROACH FOR SUBSTANCE USERS

Case studies



Minneapolis,
Minnesota U.S.A.

Supportive Housing and Managed Care Pilot: Sponsored by Hearth Connection

Background

This case study was prepared from interviews with staff at Hearth Connection and two of its partner agencies: Project Quest at the Amherst H. Wilder Foundation (referred to as “Wilder”) and the Delancey Street division of Guild Incorporated (referred to as “Guild”).

Wilder and Guild are two of five teams that provide direct service to participants of the Supportive Housing and Managed Care Pilot (the Pilot). This case study also incorporates information from evaluation reports published by the National Center on Family Homelessness¹ and other materials provided by Hearth Connection.

The Sponsor

Hearth Connection was established to implement the Supportive Housing and Managed Care Pilot. As well as overseeing the Pilot, Hearth Connection administers Pilot funding, prepares funding proposals and liaises with foundations and other potential public and private funders.

Hearth Connection also strives to develop and maintain strong working relationships between primary care providers and other service agencies, with an ultimate goal of serving the needs of the participants. Hearth Connection is the central point of accountability for the Pilot’s success, including completion of a multiyear, independent evaluation. Hearth Connection is also working with government as partners in the Pilot, and to shape public policy.

The mandate of Hearth Connection is to address long-term homelessness by assisting people who have experienced homelessness to lead healthier and more stable lives, and to do so in a cost-effective manner.

Project at a Glance

Sponsor Name
Hearth Connection

Goals

- Demonstrate that its enhanced model of supportive housing is effective in assisting people to become self reliant and lead healthier, happier lives.
- Demonstrate that it reduces participants’ use of costly crisis services.
- Work more effectively and efficiently with government and non-profits across multiple systems that impact the lives of participants including housing, health care, corrections, employment, etc.

Target Population

Single adults and families with long histories of homelessness and high service utilization, i.e. those whose homelessness is exacerbated by other difficulties such as medical problems, mental illness, chemical dependency and histories of trauma.

Housing Tenure

Supportive, permanent housing

Number of Households Served

Currently in the Pilot: 144 (57 families and 87 single person households)

Factors for Success

- Intensive case management based on trust and respect
- Intensive case management based on trust and respect
- The program’s permanency and flexible service model
- The quality and effectiveness of primary provider staff
- Helping participants to advocate for themselves
- Support from community stakeholders, the Pilot’s Board of Directors and the evaluation advisory group

Location

Ramsey and Blue Earth Counties, Minnesota, U.S.A.

Project Start Date

Hearth Connection incorporated in 1999. The first participant enrolled in March 2001.

¹ The National Center on Family Homelessness was founded in 1988. It promotes “research and evaluation, program design, service delivery, systems integration, and advocacy to help homeless children and their families.” <http://www.familyhomelessness.org/about.html>

Program Goals and History

The Supportive Housing and Managed Care Pilot is a demonstration project to address homelessness. It is designed to be intensive, flexible, housing-based and cost-effective. It involves Minnesota state and county governments, community agencies, participants and five primary provider teams in two state counties. The Pilot also includes an in-depth, independent evaluation conducted by the National Center on Family Homelessness.

The Pilot’s goals are to:

- demonstrate that its enhanced model of supportive housing is effective in assisting people to become self reliant and lead healthier, happier lives;
- demonstrate that it reduces participants’ use of costly crisis services; and
- work more effectively with government and non-profits across those systems that impact the lives of participants (such as housing, health care, corrections, employment, etc.) to simplify the interaction leading to improved services and better use of scarce resources.

The Pilot resulted from a multi-year public/private planning effort initiated and funded in part by The Corporation for Supportive Housing.² In 1996, 24 organizations including state and county governments, housing organizations, health plans, service providers for people with chemical dependency, mental illness and HIV/AIDS, advocates and consumers convened to develop a blueprint for a new effort to address the needs of families and individuals with long histories of homelessness. This effort led to the Supportive Housing and Managed Care Pilot.

Hearth Connection was incorporated in 1999 to implement the Pilot, which is largely funded by the State of Minnesota. In 2000, the state allotted funding to address the needs of homeless families. In 2001, they provided additional funding to expand the Pilot to homeless single adults. State funding is now committed until June 2007. If successful, the Pilot could be a model for addressing long-term homelessness in the entire state.

Funding for the Pilot is distributed to two Minnesota counties: Blue Earth (a largely rural county) and Ramsey (an urban county including the City of Saint Paul). This case study examines the role of Hearth Connection in connection with two of the five provider teams in Ramsey County

- Project Quest of the Amherst H. Wilder Foundation—initiated in 2001 and currently serving 34 families
- Delancey Street Division of Guild Incorporated—initiated in 2003 and currently serving 33 single adults

Program Description

The People

Participants in the Pilot are single adults and families with long histories of homelessness, and high service utilization, for example, those whose homelessness is exacerbated by other difficulties such as medical problems, mental illness, chemical dependency and histories of trauma. The Pilot helps participants find housing mostly in the private rental market, with some participants in non-profit housing. The Pilot also helps its participants qualify for rent supplement assistance and offers the necessary supports to help participants achieve increased levels of stability and satisfaction.

Participants in the Pilot are mainly in their 30’s. Participants in the family programs are, on average, 10 years younger than single adult participants. A total of 144 households are in the Pilot: 57 families and 87 single adults, and a total of 334 individuals: 159 adults and 175 children.

All households have low incomes. About 66 per cent receive their primary source of income from various government sources. The remaining households receive income from a combination of sources, including employment. Families represented a higher percentage of those who had employment income. Seventy-five per cent of participants received food stamps.

The types of households are noted in the table below.

Type of Household	Number or Proportion of Households
Single adults program	
■ Men	About 78%
■ Women	About 22%
■ Transgendered	1
Families program	
■ Men	About 6%
■ Women	About 94% (Wilder reports that of the 34 households they serve, there are currently 3 families headed by two-parents.)
Ethnic Background	
Caucasian	53%
African or African American	36%
Aboriginal (Native American)	3%
Other	Asian/Pacific Islander 2%; Multiracial 6%

² The Corporation for Supportive Housing (CSH) (www.csh.org) helps communities in the U.S. create permanent housing to prevent and end homelessness. It raises funds through philanthropic donations as well as federal, state, and local public and private sector financing. It has committed more than \$80 million (US) in loans and grants to over 400 providers to support the development of housing with services for more than 20,000 people.

The types of issues facing participants are noted in the table below.

Types of Issues	Number or Proportion of Participants
Substance use	Almost 100%
Mental illness. Formal diagnosis and/or connected to mental health team/services	Reporting: <ul style="list-style-type: none"> ■ Depression – 82% ■ Post-traumatic stress disorder – 33% ■ Other anxiety disorders – 33% ■ Bi-polar disorder – 25% ■ Schizophrenia – 17%. Participants indicate, on average, two mental health disorders. A greater number of single persons reported a mental illness compared to families.
Mental health. No formal diagnosis or connection to a mental health team/services Not all participants	Not all participants are ready or comfortable seeking mental health assessments. Of Guild's 33 single adult participants, three have no formal diagnosis or connection to mental health services. One is diagnosed with a traumatic brain injury. Two have possible mental illness, but have not been diagnosed.
HIV/AIDS	Less than 5%
Domestic violence	67%
Involvement in the criminal justice system	Some people enrolled in the Pilot have criminal histories. About 45% of Guild participants are currently on probation. One is a registered sex offender. Several have had criminal involvement in the past, though not currently.
Behavioural issues	Some
Physical illness/brain injury	The evaluations found a high level of physical illness (e.g. asthma – 23%, hepatitis – 19%, hypertension – 28%). On average, participants have at least two physical illnesses. One participant at Guild has had a diagnosed traumatic brain injury.
Traumatic events	48% of those who responded to the evaluations stated that they had experienced the violent death of a family member, friend, or domestic partner; 46% had been present when someone was killed; 34% had experienced life-threatening accidents or illnesses; and 19% had experienced the death of a child.

Other specific issues include

- participants with anti-social personality disorder in addition to depression, or other mental health issues who tend to be the most violent individuals
- vulnerable adults with below normal IQ levels
- participants and children with learning disabilities
- single adults whose children are returned to them once they are stabilized (find they face new challenges)
- participants with Post Traumatic Stress Disorder, many with long histories of incest and sexual abuse, who often require a long time for case managers to gain their trust
- participants who have committed felonies (Since landlords conduct background checks, these participants may have more difficulty finding private market housing.)

The Housing

Housing is all permanent and self-contained. Most units are in scattered private market rental buildings though some are in non-profit projects. In Blue Earth County, the team working with families has eight households at a single site apartment that is dedicated to Pilot participants. Some of the other teams have also clustered participants into an apartment building or complex. The Pilot does not own any property.

Wilder has a Housing Department that seeks out units for its family participants. Depending on family size, the housing rental cap can be quite high and may allow participants some flexibility to move to a neighbourhood of their choice. Almost all of Guild's single adult participants are in private rental units. It is difficult for single adults to access public housing, which is primarily focused on families. Guild case managers are responsible for finding housing for participants.

The Pilot has worked hard to establish good relationships with landlords. Landlords know that a Pilot participant will be supported and this makes it easier for the landlord to offer units to people who often have poor rental histories. As well, participants frequently need landlords who are willing to house people with criminal backgrounds, and this too is helped by good working relationships with the agencies. Primary providers work with participants to improve their tenancy skills.

All housing for participants must meet standards similar to HUD's Housing Quality Standards. Four of the primary provider teams have staff within their teams or agencies that are trained and certified to conduct inspections. One team uses an external inspector for this service.

Access to Housing

When there is an opening, application forms are distributed to agencies (for example, child protection services, social workers, transitional housing programs, treatment programs, shelters, street outreach workers, Health Care for the Homeless and other community agencies) that have direct contact with potential participants. Referrals are then sent to staff in either Ramsey or Blue Earth County who determine eligibility.

In Ramsey County, eligible applicants are sorted chronologically according to the date that the potential participant signed the consent to release information. Blue Earth County prioritizes referrals according to need. In both counties, to help maintain a continuum of care, priority is given to current participants who are transferring between primary provider teams and to participants who have exited the Pilot, and would like to return, presuming there are no other reasons for disenrollment, particularly violence.

Eligibility Criteria

Participants must have experienced or be at risk for long-term homelessness. The Pilot strives to serve people who have not found success in other programs, or who are not eligible for or able to access other programs. In both counties, participants must reside in the county's service area and be in need of the Pilot's intensive intervention. In Blue Earth County, single adults must have a chemical dependency and have tried treatment many times. In Ramsey County, single adults must have a mental illness and a history of substance abuse that impairs their ability to achieve and maintain self-sufficiency. Single adult participants in both counties must meet the eligibility criteria for a state income supplement program. Families in both counties

must have an adult caregiver with a mental illness and/or a history of substance abuse, or HIV/AIDS that impairs the family's ability to achieve and maintain self-sufficiency and have a family member that qualifies for and receives Minnesota Family Investment Program benefits.³

Applicants may not be eligible if

- there is concern that a potential participant may be a danger to the primary provider or others, especially if the primary provider cannot determine a method to work safely with the potential participant
- there is a potential for conflict (for example, a potential participant has a family member, former friend or partner already enrolled in the Pilot and there exists an active restraining order between the two)
- the potential participant is already enrolled in a similar program

Degree of "Housing Readiness"

In general, primary providers take a "housing first" approach with participants. Hearth Connection considers it easier and more beneficial to incorporate support services and focus on other root causes of harmful and risky behaviours when participants are housed than when they are on the street or in a shelter and struggling to survive. "Housing first," however, does not mean "support second." Participants are supported from the time they first enrol in the program while still homeless, through the housing search, and then for as long as needed after they are housed.

The Pilot is not a "housing readiness" program, in that a participant is not required to complete a treatment program or any transitional stage before moving into regular, permanent housing for the first time. For example, Guild believes

that you cannot determine housing readiness until the individual is actually assessed in housing and has a chance to live independently. Guild adopted the "housing first" approach because they were unable to establish adequate criteria about who is "housing ready" and because in some cases moving people out of shelters and off the street became essential to the individual's health and safety. Even though moving someone into housing is frequently the first and immediate goal of both participants and primary providers after enrolment, depending on a participant's individual circumstances, this does not always happen quickly.

While there are no programmatic requirements a participant must meet before moving into housing, often various kinds of support, treatment or training are encouraged. If a household struggles or is unable to maintain housing, there are many supports offered. If a household has been evicted or asked to leave their housing multiple times, primary providers may ask a participant to attend treatment, tenant classes or perform other activities before assisting with housing again. This helps keep participants from continuing to damage their rental histories and helps primary providers maintain strong relations with landlords.

Both the Guild and Wilder participants typically have poor rental histories and are living far below the poverty level. Often participants have tried multiple programs without success, or they are ineligible for other housing programs because they are still chemically dependent, have committed felonies, or struggle to manage behaviours due to chemical use, brain injuries or mental illnesses that make it difficult to maintain their housing.

³ The Minnesota Family Investment Program is the state's welfare reform program for low-income families with children. It includes both cash and food assistance. http://www.mdrc.org/project_16_12.html

Program Expectations

Expectations include the following.

- Participants must have some contact with primary providers. The actual amount and type of contact is handled case-by-case and contact is often intensive especially when initially enrolled. Services are individualized so that activities and contact are tailored to help participants meet their specific goals.
- Each rental subsidy has specific requirements. The participant must assist staff to ensure these requirements are met. For example, housing must meet HUD's Housing Quality Standards (HQS) and pass an annual inspection. Participants are expected to do their part in ensuring their units meet HQS standards.
- Participants must determine their goals, both large and small, and decide on a service plan with their primary providers.

Program Demand

There is no waiting list for the following reasons.

- There is a limited capacity for new applicants.
- The list would be extremely long and difficult to manage.
- Many applicants do not have an address and can be difficult to locate.
- Submitting an application may create false hope when openings are rare.

Harm Reduction and Substance Use

Harm Reduction

Depending on the individual or family, primary provider staff use a harm reduction approach and techniques such as Stages of Change⁴ and Motivational Interviewing⁵ to engage participants to reduce harm in their lives. While harm reduction was initially developed to improve the lives of people who are chemically dependent, Hearth Connection believes the approach can reduce the harm associated with other behaviours and conditions such as caring for one's health, treating a mental or chronic illness, or managing a relationship with someone who is abusive.

Hearth Connection views harm reduction as a continuum with abstaining from a risk behaviour as an end goal. Services in the Pilot are individualized and harm reduction supports this approach. With harm reduction, no matter what the participant's situation, one can always ask, *How can we reduce harm?* Because harm reduction and the Pilot's program focus on the individual and acknowledges that not everyone is ready or able to abstain from risky behaviours, participants are more willing to trust their primary providers and open up about their lives. Many participants are better able to sustain changes they make gradually. For primary providers, harm reduction allows them to work with participants at the participant's "stage of change." Primary providers assist participants to create an environment that reduces their risky behaviour and increases their ability to succeed in meeting probation requirements, tenancy requirements, creating a safe environment for children, etc.

Harm reduction has been working well in families. When there are children involved, the primary goal is to keep them safe. Often, Wilder has found that parents see their children as motivation to reduce risk in their homes. If a parent is engaged in harmful behaviour, they will look for ways to eliminate, reduce or keep their behaviour away from their children.

Substance Use

In interviews with 182 participants at the time they initially entered the Pilot, participants reported that they used alcohol and marijuana most extensively. Fifty per cent reported using alcohol regularly to the point of intoxication for more than 8 1/2 years and at least one substance/day for, on average, 7 1/2 years. Respondents reported the use of cocaine, crack, amphetamines, hallucinogens, heroin and polydrug use. Single respondents used substances longer than those from the family programs.

Problems related to drug dealing by the participants themselves or their associates are not uncommon. As well, occasionally some chemically dependent participants spend their money and resources on obtaining drugs and alcohol, leaving little or nothing to purchase food or other basic necessities. There are other problems that come up that may be directly or indirectly caused by substance use such as stealing, prostitution and violent behaviours. Many participants have physical and mental health concerns that may be caused or exacerbated by their substance use.

⁴ Stages of change are, "(F)undamental stages through which individuals typically progress when making behavioral changes: precontemplation, contemplation, action and maintenance of change." <http://vhaaidsinfo.cio.med.va.gov/aidsctr/safer-sex/ss16.htm>

⁵ "Motivational Interviewing is...a popular method of intervention within the field of drugs and alcohol. It is considered by many to be an effective tool for working with people with "compulsive" or "addictive" behaviour. Motivational Interviewing is a client centred approach that strategically directs clients to examine, explore, and resolve the ambivalence they have about their behaviour... (It) works on the assumption that people have implicit attachments to the behaviours they engage in..." www.smmgp.demon.co.uk/html/articles/art004.htm

Participants are always encouraged to cut down on their use. Substance use is never condoned, but primary providers are sensitive to how difficult addiction is and how it is often intertwined with participants' mental and emotional health. Primary providers work closely with participants to make sure they understand how their use is harmful, not only to their health, but how it may impact their family, friendships, housing and employment. Participants are provided a variety of options for reducing risk. Safety is critical, so participants are monitored closely and supported as they make changes in their life to reduce their use. If participants are using or are slowly transitioning off use, they are encouraged to do so away from their children and away from their apartments so they do not lose their housing. Those on probation or involved with child protection are also cautioned to avoid drug use and meet the expectations of these programs.

Participants with concurrent disorders have been found to pose a special challenge in achieving stability. The Guild team has a full-time nurse/case manager who assists with monitoring/administering medications. The team also intensely monitors mental health symptoms and a participant's follow-up with community mental health services, ensuring that participants get to appointments and receive their medications. Guild collaborates with therapists, occupational therapy (OT) programs, and other programs like day treatment or partial hospitalization programs.

Policies and Approaches Relating to Substance Use and Abstinence

Housing for the Pilot is largely scattered site and the Pilot does not own any properties. As a result, there are no program policies attached to buildings or units. Still, participants must follow the terms of their lease and primary providers discuss with them possible outcomes of their activities and different options. For example, it is made clear to participants that illegal drug use and the resulting behaviours, or the behaviours of guests that disturb neighbours, can be grounds for the landlord to evict.

Security Measures

All provider staff attend periodic personal safety training courses. A participant's behaviour that may put staff or others at risk is handled on a case-by-case basis. Primary providers may conclude that it is best to meet with a participant in public areas or in groups. They may call ahead to determine the participant's current state and then decide if a meeting should take place or be rescheduled. If a primary provider cannot determine a safe way to serve a participant, disenrollment is considered.

Guests

Guests can be a significant problem. Participants who have been homeless for years have made friends who are also homeless. Once the participant is housed, these friends sometimes wish to sleep in the home. As well, when a participant is housed and finds some stability, they often want to give back. Even after the primary provider has described possible outcomes, it is very difficult for some participants to say no to inviting street and shelter friends to stay with them. For some, it is the behaviours of guests or crowding that has resulted in the landlord asking them to leave.

Temporary Absence

Participants use a variety of housing subsidies. Each subsidy program has its own policies concerning if and for how long the program will cover a participant's rent in case of absence. For example, a participant receiving a HUD Section 8 rent subsidy will lose that subsidy after a three-month absence. If appropriate, the Pilot's Housing Fund can assist with short-term rent.

Residents Who are Able to Abstain from Substance Use

Abstinence is extremely difficult to achieve, but it can be empowering when a participant is able to control his/her substance use. Once a participant has reached this goal, primary providers continue to offer support to prevent relapse and maintain stability. Sometimes with abstinence come new challenges. For example, a parent who previously had her child taken away from her because she was unable to safely parent while she was using, may have her child returned to her. This results in major adjustments for both parent and child.

Role of Staff in Working with Residents

The primary provider works closely with participants to help them determine and achieve their goals. The frequency and location of contact depends on the participant's specific circumstances. Services are intensive and often primary providers are in contact with participants weekly either by phone or in person. Meetings usually take place in the home, but may also be out in the community. Primary providers may offer assistance with transportation to appointments and often accompany a participant to appointments or to meetings connected with a child's schooling.

Trust between the participants and their primary provider is essential to the

effectiveness of the Pilot. The hope is to build a healthy partnership in which participants are comfortable sharing intimate parts of their lives. From this, primary providers assist participants to face challenges, meet their goals, and learn how to advocate for themselves.

Legal Issues

There have been no legal ramifications for the Pilot or for staff from this program. Staff do not condone, take part in or remain present in a participant's home during any illegal activity. Guild has formed a liaison with a particular member of the St. Paul police force who they call upon if needed. Wilder has also made a concerted effort to cultivate a relationship with the police. The Police Department's Crime Free Multi-Family Housing group considers Wilder an ally and Wilder attends their meetings.⁶

Exits from housing and/or programs

Voluntary Move-outs

Through July 2004, the Pilot analyzed data from 172 participants on the reasons for changing their housing. This represents approximately 1/3 of the total housing changes. Reasons included: their choice to move (48 per cent); eviction (6 per cent); and safety reasons (12 per cent). (Thirty-four per cent reported "other," which was not defined in the analysis.) Respondents noted that they moved to get away from the temptations of drugs or drinking buddies, or to be closer to a child's school, bus lines or work.

Participants who leave their units often go either onto the street, into shelters, or stay with friends or family.

It should be noted that the Pilot's services are not linked to housing. A person may move from their housing and still continue to receive services. In addition, a participant who is disenrolled from the Pilot does not necessarily lose their housing.

Evictions

Eviction from housing does not mean a participant needs to leave the Pilot. They may continue to receive services.

Landlords have evicted or asked to terminate a participant's lease for reasons including criminal activity, disturbances, too many police calls to the unit, neighbourhood complaints or other lease violations, such as violence and drug use. Wilder Housing Department staff will always attempt to negotiate a mutual termination of the lease to prevent the family from receiving an eviction on their tenant record. Staff assists the family with moving (for example, they will provide boxes) but make every effort to have the family take responsibility for organizing their own move.

Prostitution has been a problem for some single adults. Some have lost their housing as a result. Guild then tries to re-house them. Prostitution has not generally been a problem in family homes. If there is prostitution, it will take place elsewhere. When one participant lost her housing due to prostitution, the case manager continued to visit her on the street.

Averting an Eviction

The Pilot's aim is stable housing, so primary provider staff work hard to keep participants in their units. At Wilder, Housing Department staff work closely with both the landlord and tenant to reduce crises that may lead to eviction. The Pilot's goal, when appropriate, is to keep participants in the same housing as long as possible to gain a positive rental history. The Housing Department provides tenant training, credit repair workshops, civic engagement training, workshops on repairing a family's rental history, and housekeeping expectations. Guild staff work closely with landlords and tenants to avert evictions by having meetings, setting up agreements, using behavioural techniques, and making sure participants understand the repercussions of warning letters from the landlord that specify problem behaviours and concerns. If a participant has been asked to leave their unit, Guild requests that they attend a tenant class in the community before securing another apartment.

⁶ The Crime Free Multi-family Housing Program involves, "Community Resource Officers provid(ing) a liaison between the police and apartment managers and owners in their assigned areas. The program's premise is (that): Criminals, gang members and their associates are not welcome occupants of the participating apartment complexes. With the goal of lowering the rate of crime in the complex, the police officer, property manager and property owner form a partnership. (This)...involves background checks on prospective residents and specific eviction policies for residents who violate the crime free agreement which they sign upon moving into their apartment. This agreement states that residents and their guests will not engage in any criminal behavior while living in or visiting the complex. The program also includes training the managers and owners in the crime free philosophy, and engaging the residents so that they will support the crime free effort." SAFER NEIGHBORHOODS THROUGH COMMUNITY POLICING: VOLUME I.

Services

Model of Service Delivery

The five primary providers for the Pilot are responsible for identifying resources, coordinating their delivery and co-facilitating participants’ support teams. At Guild, some participants are seen daily due to medication requirements. Staff may deliver the medications. Other participants do quite well when visited every two or three weeks, although on average, the visits are weekly. Occasionally the participants come to the Guild office but Guild case managers are usually out in the community visiting participants in their homes.

Participants become less inhibited the longer they are in the Pilot, and they express more ideas about the direction they wish to take.

Caseload

A caseload of six to nine households for each case manager is typical for the Pilot. For Wilder, which works with families, this means a ratio of approximately one primary provider to 37 participants. Wilder currently has a team of 7.5 FTEs working with 34 families and Guild has a team of 6 FTEs working with 33 single adult participants. In some cases, the single adult participants are lower functioning than adults in families. Some single adults have lost their children and there are higher rates of severe mental illness that may require more intense case management.

Service Delivery	Model
What services, who delivers them, how often, how they are coordinated, and where Case management	Primary providers support participants to find and maintain housing, and they directly provide or co-ordinate a full continuum of services. The service delivery model leading to stabilization is flexible and creative and depends on the participant’s individual needs. Building a relationship based on trust is essential to the effectiveness of case management and the Pilot. There are few reasons for disenrolling a participant from the Pilot and primary providers stick with participants through crises such as eviction or relapse. This consistent support helps build respectful and trusting relationships as well as increase stability in the lives of participants. Case managers use Harm Reduction, and techniques such as Stages of Change and Motivational Interviewing.
Assertive Community Treatment (ACT)	Guild uses a modified ACT model. Some provider teams will hire staff from a variety of disciplines (e.g. nursing, social work, psychology, etc.) or will assign staff as experts in a particular area (e.g. substance use, mental health, harm reduction, etc.).
Supportive Housing	The Pilot helps participants locate housing and provides services to help them maintain their housing.
Support Teams	Almost every participant is encouraged to develop a support team. Participants identify those who provide them with support, including family members, friends and/or professionals. Case managers assist participants to co-facilitate their support team until they are comfortable advocating for themselves.

Types of Services

Services	Type of Service Availability	Service Provider	Are Services Available on Site (Yes/No)	Source of Funding:
Medical care	Medication monitoring All other services	Nurse on staff at Guild; provides some medical care as well Family doctor, clinics or hospitals	Yes – if there is a nurse in the team. Also, some case managers are qualified to assist with medication monitoring	Pilot/Public
Mental health	Case management, counselling, therapy, groups, medication and medical care	Case managers (primary providers), clinics, county mental health, hospitals, private psychiatrists	Case Management on site, other services not.	Pilot/Attached to public assistance
Substance use	Case management, education, harm reduction and treatment programs	Community programs, case managers (primary providers), clinics, hospitals	Community programs – no; Case management yes	Pilot/Public
Employment assistance	Skill building and finding work	Case managers (primary providers)/county	Some classes on site/ others not	Pilot/Public
Money management	Education	Case managers (primary providers), representative payees	Yes	Pilot/Public
Assistance with life skills, transportation, clothing etc.	Education/skill building, resource building, gift certificates and transportation	Case managers (primary providers), community programs	Yes	Pilot/Public
Children's services	Truancy prevention, parenting skills, establishing goals for the children, with teachers/school conferences, medical care, support groups, tutoring, sports, camp, books, some school and camp supplies, Outings and activities	Case managers (primary providers), schools, child protection, county and community programs	Some yes Medical care, camps, sports, support groups, some tutoring and other activities are provided by community programs	Pilot/Public
Legal issues	Obtaining legal aid for benefits, advocacy in the criminal justice system, coordination with community probation	Case managers (primary providers), Community programs (e.g. Legal Aid)	Yes. Primary providers help participants advocate for themselves and access legal aid through community programs	Pilot/Public

*Because services are individually based, the list of service types above provides examples and is not exhaustive. Primary providers and participants are encouraged to be creative in determining services that may assist in achieving goals, increasing stability and improving health and well-being.

Changes in Services

The past several years have proved difficult for many community service agencies to maintain funding and develop resources. Some of the agencies that primary providers collaborated with or referred participants to have closed or reduced the services they offer.

Most Effective Services

Hearth Connection and the primary providers identified the following as the most effective services of the Pilot.

- intensive case management built on trust and respect
- individualized goal development and service plans
- flexibility and creativity in service delivery
- providing stable and consistent support for participants (e.g. continuing to work with participants even when in crises such as during and after an eviction or relapse)
- housing and rent assistance
- pro-active training to teach participants how to be good tenants
- building relationships with landlords
- harm reduction
- parenting classes
- assisting participants to develop and facilitate their support teams
- role modeling
- teaching self-advocacy
- acknowledging and celebrating reaching goals-both large and small

Connections With Community Programs/agencies

Formal:

There are a number of formal arrangements including

- a Participant Agreement between the participant and primary provider organization
- a service plan that evolves over time
- landlord-tenant relationships. (Many leases are six months to a year. However, primary providers usually try to find or negotiate month-to-month leases for more flexibility as participants learn tenancy skills.)

Informal:

Not all collaboration requires written agreements. For example, there is an arrangement between the provider teams in Ramsey County working with single adults and Ramsey County Mental Health Center that makes for easier access to a psychiatrist. Also, provider teams that work with families attempt to establish a contact in each school a child attends. The primary providers have found it helpful when service agencies designate liaison staff to work with them. Hearth Connection will assist when primary provider agencies find they have trouble establishing connections with other service agencies or resources.

Staffing and Personnel Issues

Primary provider teams are critical to the effectiveness of the program. Staff at these agencies must be chosen with care. They must remain flexible and focussed on the individual needs of the participant rather than on fitting the participant into program requirements. A case manager's work is rooted in relationship building. For example, a case manager may find that for a period of time, while building trust, she is simply sitting and watching TV with a participant on a visit. The program needs staff who are comfortable in what may feel like an unstructured setting.

Staff Burnout

Factors contributing to Pilot staff stress are the high level of chaos in the participant's life, the need to delicately negotiate the participant's goals and involvement in the program, the public nature of the program as a demonstration initiative, and the amount of paperwork required, especially for the evaluations.

To combat the stress, Hearth Connection has organized six joint provider meetings annually as a break from the usual workday. *"We try to recognize that these are great people doing great work and give that back."* Hearth Connection has a small budget to help bring in experts in areas such as harm reduction theory, personal safety, cultural competency and mental health conditions. Staff share a meal and receive support and training. The primary provider agencies and Blue Earth County also provide trainings for their staff. Some primary provider teams

have staff retreats to ensure that teams escape the job for a brief time and have some fun. Wilder provides opportunities for the participant families to gather for social activities (for example, bowling, skating, parties, etc.) allowing staff to interact with participants in a relaxed atmosphere.

As well, changes have been instituted to reduce staff workload. Hearth Connection is about to launch a new web-based information system that will eliminate some of the redundancy in paperwork. Each provider team has an on-call system for evening and weekend hours. Wilder instituted a pager system to reduce the time case managers must spend in the office particularly in the evenings and weekends. At Guild, on-call staff can receive commensurate time off. When there is a traumatic event, Guild brings in an outside consultant to debrief staff.

Policies for Hiring Formerly Homeless Individuals

Some agencies have hired people who have experienced homelessness. However, the hiring and the position depends on the skills of that person, and not just that they were formerly homeless. Guild includes participants in the hiring of new staff.

Hearth Connection has a consumer advisory board. All advisory board members have experienced some form of homelessness and supportive housing in Minnesota. Four of the 12 members are Pilot participants. As well, two consumers sit on the Hearth Connection Board of Directors and one member of the Board of Directors is also a consumer advisory board member.

Funding

Hearth Connection's funding comes from four general sources (numbers reflect July 1, 2003 through June 30, 2004 and all funds are in U.S. dollars):

Revenue and Sources	Amount
State Appropriation	\$1,500,000
Rental Subsidies	\$211,000
a. Housing Trust Fund ⁷	\$161,000
b. Shelter Plus Care ⁸	\$50,000
Targeted Case Management ⁹	\$476,200
Foundation Grants	\$681,000
Total	\$3,013,000

Beginning in 2001, the Minnesota state legislature authorized an appropriation to establish and maintain the Pilot for the state fiscal years 2002 through 2005. In 2002, Hearth Connection received its first award from the Minnesota Housing Finance Agency to provide Housing Trust Fund rental assistance for its participants. These funds can be used to support families or single adults for up to five years, and do not screen out people with poor rental histories or criminal records. In 2003, Hearth Connection began administering HUD's Shelter Plus Care, a permanent rental assistance program for individuals who can verify a recent history of homelessness as well as a disability.

Hearth Connection's revenue and expenses are divided into three components: services, housing and management of the Pilot. Operating costs for the Pilot for the fiscal year July 1, 2003-June 30, 2004 are shown below.

Operating Costs	Amount	Average Cost per Household
Services: all non-housing activities of the Primary Provider teams		
■ Families	\$838,600	\$41/diem
■ Single adults	\$955,500	\$31/diem
Total Services	\$1,794,100	
Housing: rental assistance and security deposits directly paid through the pilot ¹⁰ .		
■ Families	\$152,700	\$7.50/diem
■ Single adults	\$307,800	\$10/diem
Total Housing	\$460,500	
Managing the Pilot		
■ General operation	\$362,000	\$14.50/diem
■ Evaluation	\$297,500	
■ Information System Development	\$99,000	
Total Managing the Pilot	\$758,500	
Total Operating Costs	\$3,013,100	\$58.50/diem

Hearth Connection found that the initial costs related to finding housing for its participants significantly increased the per diem costs. However, with participants moving into mainstream housing subsidies or subsidies managed by Hearth Connection, both Hearth and the state expect these costs to decline. For example, between the fiscal year ending in 2002 and the one ending in 2003, the Pilot decreased the total cost per family by 15 per cent,¹¹ and it is expecting similar declines in the coming years for single adults who came to the program later than did families and whose associated housing costs are therefore more recent.

Another critical component of the Pilot's financial model is the use of flexible funding for supports to address unmet needs and to respond to individual situations. On average, \$67 per family per month and \$59 per individual per month was invested in flexible supports. The \$67 per family represents a decline of 67 per cent, down from \$205 per month the previous year.

Flexible funds for Ramsey County for both families and single persons for 2002 included the following.

Category	Amount
Basic needs and housing supports	\$13,350
Family and community building	\$7,859
Life skills and counselling	\$20
Education and tutoring	\$397
Miscellaneous	\$6,466
Total	\$28,092

Participants pay 30 per cent of income in rent. The median income for participants in the program was \$571 U.S. per month (Sept. 2004). Participants receive income from a variety of government programs and other sources, including social security, vocational programs and alimony/child support.

At present there are no new Section 8 vouchers available. As a result, many housing programs in the United States must piece together different types of rental assistance. Hearth Connection is fortunate to have \$1.5 million per year in State appropriations that is used, in part, to provide some stopgap rental assistance to Pilot participants while they apply for additional permanent program funding. Hearth Connection also administers Housing Trust Fund and Shelter Plus Care rent subsidies for its clients.

⁷ The Minnesota Housing Trust Fund is financed by interest earnings on real estate broker's trust accounts, interest accrued on revenue bond application fees and forfeited fees, and state appropriated funds. The size of the Fund is currently \$2 million per year. The Fund provides zero-interest, deferred loans for affordable housing for renters and homeowners and rental assistance funding that is either tenant-based, sponsor-based, or project-based. The rental assistance is intended to be temporary.

⁸ Shelter Plus Care is a rental assistance program from HUD for hard to serve persons with disabilities in connection with supportive services funded from sources outside the program. www.hud.gov/offices/cpd/homeless/programs/splusc/index.cfm

⁹ Targeted Case Management is flexible case management that enables states in the U.S. to target Medicaid services to specific classes of individuals and/or to individuals who reside in specified areas.

¹⁰ A significant number of participants receive rental assistance from mainstream sources (including HUD Section 8) that are not accounted for here.

¹¹ *Report to the Legislature, The Supportive Housing and Managed Care Pilot, Year 3*, prepared by the Minnesota Department of Human Services, December 2003, p. 11.

Outcomes, Challenges and Factors
for Success

Impact of the Program on Residents

The following outcomes are taken primarily from the *Minnesota Supportive Housing and Managed Care Pilot Qualitative Evaluation: Year Two and Year Three* published by the National Center on Family Homelessness.¹² Comments from interviews with Hearth Connection and representatives from Wilder and Guild have also been incorporated. The evaluation assessed if the Pilot’s approach resulted in concrete improvements in participants’ lives as well as reduced use of costly public programs such as shelters, emergency medical care, corrections and foster care. The Year Two evaluation report, published in 2004, indicated that, “the Pilot provides critical emotional and tangible supports for participants, and that participants are highly satisfied with services.”¹³ The Year Three evaluation echoes this satisfaction. (So far, the evaluations have been qualitative but quantitative data is forthcoming.)

As stated in the 2004 evaluation, “The positive impact of the pilot on participants is a major achievement. The participant’s relationship with the primary provider is the linchpin of effective service delivery. When this is combined with the provision of tangible supports, particularly housing, the impact is even greater and leads to an increased likelihood that the participant will continue in ongoing services. When services are provided in a flexible manner and realistic goals are negotiated, participants report greater success and feelings of achievement. This creates a positive cycle that sets the stage for continued positive change.”¹⁴

Some reported outcomes for the Pilot are listed below:

Resident Satisfaction

The evaluations have indicated that residents are generally satisfied with the services provided by the Pilot. Respondents stated that the support they received from the primary providers gave them renewed hope, and that this hope motivates them to keep on in the program and make progress in their lives. Respondents who were already housed at the time of the evaluations expressed greater satisfaction with the Pilot than those who were not yet housed. However, all respondents were highly satisfied with their relationship to their primary providers. “Participants also cite(d) satisfaction with pilot services because the providers allow them to set reasonable, obtainable goals.”¹⁶ Most respondents could not come up with any

Measures of Success	Outcomes
Residential	Single Adults: <ul style="list-style-type: none">■ Attrition: 5% annually■ 66% have stayed in their housing■ 20% have been very difficult to house and keep housed (2003) Families: <ul style="list-style-type: none">■ Attrition: 14% annually■ Slightly more than 70% have stayed in housing■ Families are beginning to exit the program because they don't need the services anymore. (2003)
Substance use	Providers report more participants are now willing to discuss their use and look at alternatives.
Mental health	Guild reports that more single adult participants now have regular psychiatric appointments. Approximately 30% of the participants are on administered medication, set up by the Guild nurse and delivered by staff. Another 12% are on medication monitoring where they set up their medications while staff observes.
Physical health	“Both family and single participants report increased use of primary care doctors, dentists and psychologists. Participants who describe previously receiving all their medical care from emergency rooms now report using primary care physicians for routine medical care. A large number of those interviewed have seen psychiatrists and received medications since enrolling in the program. Several single participants also described decreased use of detox facilities. Primary provider staff also report changing service use patterns. Each primary provider agency and its staff members view these changes as major indicators of participant success.” ¹⁵
Income	Guild reports that 100% of their participants have some sort of income.
Education/ Training	About 15% of Guild participants are enrolled in some type of school.
Personal networks	Guild reports that three participants who before enrolling in the program did not have regular visits with their children, now do. A number of others have reconnected with siblings or family.

12 Qualitative reports can be found at www.familyhomelessness.org/hearthconnection.html

13 National Centre on Family Homelessness, *The Minnesota Supported Housing and Managed Care Pilot: Qualitative Evaluation, Year 2, 2004*, p. 8

14 Ibid., p. 11

15 Ibid., p. 12.

16 Ibid., p. 10.

examples where the Pilot had not given them what they hoped for. As well, family respondents reported that the Pilot has worked well for their children and families. Ramsey County reported increased satisfaction from the previous year's evaluation. However, respondents noted that the most at-risk children received more attention, leading to the possibility that children who were not as much at-risk were being overlooked. In the Year Three evaluation, participants expressed the desire for more child-related services, and for more educational and career opportunities.

Reasons for Success

Hearth Connection defines success for its Pilot as stabilizing participants in decent affordable housing with improvements to their mental and physical health and general well-being, and a reduction in the amount of substances they may be using. As well, success would demonstrate more cost-effective use of resources. Hearth Connection and the primary providers attributed the Pilot's success to

- participant-driven, flexible and intensive case management based on a trusting and respectful relationship between the primary provider and the participants;
- the Pilot's status as a program that works with participants as long as they want rather than one that has a limited timeframe after which a participant would be cut off from housing and supports;
- the quality of case managers and other staff at the primary provider agencies;
- guidelines, financing systems and sufficient resources that promote effective teams;

- helping participants see they have options and helping them to advocate for themselves, leading to hope for the participants and the ability to believe in themselves;
- strong support from a broad range of community stakeholders, as well as the diverse skill and knowledge of the Pilot's Board of Directors and advisory groups;
- developing and maintaining strong working relationships with landlords, U.S. Housing and Urban Development (HUD), Minnesota Housing and Finance Agency (MHFA), other rental subsidy administrators;
- working towards stable and permanent housing through tenancy skill building and developing resources to make housing more affordable and accessible (such as education, employment, rental subsidies, etc.);
- providing services to children that focus on their stability and specific goals including school and academic assistance, health care, and community programming;
- assisting participants to find ways they can give back to the community and increase their own self-reliance, by helping with skill development, employment searches, and connecting participants with community groups and programs;
- hearth Connection's role bringing stakeholder and resources together, managing the evaluation, and advocating at a policy level.

According to the program evaluation, "Successfully housing participants and helping them maintain their housing continue to be the strength of the Pilot. Primary providers have created individualized

housing responses. (They) do not place all participants in the same kind of housing on the same schedule. Instead, the timing of housing placement and the type of housing sought are based on a combination of factors including participant preference, level of engagement, and service and resource needs."¹⁷

Challenges

Some respondents to the evaluations felt that some primary provider staff can be too intrusive. Others reported favouritism and preferential treatment among provider staff. As well, the evaluations found that stakeholders and staff continue to struggle with issues of ethnicity, culture, class, and how to fully integrate participant input into the process.

Other challenges include

- obtaining enough information from participants and building their trust;
- determining the best place to house participants, noting that some are more difficult to house than others. For example, it can be particularly challenging to find housing for an entire family; single adults with concurrent disorders coupled with violent behaviour and long histories of eviction and felonies; and other participants who have committed felonies.
- working with the financial environment in Minnesota and the lack of Section 8 subsidies to new applicants. (As well, there are fears that cuts to Section 8 will be deep enough to cause participants with this subsidy to lose their housing.)
- the paperwork and evaluation scrutiny sometimes onerous for primary provider staff;

17 The National Center on Family Homelessness, *The Minnesota Supportive Housing and Managed Care Pilot Qualitative Evaluation: Year Three*, January 2005

- obtaining access to or cooperation among service agencies to allow for the range of services a participant needs.

The Pilot is aware of and actively addressing all of these challenges. For example, much time is spent working on building the trust of participants, finding and maintaining housing and determining culturally and individually appropriate services. The Pilot actively seeks new resources, funding and subsidies. Hearth Connection is preparing to train providers on a new information system to assist with some of the paperwork and evaluation requirements. In addition, Hearth Connection and all of the provider teams are committed to improving relations with the community and the diverse array of stakeholders.

Lessons Learned

Staff are a key component to making the Pilot work effectively. Staff must love what they do and feel committed to the goals of the program and to building healthy, trusting relationships with participants. They must find inspiration from each other and from participants. Hearth Connection feels very fortunate to work with five primary provider teams who they consider exceptional at what they do.

Staff need training and support on best practices and the many domains they encounter with participants (for example, mental illness, addiction, harm reduction, employment, housing, disabilities, etc.)

Stakeholders from the community created the model for the Pilot. These included health departments and organizations, counties, social service agencies, supportive housing programs and consumers. Hearth Connection and primary providers continue to involve them. Their on-going input and commitment to the Pilot is important to ensure accountability.

It is also important to

- have adequate resources and flexible funding
- have a link between housing and services
- evaluate services and allow for the program to evolve as needed to effectively serve participants
- give new staff 30-60 days to prepare before starting with a caseload

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INNOVATIVE SUPPORTIVE HOUSING THROUGH A HARM REDUCTION APPROACH FOR SUBSTANCE USERS

Case studies



Manchester, England

Heavy Drinkers Project Sponsor: Manchester Methodist Housing Association

Background

This case study has been prepared based on an interview with staff from the Heavy Drinkers Project and additional written information that they provided.

The Sponsor

The Heavy Drinkers Project offers a variety of supported accommodation, including a group home and scattered units, for men and women who are unable to maintain independent accommodation. Clients are long-term heavy drinkers.

A “drinking plan” to stabilize alcohol consumption and reduce the harm caused by heavy drinking is drawn up. Residents are allowed to drink alcohol, although sharing is discouraged.

Program Goals and History

The Manchester Methodist Housing Association, an independent voluntary organization established in 1971, is regulated by the government and receives some public funding and raises private finance. It provides social housing for a variety of client groups, with about 12.5 per cent or 750 bed spaces in supported accommodation, including projects for young mothers and babies, people with HIV/Aids and asylum seekers.

The Heavy Drinkers Project was established in 1991 for men and women who have a history of long-term alcohol misuse, leading to difficulties maintaining accommodation. Unlike most supported housing, demands are not made for residents to stop or reduce their alcohol use. Instead a model of harm reduction is used; supporting residents to address issues such as housing, health, social networks, family and occupation. Residents are encouraged to look at the impact of alcohol use, move to other less harmful types of alcohol (for example, from very strong cider to lager) and, over time, reduce consumption.

Project at a Glance

Sponsor Name

Heavy Drinkers Project Manchester Methodist Housing Association

Goals

- Help residents maintain their accommodation
- Support residents to reduce alcohol consumption
- Maximize independence
- Promote good physical and mental health
- Minimize offending behaviour (crime and disorder)

Target Population

Men and women
Long-term heavy drinkers

Housing Tenure

Permanent

Number of Suites

36 places

Factors for Success

- Intensive support to maintain accommodation
- Harm minimization
- Flexible and individually tailored approach to each resident and incident

Location

Manchester, England

Project Start Date

1991

The project was developed as the local authority began to move away from large-scale, generic shelters, to smaller specialized accommodation for people with different support needs. There also was recognition that “dry” accommodation is not suitable for everyone, and that some clients would never be able to stop drinking.

Program Description

The Heavy Drinkers Project provides two levels of care for heavy drinkers. Docherty House offers 24-hour support for seven men. Shared and single accommodation units close to Docherty House offers less intense support but workers visit regularly and monitor people’s welfare. All residents may drink alcohol in their own homes, either in private rooms or communal areas. Visitors may not bring alcohol with them, and residents may not share alcohol with each other or with visitors.

The Heavy Drinkers project provides good quality, safe and secure accommodation to persons who often lost accommodation due to being unable to stop drinking. All residents must agree to a drinking plan which is a voluntary agreement on what residents will drink (type of alcohol, quantity/strength, how often/times of day). A drinks diary is kept for both staff and residents to monitor consumption.

Emphasis is placed on

- safer drinking
- minimize drinking of crude spirits (for example. surgical spirit);
- reduce or eliminate binge drinking
- consider different strengths—for example resident may drink higher quantity of normal strength lager instead of lower quantity of high-strength cider

- drink inside and not on the streets
- Education – on alcohol units, damage caused by alcohol and so on
- Health and diet – encourage and provide healthy and regular diet, encourage regular health checks and compliance with treatment.

The People

The Heavy Drinkers Project is funded to provide 31 places for single men and five for single women. No resident is under 22 and the majority are 51 and older. There were 14 new residents in 2003 (for example, 14 moved on or died).

Types of Issues	Number of clients	Per cent of clients
Mental health diagnosis	1	
Substance use issue	36	100%
Concurrent disorder (mental health and substance use)	2	
Physical health diagnosis	36	
Total clients	36	

The vast majority of residents have physical health problems related to long-term heavy drinking. All residents are supported in gaining access to health care on a regular basis.

Residents using both alcohol and drugs are very difficult to house and support in this type of accommodation. Therefore only those residents using drugs and who are already accessing support from another organization to address this can be accommodated.

Residents drinking heavily who also have mental health problems can be particularly challenging, as statutory¹ mental health services will not work with them unless they stop drinking, while alcohol services will not address mental health issues

The Housing

The housing consists of 11 self-contained units, 18 private bedroom in shared house (2 per house) and 7 private bedrooms in large house (7 residents). All accommodation has been adapted to a high standard, including high quality furnishings, fittings, decoration, etc. Residents have their own fully furnished private room and access to shared lounges. They are provided with breakfast, sandwiches and a hot meal (half board) every day. Residents are responsible for cleaning their own home with the assistance of a cleaner who visits regularly.

Shared accommodation (2 per house) is not as popular as single accommodation, although shared accommodation can be better at meeting residents’ support needs. Some accommodation is in unpopular areas of the city.

The shared accommodation (7 in one large house) offers high support, and is very popular with applicants and referral agencies.

Access to Housing

Referrals are taken from any organization working with this client group— frequently from homelessness/outreach services, social services, drop-in and day centres, other supported accommodation where residents cannot drink. Residents also can refer themselves, although additional information from other agencies they are involved with will be gathered.

¹ Statutory services are those established or in conformity with laws passed by a legislative body such as Parliament.

Eligibility Criteria

The process for gaining access to a unit includes

- completion of a referral form (completed by applicant or referring organization)
- an assessment meeting—staff member meets applicant to discuss support needs
- information from other agencies—written information about support needs and risks from other agencies involved with the applicant. Information also sought from previous landlords, if there are any
- risk assessment—the risks are assessed and the evaluated to see if the support needs can be met
- manager makes decision to offer or decline (no committee or tenant involvement)

People with a history of serious violence or anti-social behaviour (for example, harassment/neighbour nuisance) arson, certain sexual offences, and drug use who are not prepared to follow a treatment program, are excluded.

Degree of “Housing Readiness”

Many applicants are homeless, have long histories of unsettled accommodation, and will find it difficult to adjust to living in their own home. Much of the support is geared towards supporting them to maintain their accommodation. The project has never declined a referral on the grounds of not being “housing ready.”

Program Expectations

Residents are required to access support (for example, attend support sessions and agree to support plans) but not to enter any structured program. They are to meet a support worker weekly, but there is flexibility as long as residents meet on a regular basis. There is no requirement for a structured plan for alcohol, but residents are encouraged to enter into a voluntary agreement.

All residents have an occupancy agreement, a “tenancy” style contract between them and the project that covers their accommodation and support services. This covers residents’ rights and responsibilities and grounds for ending the agreement.

There is a supported housing residents’ handbook, written in easy-to-understand language. This covers rights and responsibilities in more detail, describes the support that can be offered, and includes suggestions on how to get the best out of supported housing.

Program Demand

The waiting list varies in length. For popular accommodation it can be months or even years. For less popular accommodation there tends not to be a waiting list.

Harm Reduction and Substance Use

Substance Use

All residents use alcohol heavily. Residents who also use drugs will be accepted but only if they agree to take part in a program with an organization that deals with drug use to address this.

Policies and Approaches Relating to Substance Use and Abstinence

Use of Substances

All residents are encouraged to reduce alcohol consumption or drink less harmful types of alcohol. However, this is done by consent and on a voluntary basis. The extent of the encouragement varies on an individual basis, depending on the circumstances of each resident at the time. All the support is individually tailored, and highly flexible to accommodate any change in circumstances.

All residents may drink alcohol in their own homes, either in private rooms or communal areas. Visitors may not bring alcohol with them and residents may not share alcohol with each other or with visitors.

No drugs may be used on the premises and the selling of drugs is strictly forbidden.

Residents in need of medication for mental illness are not required to take these but are strongly encouraged to do so.

Security Measures

All houses have external doors which self-close and lock to prevent residents leaving the doors open.

All houses have high-quality smoke detectors and sprinkler systems.

All houses have emergency alarms to allow residents to call for support.

Guests

All residents may have visitors, but remain responsible for the behaviour of their visitors and must stay with them at all times. Overnight visitors are not permitted.

Conflicts Among Residents

All residents are required to respect other residents, staff and visitors, as well as the project's neighbours. The policy on managing challenging behaviour focuses on support interventions backed up by warnings and notices. Staff act as mediators to resolve conflict. Each incident is dealt with according to the individual circumstances. The approach is to offer support to minimize such behaviour, rather than to penalize it. On occasion some residents do lose their accommodation if there is serious nuisance behaviour.

Residents are encouraged to participate in courses for managing aggression.

Temporary Absence

Some of residents do become abstinent. At this stage, they generally wish to move to independent living or dry supported accommodation. They are helped to do this.

If they wished to stay, there would be a need to demonstrate that they need support from the project to remain abstinent. If this could not be done, they would need to move on (although this has never occurred).

Residents Who are Abstinent

In the fully supported housing, staff is on site 24 hours a day. Each member of staff would expect to have informal contact with every resident, checking they are ok, encouraging them to eat or participate in activities. In the evenings and at night staff will spend more time working informally with residents, discussing needs and aspirations. Each resident also has at least one "formal" support session every week, focusing on structured support. (Note: "formal" support tends to have a very informal feeling, but forms the basis of support planning and structured proactive support.)

In the scattered schemes, staff meet with residents at least weekly for a "formal" support session, focusing on structured support. They may see some residents more often, in response to requests for more support, or reacting to any change in circumstances.

Staff have a formal case working relationship with residents. The relationship works as a mix of formal and informal contact, based on building up a relationship of trust but always maintaining professional boundaries. All staff play a role in encouraging residents to access support and participate in project services and decision-making. Many residents can be hard to engage in services. Staff focus on getting a "foot in the door"—finding a common interest, or a reason for the resident to engage with staff. Staff often need to be very creative—sometimes opportunities arise from outside the immediate contact with residents that provide a chance to engage with them.

Legal Issues

There are legal issues in the U.K. regarding drug use—landlords have certain obligations to prevent drug use in their premises, therefore the police would be informed of any drug use.

Some of the residents may be involved from time to time with prostitution. If staff becomes specifically aware of this, the police would be informed although there have not been any such incidents in the last few years.

Exits from Housing and/or Programs

Voluntary Move-outs

All the accommodation is long-term—residents can stay as long as they wish, unless they breach their occupancy agreement or no longer need support.

Residents who may move out because they wish to live without support or they cannot keep to the rules regarding behaviour. They can apply for social or private rented housing without support (for example, from local authority or private landlord). They may also choose to move to bedsits, stay with friends, or other temporary accommodation.

Evictions

Residents may be evicted for serious incidents of violence, offending behaviour, threatening behaviour to staff or residents, harassment (including racial and sexual harassment), or neighbour nuisance. Other reasons for eviction include arson, using or selling drugs on the premises and large rent arrears.

All violence, harassment and so on, is seen as potentially "serious," however people would not necessarily be evicted for first or minor offences-individual circumstances would be considered and work undertaken with residents to avoid a repetition wherever possible.

There is always an effort to prevent an eviction by supportive intervention before an incident occurs—for example, anger management, working with probation services, supporting residents to pay rent, use of warnings and notices. Eviction is always a last resort, and only used when necessary to manage risk or protect staff or residents.

Services

Model of Service Delivery

Much of the work is based on supporting residents to access statutory services, which are publicly funded (for example, health or employment services). On site the focus is on providing support to develop life skills and address alcohol issues. These services are provided on site and in residents' homes. Planned support sessions are held weekly, but can be more often if needed. The approach is to be as flexible as possible, recognizing that often the residents will find it difficult to access structured support, and sometimes support needs to be provided "on demand." Informal support occurs all the time. Staff act as co-ordinators, as part of the support for residents to access other services. Staff will arrange appointments, liaise with staff in other services, arrange case review meetings and so on. Statutory services are usually provided off site, wherever that service is based, unless the service is one that would usually be provided in the resident's home.

Types of Services

Residents receive the shown in the table at left services

Changes in Services

Due to funding changes, there is now a requirement that all of the support provision is "housing-related" that is, that the work specifically supports residents to maintain their accommodation. The Heavy Drinkers Project is not funded to provide social services/social care (such as assisting with transport, accompanying on leisure activities) or health provision.

Services	Type of Service Availability	Service Provider	Are Services Available on Site (Yes/No)	Source of Funding: Public Private Charitable
Medical care	Support to access services	Statutory health services	No	Public
Mental health	Support to access services	Statutory health services	No	Public
Substance use	Alcohol – harm minimization – all residents Drugs – support to access treatment from other providers – as needed	Alcohol – Project, also liaise with statutory services Drugs – specialist providers and statutory services	Alcohol - Yes Drugs - No	Public Public
Employment assistance (training/finding work)	Support to access education, training, voluntary or paid work – available whenever resident identifies aspirations for this	Variety of statutory and voluntary providers	No	Public
Money management	Support to claim benefits, maximize income, budget and pay rent/other debts etc – all residents if needed	Project	Yes	Public
Assistance with life skills, food, transportation, clothing etc.	Support with life skills, food provided. Support to access transport although we do not provide this	Project	Yes	Public (residents pay for own food)

Furthermore, the funding system has recently changed from permanent funding to a short-term, contract-based system. The system is in transition, and it is hoped that the project will move towards a three-year contract. Currently there is only a temporary contract with no guarantee of longer-term funding.

Most Effective Services

The provision of accommodation (and support to maintain this) is in itself the biggest factor. Harm minimization is an integral part of this.

Connections With Community Programs/agencies

There are no formal agreements with other agencies—most of them have a statutory duty to provide services to residents, and the role of the Heavy Drinkers Project is to act to coordinate this provision and support residents to access the services.

There are connections with alcohol detox services, sympathetic primary health care services (local general practitioners who have worked with the project for many years, and are sympathetic to providing residents with a good service).

Staffing and Personnel Issues

The requirements for staff are

- experience in working with challenging clients
- understanding of alcohol misuse issues
- empathy with clients-objective and non-judgmental approach
- clear professional boundaries
- teamwork
- flexible, innovative and creative approach to problem solving

Staff Burnout

The client group can be chaotic, and although structured and proactive support is provided, there will always be a higher element of reactive and unplanned support than with other client groups. Staff have a lower caseload than for projects with other client groups to address this. All staff have regular supervision with their line manager, with much emphasis on teamwork and mutual support. The organization also provides free access to a confidential counselling service for staff to use as they wish.

Policies for Hiring Formerly Homeless Individuals

There is an equal opportunities policy for staff recruitment and the project always endeavours to appoint the best person for the job. If staff have a history of substance abuse, this can bring benefits such as a detailed understanding and experience of the issues. However, it may also bring disadvantages, such as difficulties remaining objective or maintaining professional boundaries. Each recruitment decision needs to be made according to the individual circumstances.

Funding

Supporting People—£305,000 maximum per annum—paid by local government towards the cost of support services. This funding is dependent on occupancy rates and only paid for each bed occupied. This charge is means tested: residents with an income may have to pay some or all of this charge themselves.

The Supporting People funding is new, and not currently stable. The Heavy Drinkers Project hopes to be awarded a three-year contract, but currently have no security for this funding. The other funding is largely dependent on the project receiving Supporting People funding—without this the project would close.

Social services grant – £89,000 per annum—this annual grant from Social Services is received for work in the 24-hour project with the 7 residents with high-support needs. This money meets the cost of some social care not covered by other funding streams.

Rent and service charge – £175,100 maximum per annum—paid by Housing Benefit (administered by local government, also means tested)—towards the cost of the accommodation. Only paid when a resident is occupying a room.

Residents' service charge – £67,350 maximum per annum—residents pay this themselves, towards cost of food, fuel bills etc.

Rent charges are fixed according to the type of accommodation and services provided. Most of the charges are paid by the local authority and unless a resident is earning or has high savings, they only have to pay for food, fuel bills etc. The average charge is £35 per week—this covers all their food, bills and so on, and is much cheaper than the average cost of living independently.

Outcomes, Challenges and Factors for Success

The project has been very successful in helping people maintain accommodation as well as reducing alcohol use, offending and ill health (physical and mental). In terms of alcohol consumption the main changes have been from crude spirits (for example, surgical spirit) to strong lager or cider (due to the fact that strong lager/cider is cheaper than it used to be)

Impact of the Program on Residents

Currently only throughput, length of stay, and participation in harm minimization is monitored. Many residents have shown significant progress in the other areas identified, but this is not accurately monitored.

Reasons for Success

- intensive support to maintain accommodation
- harm minimization
- flexible and individually tailored approach to each resident and incident

Outcomes	Examples of Changes
Residential stability	Length of stay for current residents: Over 2 years – 48% 1 – 2 years – 14% Under 1 year – 38%
Substance use	83% residents currently actively taking part in harm minimization programs (i.e. structured support to reduce drinking or minimize harm)
Mental health	Not actively monitored
Physical health	Not actively monitored
Employment	Not actively monitored
Income	Not actively monitored
Education/Training	Not actively monitored
Improved self-care	Not actively monitored
Personal networks	Not actively monitored
Other	

Challenges

The major challenges of this project include managing this client group in the community—it will always be difficult. There is a high likelihood of anti-social behaviour, nuisance and so on. NIMBY is often an issue. Residents do suffer from stigmatization, but can also be responsible for unacceptable anti-social behaviour. There are constant efforts to provide intensive support to minimize and prevent anti-social behaviour. It also is important to act quickly and firmly to address it, including evicting residents if this is the only solution. There is an open complaints procedure and the project works closely with neighbours to resolve problems as they arise.

Dealing with challenging clients (such as, persons with problems of mental health and alcoholism) is demanding as well. A major barrier is finding services (such as, GPs) who are sympathetic and knowledgeable.

Securing and maintaining funding is another challenge.

The way to overcome these is through hard work, commitment, creative and flexible approach, and leading by example

Lessons Learned

It can be done!

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INNOVATIVE SUPPORTIVE HOUSING THROUGH A HARM REDUCTION APPROACH FOR SUBSTANCE USERS

Case studies



Blackburn, England

In Partnership Sponsor: Manchester Methodist Housing Association

Background

This case study has been prepared based on an interview with staff from the In Partnership Project and additional written information that they provided.

The Sponsor

The In Partnership Project is the only women-only housing provider in the Blackburn area that is willing to accommodate young women aged between 16 and 25 years who are current substance abusers. It is part of Manchester Methodist Housing Association, an independent voluntary organization established in 1971. The In Partnership Project, which was established in 1997 as part of YWCA (Young Women's Christian Association of Great Britain), offers housing and in-house support, including a substance misuse worker.

Program Goals and History

The Manchester Methodist Housing Association, an independent voluntary organization established in 1971, is regulated by the government and receives some public funding and raises private finance. It provides social housing for a variety of client groups, with about 20 per cent or over 1,000 bed spaces in supported accommodation, including projects for young mothers and babies, people with HIV/Aids, and asylum seekers.

Project at a Glance

Sponsor Name

In Partnership Project

Goals

- Provide linked accommodation and support service for women who misuse substances
- Provide an environment which is supportive of young women overcoming difficulties and learning to manage their lives effectively
- Equip young women with the necessary skills and confidence to enable them to live independently
- Provide in-house activities aimed at developing basic life and social skills
- Encourage young women to participate in decisions affecting their daily life
- Encourage young women to adopt safer lifestyles as part of a harm reduction programme

Target Population

Women 16-25 years old with problems of substance misuse

Housing Tenure

2 years maximum

Number of Suites

17 apartments

Factors for Success

- Residents are not worried about losing their accommodation because of drug use which allows them to stabilize and deal with the various issues in their lives
- Interagency links and co-ordination

Location

Blackburn, England

Project Start Date

1997

The In Partnership Project came about as a response to Local Authority and YWCA youth and community workers’ concerns in the late 1980s when they found themselves working with increasing numbers of young women who reported various types of childhood abuse. These workers were unable to access specialist support so set up a steering group to develop a service.

In 1997 the project began to provide accommodation for young women who were survivors of abuse confronting problems such as substance misuse, offending, mental health issues, self harm/suicide attempts, prostitution, poor experience of the care system, poor educational attendance and attainment, and lack of meaningful employment or activity.

The accommodation consisted of 39 rooms in a hostel setting with shared facilities. The project did not use all 39 rooms as this was felt to be too large and opted for 29 bed spaces on opening reducing to 22 after the first year.

Although the project was not set up specifically for substance misusers this group was never excluded, as drug use is often a coping mechanism for abuse survivors. In May 2000 the Project was taken over by Selhal Housing Association and the new management group felt that the project needed some redefinition to better meet the needs of the young women it was housing. Through consultation with service users and stakeholders a number of elements were identified as key to improving services, notably making the building more suited to the purpose of the project (reducing the numbers and having self-contained accommodation), extending the range of support services offered (developing a Structured Day Programme) and strengthening the links with other agencies in the local area.

A bid was submitted to the Housing Corporation (who fund projects throughout England and Wales) in 2001 and this was successful. In April 2003 work on renovation and reconfiguration of the building began. At the same time Selhal merged with MMHG. The Project was closed for seven months and reopened in November 2003 as 17 self-contained flats and a training suite.

Program Description

The project provides 17 self-contained units, one of which is wheelchair accessible. Ten units are in the higher support Stage One Unit while the seven others are in a Move On Unit.

The project is based on close collaboration with other agencies to provide a holistic, caring service.

The People

Most of the women have had very chaotic lives—stepparents, care parents, abandoned or abused as children, early responsibility for younger siblings, and so on. For these women, substance abuse is a coping mechanism.

Women with an enduring mental illness (for example, schizophrenia) and who do not take medication pose a problem for the project, especially if their situation is very chaotic. The project does not have the expertise to deal with dual diagnosis—often these people become a ping-pong ball between different services. However if the women are on medication, they can be accommodated. Many of the young women living in the project do have problems such as depression or an eating disorder.

Very young women (for example, 16 years old) are often challenging, as are the women who are aggressive because of alcohol use.

Types of Issues	Number of clients	Per cent of clients
Mental health diagnosis		
Substance use issue	17	100%
Concurrent disorder (mental health and substance use)	6	35%
Physical health diagnosis	5	30%
Total clients	17	

The Housing

The housing consists of 17 self-contained units, one of which is wheelchair accessible. The units are all fully furnished to a high standard and are fully equipped. Ten of the units are in the first-stage high-support section, while the remaining seven are in the Move On unit. The building, which was renovated in 2003, also has an IT suite, a training lounge, a training kitchen, a therapy room and two key work rooms.

Access to Housing

Eligibility Criteria

The residents can either be referred to the project by agencies working in the community or through self-referral. To be eligible the women must be between 16 and 25 years and be substance abusers. In an interview, potential residents are asked about their current living arrangements, physical and mental health, ability to pay and support needs. Someone else, such as a social worker or a care worker, can accompany the potential resident for the interview. A risk assessment of the woman is undertaken, based on the interview and on the two-three references that are requested. This risk assessment helps identify what problems

are evident (for example, depression) so that safety measures can be put into place through the support plan (for example, visit with a GP). The decision to admit someone is based on a rigorous assessment process and not just a “gut reaction” about the person. However reasons for not taking someone can include not needing the level of services being offered, or that the person is too challenging (but this is considered in terms of how many other “very challenging” women are living in the project).

Degree of “Housing Readiness”

Part of the first phase of the program is to help people get housing ready. Staff, including life skills workers, are available 24-hours a day during this stage. This can be a slow process, starting with very basic issues. For example, one woman had to learn to sleep on a bed rather than on the floor. Many are not used to having any possessions and have to get used to a sense of ownership.

Program Expectations

All residents are expected to participate in a Structured Day Program. There is a “breakfast club” that gets the women into a daily routine of having breakfast and planning daily activities (for example, going to appointments). The day program is flexible and fluid—over a period of a week, for example, the women will have seen their key worker, the life skills worker and drug worker, as well as signed on for benefits, met with probation officer, etc.

The program is set up in a way that the women start by meeting small goals—for example, taking medication, getting a medical doctor. This is essentially a lifestyle plan based on what is important to them rather than what the staff sees as important for them. The women then move onto other levels, such as cooking classes.

The women must meet with their key worker at least once a month, but usually this occurs more often. The key worker co-ordinates the support plan which usually focuses on three areas—budgeting and finances, substance misuse and physical health.

Program Demand

There is rarely a waiting list. Often the women are in a crisis and if they can't be accommodated they go elsewhere. In Partnership Project can usually find them a referral in 24 hours.

Harm Reduction and Substance Use

Substance Use

Current residents use heroin, some crack cocaine, alcohol and cannabis. Crack cocaine seems to be an issue that comes and goes—currently it is more of an issue than heroin use—but this would appear to be related to what dealers have to offer. Alcohol is the drug of choice for many of the younger residents and its use causes problems because of the unacceptable behaviour that often comes with intoxication. To comply with the law, the Project has to be proactive in preventing cannabis use.

Policies and Approaches Relevant to Housing the Target Group

Use of Substances

The approach to substance use is anchored in helping the women move to safer use of substances (for example, using clean needles) and less harmful practices (for example, use of condoms). Thus the work is not focused on rehabilitation and detox but more in getting the women ready for this, if they desire.

The Project's Drug Policy complies with the law (*Misuse of Drugs Act*). It is understood that the women use substances on site but the workers do not know who is using at any particular time. The house rules make no mention of use in individual rooms—the provider cannot condone or encourage the use of drugs, but In Partnership Project will not evict the women for use nor will they check whether the women are consuming. Use in the grounds or in the vicinity of the project is prohibited, as is buying and selling.

Security Measures

Access to the building and the grounds is controlled and there is full CCTV coverage. One of the strategies that has been used to help the women feel safer is a process of complaint to the police that is not “official” but flags problems with certain men in the red light area. This is for use by current residents and former clients and is known as the “dodgy punters book.”

Guests

No males are permitted on the site. Prostitution is an issue for many of the women and they appreciate having a home that is free from this activity.

Conflicts Among Residents

There are policies prohibiting violence or verbal aggression, although issues such as borrowing clothes or money can cause conflict between residents. These arguments are dealt with on a case-by-case basis.

Temporary Absence

The policy on temporary absences depends on how long the woman will be gone and whether they can continue to pay the rent or be eligible for benefit. Residents may be absent because of health reasons, treatment or prison. The women are asked to let staff know if they are gone for the night. There have been cases where women disappear completely and abandon their property and support process. The breakfast club is one of the means that is used to check if there is a missing person. A policy is in place to deal with these cases.

Residents Who are Abstinent

This is difficult in the project since the women are surrounded by others who are using.

Role of Staff in Working with Residents

Staff have to work hard to maintain strictly professional relationships with the women. The relationships are very close and very tactile with lots of hugging and comforting of residents. The Association has a set of guidelines which staff must follow so that they do not get over-involved and are thus able to offer a fair service to all service users. It is an area that staff struggle with. Most of the staff are women.

Legal Issues

Since the Wintercomfort case in 2000, projects using a harm reduction approach to drug use have been on very fragile ground.¹ It is important for the In Partnership Project to work closely with the police and this has been largely successful, including securing support from a senior officer at a policy level. For the most part the police are not interested in the drug use of the women—drug dealers are of greater interest—as are issues such as prostitution in residential areas and shoplifting that are tied to the women's drug use. However, some new police officers who may not be as familiar with the law or the work of the project may view the Project as “turning a blind eye” to the drug use. To date no legal action has been taken against any resident for drug use.

Services	Type of Service Availability	Service Provider	Are Services Available on Site (Yes/No)	Source of Funding: Public Private Charitable
Medical care	Support to access services	Statutory health services	No	Public
Sexual health	Health screening and advice	Voluntary health services	Yes	Public
Mental health	Support to access services	Statutory health services	No	Public
Substance use	Specialize worker	Lifeline	Yes	Public
Employment assistance (training/finding work)	Part of the Structured Day Program	In Partnership Connexions Local College	Yes	Public
Money management	Part of the Structured Day Program	In Partnership	Yes	Public
Assistance with life skills, food, clothing etc.	Part of the Structured Day Program	In Partnership	Yes	Public
Confidence raising, assertiveness training	Part of the Structured Day Program	Youth Service In Partnership	Yes	Public

Exits from Housing and/or Programs

Voluntary Move-outs

With the new project of 17 units few of the women have moved out. Some have gone back home, moved in with boyfriends, or have gone into a detox program. There is core group of women who currently live in the project who lived in the hostel setting before renovations.

Evictions

Violence is the only reason why people have been evicted, and this is an immediate action. There can be problems with paying the rent but work is undertaken with the resident to try to avert eviction. If they are forced to leave they can reapply to the project at a later date providing they can demonstrate improvements in their behaviour.

¹ This case, based on drug dealing in a homeless shelter in Cambridge, resulted in a five-year jail term for the director of the charity and a four-year jail term for the manager of the day centre.

Services

Types of Services

Support services are given on a one-to-one basis or through group work sessions. Services are delivered by staff or by external partners. The framework for the support is the Structured Day Program that is tailor-made for each resident. The goals are to help the women re-establish appropriate social, educational and occupational activities. The program can include

- educations, life skill and sport sessions
- diversionary and leisure activities
- complementary therapies
- independent living activities

Some of the support services include

- training advice and preparation work
- youth work sessions
- health drop in and STI (Sexually Transmitted Infection) testing
- sexual health issues group
- can't cook, learn to cook group
- newsletter and creative writing
- basic literature
- young women's chill out and pamper session
- on-to-one cooking sessions
- form filling and welfare benefit sessions
- budgeting and shopping assistance
- life skills
- craft groups
- alternative therapies
- drug counselling and relapse prevention

Changes in Services

The project changed its orientation and operations when the building and services were modified in 2003.

Connections With Community Programs/agencies

The relationship with Lifeline (Drugs agency) is particularly beneficial. The project has a full-time seconded specialist worker on site and access to prescribing services via this for all residents. The worker also has connections with detox and rehab services.

The relationship with Brook (sexual health service) is also very beneficial as this entails a screening service for STI and general health check-ups, access to free condoms and advice on safe sex for residents.

Staffing and Personnel Issues

Current Staffing	Ideal Staffing
Operations Manager Senior Project Officer Program Co-ordinator Resettlement Officer Seconded Drugs Worker 5 Project Officers 2 Assistant Project Officers 2 Relief Assistant Project Officers Cleaner	The Project has full double cover at all times. It would be useful to have an on-site youth worker to assist in delivering group work.

Staff Burnout

There is low staff turnover in the project. Most people know very soon after starting if the job is for them and stay in the field for a long time. There is regular monthly supervision for staff at all levels and weekly

meetings for front-line staff to discuss difficult areas. The Association provides a free counselling service for staff who are experiencing difficulties with work or in their personal lives.

Policies for Hiring Formerly Homeless Individuals

No policy about this exists, although it would be important that the person have been drug free for a long time—probably over two years. One ex-resident did apply for a job but did not meet the essential criteria to be hired.

Funding

The core funding for the housing is stable (that is, 95 per cent of the staff are funded through this). However, recent funding changes require that all of the support provision be “housing-related”—that the work specifically supports residents to maintain their accommodation. Thus, positions such as that of the substance abuse worker and some other activities are not funded from core funds. These costs come from external sources that are on a year-by-year basis and not as stable.

Annual Revenue

Source of Revenue	Amount
Supporting people	£306,642
Rents and services	£129,011
External funding	£55,000
Total	£490,653

Costs	Amount
Staffing	£228,472
Program costs	£262,181
Total	£490,653

Housing charges to residents

Rent	= £69.86 (<i>payable by benefits agency</i>)
Services	=£86.33 (<i>payable by benefits agency</i>)
Own share	=£ 7.13

Outcomes, Challenges and Factors for Success

The definition of success is different for each young woman. While having someone go into detox or rehabilitation is an obvious definition of success, for some women success is just to stay alive.

Some women have gone into treatment and are off drugs. Some of the women will stay in the project, put down roots, start to get “property” (for example, clothes and other things that belong to them), will comply with treatment, reduce consumption or use more safely (for example, use the needle exchange). There are different levels of “normal life” that the women achieve—as there are differences in the levels of “constant chaos” when they arrive. It should be noted however, that all the residents are using condoms and clean needles and disposing of needles appropriately.

Three women have gone home to their parents, but it is not clear how long this situation will last. For many there is a change in the way that they feel about themselves—becoming less judgemental about themselves.

Because there is no single definition of success and because the process is slow—made up of little steps—this can be frustrating for staff. There is an acknowledged recognition that some of the In Partnership Project staff are only just beginning to understand the cycle of change and accept that relapse is often to be expected and does not mean failure.

Impact of the Program on Residents

Outcomes	Examples of Changes
Residential stability	Living in stable accommodation for more than a few weeks at a time has a major impact on residents' lives allowing them to access other services and improve their health and well being.
Substance use	The use of substances is reduced and the method of use becomes safer.
Mental health	Many of the mental health problems are situational (e.g. depression or stress). Stabilizing the housing situation helps to a large extent as does having a better diet and access to a GP (i.e. who can then prescribe anti-depressants).
Physical health	This is very noticeable and perhaps one of the major changes. The women get rid of infections and infestations, they eat better, their skin improves, as does their self-esteem. Sexual health issues and a clinic to deal with Sexually Transmitted Infections (STI) are available on site.
Employment	Maintaining a steady employment is a challenge. Many earn so much as street workers that it is hard to have them accept much lower incomes from other employment. (For example, as a street worker they can earn £35,000/year.) Some have police records (e.g. because of shoplifting) making it difficult to find a job. Needing to use several times a day is not compatible with holding down a job.
Income	Residents are helped to claim all the welfare benefits they are entitled to in order to maximize their income. Income increases as drug consumption is reduced.
Education/Training	Some residents have gone on to college. Some have joined training schemes.
Improved self-care	There is improved self-esteem and pride on the part of residents. Personal hygiene of all residents is of an acceptable standard.
Personal networks	Family reconnection can be a problem for women who have lived through incest. However, some of the current residents do visit parents over weekends and younger residents have moved back with their parents.

Resident Satisfaction

MMHA carries out a satisfaction survey of all residents every two years. This Project has not been open in its present guise for long enough for a survey to have been conducted.

Reasons for Success

Because the women are not worried about losing their accommodation because of drug use, they can be honest and the issues can be addressed.

Any issues that arise (such as damage or aggression) are dealt with on a case-by-case basis looking at everything that is going on for those involved at the time rather than adopting a system such as “three strikes and you are out” to deal with unacceptable behaviour.

The interagency links and the co-ordination have been very important—including the links with social services and the police. The project can work in partnership with them rather than battling the agencies.

Challenges

There are a number of challenges to the work. The first is the lack of clarity in the drug laws and some of the difficulties in using a harm reduction approach.

Funding is a challenge—especially for the non-housing components of the project.

Dealing with neighbours and NIMBY has required care. When the project reduced the number of spaces from 22 to 17 this feature was used in selling the project. Other efforts to reduce negative perception include meetings and letters sent to the neighbours to help them become more aware and accepting of the project.

Lessons Learned

It is critical that all staff are trained to know and understand exactly what the drug laws require from them.

Working with other agencies, for example the police, is important.

The larger organization needs to understand the work and the goals of the project.

When the project is seen to be successful the accolades are high but so are the risks. Because activities such as substance use (and therefore the potential for supply) and prostitution are illegal if things are allowed to slip and care is not taken, In Partnership Project could be closed down.

According to the manager of the project, “You need to be sure of what you want to do and have the passion to do it.”

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INNOVATIVE SUPPORTIVE HOUSING THROUGH A HARM REDUCTION APPROACH FOR SUBSTANCE USERS

Case studies



Seattle, Washington

The Lyon Building: Developed by AIDS Housing of Washington, and operated by the Downtown Emergency Service Center

Background

This case study was prepared based primarily on an interview with staff from the Downtown Emergency Service Center (DESC). Other sources of information included an Evaluation of the Lyon Building Housing Program,¹ the Lyon Building Service and Management Plan² and the DESC website.

The Sponsor

Downtown Emergency Service Center (DESC) is a non-profit organization in Seattle, Washington dedicated to helping the most disabled and vulnerable homeless people survive and achieve their highest possible level of self-sufficiency.³ DESC was established in 1979 to provide an emergency shelter for people living on the street who had a mental illness and chemical dependency.

Since then, DESC has become one of the largest multi-service agencies serving homeless adults in the Pacific Northwest. In addition to its emergency shelter, DESC provides a range of clinical programs and supportive housing to 7,200 people annually. The Lyon Building is the only project operated by DESC that it does not own and did not develop. The building was developed by AIDS Housing of Washington.

Project at a Glance

Sponsor Name

Developed by AIDS Housing of Washington, and operated by the Downtown Emergency Service Center

Goals

Work with the most vulnerable groups of homeless people to end homelessness, through the provision of housing and support

Target Population

Homeless people with HIV/AIDS, mental illness and/or substance use issues

Housing Tenure

Permanent housing

Number of Units

64

Factors for Success

- 24/7 staffing
- Approach and attitude of staff that attracts tenants to services
- Flexible approach to problem solving geared to maintaining the tenancy
- The planning process
- A clear mandate to create a housing program that will accommodate the population

Location

Seattle, Washington

Project Start Date

September, 1997

¹ Northwest Resource Associates. 2002. Evaluation of the Lyon Building Housing Program. Seattle, Washington: Downtown Emergency Service Center.

² Lyon Building Service and Management Plan - July 18, 1997. Online at http://www.aidshousing.org/ahw_library2275/ahw_library_show.htm?doc_id=35863

³ <http://www.desc.org/programs.html>

Program Goals and History

Planning for the Lyon Building began in 1994. AIDS Housing of Washington (AHW) identified a need to provide housing for people who had AIDS and other problems. AIDS service agencies were noting a change in the profile of people with HIV. They were finding themselves with increasing numbers of clients who had more challenges than they were used to dealing with, such as substance use, mental illness and greater poverty. AHW invited a number of agencies to a series of forums to discuss the needs of their clients. This included agencies providing services to people living with AIDS, mental illness, chemical dependency and the homeless. DESC was one of the organizations involved in the planning sessions. AHW determined the client population and size of the Lyon Building and then approached DESC to see if they would be interested in operating the building. DESC agreed. DESC then initiated a planning process to obtain feedback from various service providers to develop a management plan. The Lyon Building opened in September 1997.

The goal of the Lyon Building is to work with the most vulnerable groups of homeless people to end homelessness, through the provision of housing and support. The top priority is to support tenants in maintaining their housing. It is expected that once tenants secure stable housing, they can start to address other issues in their lives that may have led to previous housing instability.

Program Description

The People

The Lyon Building is targeted to people who are homeless and who have two of the following three diagnoses

- HIV/AIDS
- mental illness
- chemical dependency/substance use issues

Sixty-four individuals can be housed at any one time. About three quarters of the tenants are male (78 per cent), 16 per cent are women, and 5 per cent are transgendered. Almost all tenants are between the ages of 23 and 50. A few are 51 and older. The average age is 42 years old.

All the tenants have extremely low incomes. Information about clients who move in shows that 84 per cent received income assistance only, 5 per cent received income from employment, and 1 per cent received pension income. About 10 per cent of tenants have no income upon move-in, however, these individuals usually obtain income assistance within two months. More than half the tenants are Caucasian (58 per cent), 25 per cent are African American, 8 per cent are Latino, 5 per cent are Aboriginal, 3 per cent are multi-racial, and 1 per cent are Asian.

As noted in the table, almost all the tenants in the Lyon Building (97 per cent) have substance use issues. Eighty-eight per cent have a mental illness and 86 per cent have concurrent disorders.

Types of Issues	Per cent of clients
Substance use issue	97%
Mental illness	88%
Concurrent disorder (mental health and substance use)	86%
HIV/AIDS	68%
Chronic illness	19%
Mobility impairment	4%
Developmental disability	1%
Vision impairment	1%

The Housing

The Lyon Building provides 64 units of supportive housing. The building is close to 100 years old. It was an old office building that was totally renovated and converted to provide housing for the target group. All the electric and plumbing systems are new. Each unit is self-contained, and there is a mix of studio and one-bedroom apartments ranging from about 300 to 600 square feet. Many of the units are larger than a person who has been homeless would be able to find elsewhere. Each unit has a full bathroom and kitchenette. There is a microwave, fridge and sink, but no stove/oven. Each unit is furnished with a bed, table, chairs and a dresser. The housing is considered permanent, and tenants sign a lease.

The main floor of the building provides a large amount of common space for meals, social interaction and relaxation. In addition, there are meeting rooms, a common kitchen and staff offices.

Access to Housing

Applicants to the Lyon Building are referred by about 20 to 30 service provider agencies that are likely to come into contact with DESC's target population. These include about 12 mental health agencies, 6 agencies that serve individuals with HIV/AIDS, and 6 chemical dependency service organizations. Agencies that refer clients to DESC are required to sign a Cooperative Service Agreement with DESC. According to the Agreement, DESC will provide housing and on-site supportive services, the agency will provide support services, and together they will develop a plan to serve each individual client. The referral agency is responsible for completing a referral form and providing documentation about the client's housing/homelessness status, diagnoses and income verification. DESC conducts a criminal background check.

When an agency refers a client to DESC, DESC arranges for an interview with both the client and agency. An assessment is conducted to screen in people with the greatest vulnerabilities. This is the beginning of the client's relationship with DESC. DESC encourages people to be open and honest with them. DESC makes it clear that there is virtually nothing the person could say about their past that would result in them being denied housing. "If everything was roses, they wouldn't need or get the housing."

Eligibility Criteria

To be eligible for housing in the Lyon Building, applicants must be homeless and have a very low income. This means an income less than 30 per cent of the median income for the area. Most applicants usually have less than 15 per cent of the median income for the area. In addition, applicants must have two

of three diagnoses for HIV/AIDS, mental illness and/or substance use.

Priority for units is determined as follows.

Category 1	Disabled by AIDS and have a mental illness. May or may not have a substance use disorder.
Category 2	Disabled by AIDS. Do not have a mental illness but have a substance use disorder.
Category 3	HIV positive, but not disabled by AIDS and have a mental illness.
Category 4	HIV positive and have a substance use disorder OR have a mental illness and substance use disorder (but not HIV positive).

Applicants will be denied access to housing in the Lyon Building if they are too high functioning or their recent behaviour indicates that they would pose an imminent danger to others. Here are some of the factors to be considered.

- Does the applicant have a history of assault?
- Has the applicant committed other types of crimes against vulnerable people in the past?
- Is there reason to believe the person has changed?

The Lyon Building considers each crime, the victim, the circumstances of the crime and the likelihood that the person will re-offend. For example, if the applicant has a history of offences against a minor, this may not be a problem since there are no minors in the Lyon Building.

Degree of "Housing Readiness"

DESC does not apply "housing readiness" standards to Lyon Building applicants. The Lyon Building was created specifically to serve individuals who are unable to be housed elsewhere. They have severe challenges and vulnerabilities. DESC believes that housing needs to adjust to the person. There is no requirement for applicants to be stable. They do need to be connected to one of the referral agencies, but not highly engaged. For example, if an outreach worker from a referral agency has established a relationship with an applicant to the Lyon Building, this level of connection would be sufficient. The outreach worker would be expected to maintain this relationship.

DESC has always had a "harm reduction" approach and developed a "housing first" approach, although they did not always use these terms. They created their first shelter because there were people on the street who were not being served. They saw the shelter as a "death prevention" strategy. DESC got to know their clients. They learned that their clients would "bolt" when they were forced down a road where they didn't want to go.

According to DESC, the harm reduction and housing first approach works with people "who don't want what we want them to want yet."

Program Expectations

Upon move-in, an on-site Clinical Support Specialist works with each tenant and the referring case manager to develop a Residential Services Plan. The purpose of this plan is to guide staff in how they work with the individual. The plan sets out the needs and challenges facing each person as well as their strengths, goals and methods for achieving their goals. The goals and methods are determined based on what the client wants.

The plan includes information about regular case manager visits to the Lyon Building and a crisis response plan for the tenant, including emergency numbers for tenants or staff to call on a 24-hour basis. The plan may also include information about activities the tenant will participate in and the way in which services will be provided and coordinated.⁴ If an individual has issues associated with substance use, this most likely would be one of the areas addressed in the plan.

There is no requirement for tenants to take their medications. However, DESC provides assistance to help tenants take their medicines as prescribed. For example, staff maintain a record that shows what medications each tenant should be taking and when, and will note if a tenant has taken his/her medicines or not. Most tenants get into a routine and ask for their medication. If a tenant doesn't come to take his/her medications, staff will give a reminder call. Staff may also store medications in a secure location.

Program Demand

The Lyon Building is somewhat different from other buildings owned and managed by DESC because of its funding and more specific target population. They do not maintain much of a waiting list for the Lyon Building because there are so few move-outs. In October 2004, there were 33 individuals on the waiting list.

Harm Reduction and Substance Use

DESC uses a harm reduction approach. They accept the notion that people are the way they are and are not likely to change just because they are told to. They acknowledge where their tenants are and respond to this in certain ways. DESC notes that there is some misunderstanding about the concept of harm reduction. They have found that some people think this means "anything goes." However, the Lyon Building has rules and expectations about behaviour. They explain to their tenants that "the street ends down the street," and that living indoors is different from the street.

DESC focuses on "alliance building." They work with each individual to create an approach based on what the individual wants and the resources available. DESC presents options and opportunities. They accept that people will make their own decisions.

Another aspect of DESC's approach is to be "assertive." Staff don't expect tenants to "accept their wisdom" from day one, but they don't give up either. They recognize that it will take time to have an impact on the tenants. While there is no requirement for tenants to see a counselor or attend sessions, tenants are invited to participate in these services. If tenants tell staff to "get lost," staff will continue to encourage tenants to get involved. Staff are not hands off. At first, the tenants want just an apartment—safety and stability. DESC makes it as easy as possible for people to get this. However, they also make it clear from the beginning that they want to be involved in the tenants' lives. Staff work to accomplish this and introduce new ideas to tenants over time.

DESC decided to adopt this approach because they realized that other approaches were not working. During the course of operating their emergency shelter, DESC developed expertise on how to work with the client group. They learned what the clients would accept and what they wouldn't. The clients accept a relationship with people they trust. They do not accept people telling them how to live their lives.

Another reason why DESC adopted a harm reduction approach is because many individuals have been through treatment programs—perhaps multiple times. Nevertheless, they continue to use substances, despite the consequences. DESC doesn't think it makes sense to replicate the same kinds of approaches that their clients have already experienced. Individuals for whom treatment programs have worked do not need DESC. The goal of DESC is to help individuals for whom the other approaches did not work.

Substance Use

Lyon Building tenants use a variety of substances, including alcohol, marijuana, crack cocaine, heroin and crystal meth.

Crack has been evident in Seattle since the mid-1980s. Use of this drug grew steadily and reached a plateau during the 1990s. The use of crystal meth has increased since the 1990s. Heroin has maintained a strong presence.

DESC has found that the use of illegal drugs poses problems that alcohol does not because of the illegal activities that go along with procurement. DESC has also found that the combination of alcohol and crystal meth are more likely to result in aggressive behaviour than heroin. Heroin is more likely to result in accidental overdoses. It should be noted that Washington State permits the

⁴ Lyon Building Service and Management Plan—July 18, 1997.

possession of small amounts of marijuana for medical purposes, and with the approval of a medical doctor.

DESC does not have a formal position on harm reduction strategies that would encourage a switch from one substance to another. Rather, they devise a strategy for each individual tenant.

Some of the specific harm reduction strategies employed by DESC in terms of substance use include the following.

- posting warnings about dangerous substances on the street (including products associated with more overdoses)
- encouraging tenants to use clean needles
- providing for the safe disposal of needles
- informing tenants about the location of needle exchange programs

In addition, Lyon Building staff “encourage honesty with regard to substance use rather than secrecy and shame.”⁵ The goal is to help tenants reduce the harmful effects associated with substance use and foster a relationship where staff and tenants can work together to establish “therapeutic rapport” and develop strategies to reduce their substance use.

DESC staff also engage in motivational interviewing to help tenants address their substance use issues. This approach is designed to help tenants address their ambivalence and explore options for changing their behaviours regarding substance use. Staff deliver a consistent message to encourage tenants to make changes in their lives to reduce their use of substances, move to less harmful substances, or enter treatment. One of the staff mottos is “persistence rather than insistence.”

DESC has found that it is difficult for their tenants to access in-patient treatment. These services tend to be used by people with less severe problems. Outpatient treatment works for some of their tenants. However, most of their tenants want to “descend the ladder one step at a time.” DESC has found that most programs don’t work like that—they require abstinence. Most of the Lyon Building tenants work with on-site staff or other programs that tend to have a more flexible approach to addressing substance use issues.

Policies and Approaches Relevant to Housing the Target Group

Use of Substances in and Around the Building

Alcohol is permitted in individual tenant apartments but not in common areas. The law requires that illegal substances are not permitted anywhere in the building. DESC does not search for illegal substances.

DESC focuses on preventing behaviours that are annoying to other tenants. For example, knocking on other tenants’ doors to either buy or sell drugs inevitably angers other tenants and is not permitted.

Security Measures

The front door to the Lyon Building is the only permitted point of entry and exit into the Lyon Building. Other doors to the building are secured by an alarm system. Next to the front door is a desk staffed by a Residential Counsellor 24 hours/day. The front door is kept locked, and tenants must have a key to enter. Visitors must sign in. There is also a closed circuit TV system in hallways that lets staff monitor these areas of the building.

Guests/Visitors

According to DESC, the main difference between the Lyon Building’s rules and those in independent market housing is that the Lyon Building has rules that regulate visitors. A visitor policy is seen as critical because it has been the experience of housing providers that disturbances within their buildings are most often caused not by the tenants but by their guests. The purpose of the Lyon Building visitor policy is to help tenants set limits on their visitors. The policy provides that regular visiting hours are between 8 a.m. and midnight. Tenants may have no more than two visitors at a time, and must accompany visitors at all times. Overnight visitors are limited to one per night a few nights a week, and they must be approved by management. Visitors must check in at the front desk, and certain visitors may be barred from the building.

Sex Trade/Prostitution

Sex trade/prostitution can be an issue—generally with more dysfunctional tenants who have a mental illness and who bring in visitors seeking sex in exchange for money and/or drugs. Staff intervene and discuss the issues with the tenant. They try to encourage the tenant to agree to more restrictions about who can visit—perhaps limiting the list to family and some specific friends. The goal is to limit the random bringing in of people off the streets. With a consistent staff, the Lyon Building is able to get a sense of “friend” versus “predator.”

5 Lyon Building Service and Management Plan—July 18, 1997.

Temporary Absence

If a tenant is temporarily absent from his/her unit (for example, enters a residential treatment program or is hospitalized), the tenant may keep the unit for up to 90 days. After 90 days, DESC staff will assess the situation. DESC cannot keep a unit vacant for more than 180 days.

Residents Who are Abstinent

Most tenants who become abstinent want to continue living in the Lyon Building. Sometimes, they want everyone else in the building to become abstinent. Other tenants who become abstinent do not want to stay. DESC helps these tenants transition out. However, sometimes when a tenant wants to move out, DESC expresses concern to the tenant that this might not be the best option for them. This could arise if based on the tenant's previous history, the period of abstinence is likely to be short-lived, and there is a good chance that the tenant will be homeless again soon.

Role of Staff in Working with Residents

The amount of contact staff have with each tenant varies. On-site Clinical Support Specialists are expected to communicate with their clients at least once a week. Some clients want less contact, however, it is up to the Specialist to try and make contact in a way that will be accepted by the client. This contact may be in the office, client's room or a hallway. In addition, Specialists are expected to communicate with their clients' outside service provider at least once a week.

Residential Counsellors are expected to see tenants more often. This may be in passing and informal. For example, Counsellors may simply try to strike up a conversation when they see a tenant in the lounge or in the

hallway. Residential Counsellors keep a log of when they see each tenant. If they don't see someone for three days, they try to find them. They may check their apartment, contact other service providers, the hospitals or jails. Residential Counsellors are located in the main area of the ground floor.

Legal Issues

There have been no legal issues arising from the use of illegal substances in the Lyon Building. When planning first began, the DESC Executive Director met with the City of Seattle's legal staff and County prosecutor to explain the mandate and goals of the building and harm reduction strategy for the tenants. The City's attorney and County prosecutor expressed support for the program, as long as there was no drug dealing and as long as the building didn't create problems in the community. To date, there have been no problems with the police.

Exits from Housing and/or Programs

Voluntary Move-outs

The most common reasons why tenants will move out of the Lyon Building are

- the tenants need less support than they did when they moved in;
- the tenants have reduced their substance use and want different neighbours;
- the tenants require more nursing care due to failing health;
- the tenants are unable to accept the rules of the building; and
- death

In general, most tenants move to other subsidized housing that offers less support, hospitals, nursing homes, or market housing (where the tenant may share rent with another person). Occasionally, a tenant may go to jail or return to the streets. Some tenants leave the area and DESC does not know where they go.

There are no program reasons why a tenant would be required to move out of the Lyon Building.

Evictions

The safety of other tenants is the prime factor DESC considers when deciding whether or not to evict a tenant. DESC will take into account if a tenant has engaged in repeated dangerous behaviours, caused damage to his apartment or the building, or engaged in behaviours that make the building unsafe for other tenants. DESC will also consider the likelihood of the tenant changing his/her behaviour.

Assaulting another tenant is the most common reason for an eviction. Sometimes, if one tenant has assaulted another, DESC will call the police and move for an eviction while the tenant is in jail.

When issues/concerns arise with a tenancy, DESC tries to resolve the problem by working with the tenant to find solutions. For example, if problems arise with visitors, DESC will encourage the tenant to limit the number of visitors for a period of time.

For violation of rules that are not grounds for immediate eviction, DESC may issue a "10-Day Notice to Comply or Vacate" as required by the Washington landlord and tenant legislation. Sometimes, simply the threat of issuing a notice is sufficient for a tenant to change certain behaviours.

Services

Model of Service Delivery

The Lyon Building provides supportive housing. This includes housing with intensive and comprehensive services provided both in-house and by outside agencies. DESC believes the development of successful relationships between tenants and social service providers is crucial to long-term housing success. They believe their tenants need a place to live and must have whatever support services they need to help them stay housed.

DESC calls their model of service delivery “community support case management.” The goal is to “coordinate community support services to meet the needs of the client in order to promote the client’s highest level of stabilization in the community.”

This model involves three components

- case management from referring provider agencies
- on-site clinical support services—provided by Clinical Support Specialists
- a flexible residential program designed to promote housing success—with clear and understandable rules designed to complement the provision of individual client support services

All Lyon Building staff are familiar with each tenant’s clinical needs and remain in close communication with tenants’ outside service providers. The Lyon Building on-site Clinical Support Specialists work together with each tenant’s outside case manager to ensure that each tenant receives a comprehensive service package through a combination of on-site and external staff support. DESC believes this integrated approach creates a

comprehensive service model, and avoids fragmentation that can occur when building management is separated from the provision of support services.

Types of Services

Tenants at the Lyon Building receive the services set out below. Most of these services are publicly funded. Grants may also be provided for a few specific programs (for example, art supplies). DESC also undertakes its own private fundraising initiatives.

Medical services: Tenants may access primary health care services off site.

Mental health: Upon move-in, the tenant, his/her mental health case manager and a Lyon Building Clinical Support Specialist meet to determine what building staff can do to support the tenant’s treatment plan and to maintain consistent strategies for responding to behaviours exhibited as a result of the mental illness. After move-in, Lyon Building staff encourage tenants to continue accessing the mental health services they received before move-in, and maintain regular contact with mental health providers to keep informed about each tenant’s mental health status. Some tenants see their mental health workers off-site. Mental health service providers are also encouraged to make regular visits to the Lyon Building to meet with their clients on-site. Most Lyon Building clients who are enrolled in mental health services receive those services from DESC’s own licensed mental health program. Clinical Support Specialists located on the ground floor of the Lyon Building are also available to provide mental health support to Lyon Building tenants.

Substance use: Substance use issues may be addressed by referral agencies that specialize in chemical dependency or mental health. Mental health providers are often trained in concurrent disorders. On-site staff also provide services. Staff members help tenants with histories of substance use participate in support groups such as Alcoholics Anonymous, Narcotics Anonymous, 12-step, and a group for methadone consumers. Clinical Support Specialists, one of whom is certified as a Chemical Dependency Professional, are also available for one-to-one counseling about substance use related issues. Staff attempt to provide a safe environment for open discussion of substance use issues while supporting tenants in all attempts toward sobriety and safe, healthy lifestyles.

Money management: About half the Lyon Building tenants are on money management programs where a representative payee handles the tenant’s money and pays the rent. This service is usually provided by a mental health or substance use service provider. Usually this arrangement has been mandated by the tenant’s funding source. The other tenants are responsible for their own finances.

Meaningful activity: Both on-site and external service providers work with their clients at the Lyon Building to develop plans to fill the tenant’s day with activities the tenant defines as meaningful (for example, recreation, volunteer activity, day programs and employment). On-site staff organize games, art projects, interest groups and therapeutic support groups. Many tenants need substantial help to find and maintain work.

Food programs: The Lyon Building provides a free dinner in the building seven nights a week. Staff encourage tenants to attend these meals regularly for good nutrition and social involvement. Staff also obtain groceries from a food bank and distribute them to tenants who want them.

Life skills: Lyon Building staff offer a great deal of individual one-on-one assistance with life skills such as hygiene, housekeeping, and how to use the bus.

Transportation: The Lyon Building is located in a central spot for public transportation, and it is very easy for tenants to get around the city. DESC also has agency vans. Staff organize regular trips to grocery stores and use the vans for field trips. Staff may also help tenants get to medical appointments. Staff may escort tenants by bus or case managers may drive tenants.

Social support network: Case managers from referral agencies and Lyon Building staff work together with their clients to identify and construct a network of friends, family and professionals who can socially support the tenant's stability in the Lyon Building. On-site staff encourage tenants to participate in support and discussion groups and to engage in group activities to strengthen their social support network.

Most Effective Services

DESC believes that the services most effective in promoting stability among their tenants in the Lyon Building include

- 24-hour staffing by personnel who know the tenants and can provide ongoing support and crisis intervention
- individual Residential Service Plans that are created at the beginning of the tenancy

- the attitude of hopefulness among Lyon Building staff—that things will work out and problems can be resolved to maintain the tenancy.

Connections With Community Programs/agencies

Formal: With referral agencies that sign the Cooperative Service Agreement

Informal: Staff have frequent contact with a variety of different programs such as the needle exchange, health department, day programs for people with AIDS, and other organizations.

Staffing and personnel issues

The Lyon Building has the following staff.

Project Manager. One project manager is responsible for overseeing all project operations, support service delivery, and staff in the building. This position is filled by a social worker or other social service professional.

Clinical Support Specialists. There are four full-time Clinical Support Specialists at the Lyon Building. One of these positions is designated as a Chemical Dependency Specialist. Clinical Support Specialists are responsible for becoming familiar with tenants' needs and building a trusting relationship with them; creating a Residential Services Plan for each Lyon Building tenant; and coordinating treatment and service planning with case managers from the outside referral agencies. They serve as the liaison between the Lyon Building staff and the outside case manager. Other services include coordinating support groups, and educational and recreational activities.

Each tenant is assigned to one Clinical Support Specialist for primary on-site service coordination. The caseload ratio for the Chemical Dependency Specialist is 10:1. All the tenants on this caseload have

significant substance use issues. The other Clinical Support Specialists have a caseload ratio of 17 or 18:1. While all the Clinical Support Specialists are familiar with substance use issues, the Chemical Dependency Specialist is a professional in this field.

DESC makes it clear to its staff that it is OK for clients to "fire" their case manager, but it is not OK for staff to fire their clients. Staff are expected to try and engage the tenants, and to be persistent in these efforts. If difficulties arise, case managers are expected to brainstorm ideas with other staff. If a particular relationship is not working out, DESC may switch a tenant to another Specialist's caseload.

Residential Counsellors. Residential Counsellors have dual responsibilities for property management and interacting with the tenants. Specific duties include

- maintaining direct contact with tenants and providing informal counseling
- knowing each tenant and his/her service plan
- facilitating meaningful activities and social interaction
- crisis intervention
- enforcement of rules
- reception and working at the front desk 24 hours per day
- security
- assisting the project manager with leasing, rent collection and data collection

In the first few years of the Lyon Building, two Residential Counsellors were on duty at any one time, around the clock. More recently however, due to funding limitations, there are periods when only one Residential Counsellor is on duty.

DESC points out that most supportive housing projects separate the delivery of services from property management. DESC doesn't do this. They prefer an integrated approach whereby staff have these dual responsibilities. DESC wants all staff to get to know the tenants as well as possible and develop effective approaches to working with them. By having an integrated staff that know all the tenants, staff can tell if a tenant's behaviour is typical or something to follow up on. Steps can be taken immediately if they observe things that are out of the ordinary. DESC also believes it is easier to teach property management to a social worker than the other way around.

Staff Burnout

Staff burnout can be an issue. Some staff find it too difficult to see tenants continue to make choices that harm themselves. This affects some staff more than others. Some staff decide that the Lyon Building is not the right working environment for them. There is informal peer support and most staff have developed close relationships with their co-workers. In addition, training sessions are held for all staff once a month. Some of these sessions are on stress-reduction and taking care of oneself. All staff are covered by a health plan and can obtain counselling if they want. DESC notes that low wages do not help with staff burnout.

Policies for Hiring Formerly Homeless Individuals

DESC has policies in favour of hiring consumers. They have hired staff who are formerly homeless, as well as people who have issues with mental health and substance use.

Funding

Funding for the Lyon Building has been fairly stable. However, budgets are tight because fixed costs have increased (for example, property insurance, general liability insurance, employee medical insurance and utilities). DESC has managed to obtain slight increases in funding and has reduced some staffing costs.

Most funding is provided annually. DESC assumes that funding will be renewed, however, they still need to apply every year.

Tenants pay 30 per cent of their adjusted gross incomes to rent. The following sets out the Lyon Building budget for 2004.

Annual Budget 2004

Source of Revenue	Amount
Federal Government (HUD – McKinney Supportive Housing Program)	\$370,000
City of Seattle (Housing Opportunities for Persons With AIDS – HOPWA)	\$120,000
Residential rents (including some federal funding for rent subsidies)	\$215,000
Commercial rents	\$70,000
Total	\$775,000

Costs	Amount
Personnel	\$560,000
Operating (including utilities, insurance, repair and maintenance, telephone etc.)	\$215,000
Total	\$775,000
Per diem on total	\$33 per client per day

Outcomes, Challenges and Factors for Success

DESC measures success for the Lyon Building by the length of time tenants remain housed, particularly when compared to their tenants' histories prior to moving into the Lyon Building. Looking at this measure of success, the Lyon Building has been very successful. The average tenant was homeless for about one-third of his/her adult life—approximately eight years before moving into the Lyon Building. About 88 per cent of tenants stay at least one year in the Lyon Building and close to 80 per cent stay for two years. Very few tenants move out after that. Of those tenants who have moved out, more than 60 per cent went to another stable housing situation. DESC believes they have been successful in ending homelessness for their tenants.

DESC has less information on the degree to which their tenants have achieved stability in areas of their lives not related to housing outcomes. However, they believe that stabilization in these other areas happens over time. DESC believes that the Lyon Building and other supportive housing programs have proven that their target population can be housed the way they are.

Impact of the Program on
Residents

DESC reports that the Lyon Building has had the following outcomes and impacts on the tenants.

Measures of Success	Outcomes
Residential stability (e.g. length of time housed)	The average length of stay for tenants is 3 years. More than 35% have stayed 4 years or longer. Of those who have moved out, more than 60% went to an adequate housing situation.
Substance use	Decrease in average severity of substance use impact; decrease in average use of heroin. ⁶
Mental health	DESC has tracked the use of crisis services; 75% of Lyon Building tenants reduced their use of crisis services within 6 months after moving into the building.
Increased participation in employment, volunteer or other community activities	30-50% of all tenants have obtained volunteer or paid work or started to participate in a vocational training program.
Income	90% of tenants received some form of income assistance upon move-in. All tenants had access to income within 60 days of move-in.
Personal networks (e.g. more contact with family, new friends)	30% of tenants attend at least one community meeting each year.
Improved use of mental health services and primary health care	All new tenants participate in the development of a Residential Services Plan. Approximately 50% actively participated in revisions to this plan.

Resident Satisfaction

As part of an evaluation of the Lyon Building, 53 tenants were interviewed between January and April 2002.⁷ More than half the tenants reported a perceived increase in access to medical care (greatly improved or somewhat improved—55 per cent). Forty-seven per cent reported improved access to mental health care, and 42 per cent reported improved access to substance abuse treatment. About half the tenants felt that access to mental health care and substance abuse treatment was unchanged.

Access to care	Medical care	Mental health care	Substance abuse treatment
Greatly improved	38%	28%	25%
Somewhat improved	17%	19%	17%
Unchanged	42%	49%	51%
Somewhat worse	2%	4%	2%
Much worse	2%	0%	2%
Total	100%	100%	97%

6 Northwest Resource Associates. 2002. *Evaluation of the Lyon Building Housing Program*. Seattle, Washington: Downtown Emergency Service Center.
7 Northwest Resource Associates. 2002. *Evaluation of the Lyon Building Housing Program*. Seattle, Washington: Downtown Emergency Service Center.

In the tenant interviews, participants were asked about how in control of their own lives they felt since moving into the Lyon Building. More than three quarters (77 per cent) reported feeling more in control than prior to moving into the Lyon Building. Fourteen per cent of respondents reported feeling less in control, 8 per cent reported no change, and 2 per cent didn't know.

Tenants were also asked to rate their overall quality of life since moving into the Lyon Building. "The overwhelming majority (83 per cent) of respondents reported an overall improved quality of life in the Lyon Building compared to their past experiences." Fifty seven per cent reported that their quality of life was greatly improved, 26 per cent reported that it was somewhat improved, 11 per cent reported no change, and 2 per cent reported that they felt the quality of their lives was somewhat worse. Four per cent reported that they felt their lives were much worse.

When asked about their future plans to remain in the Lyon Building, 77 per cent said that they plan to remain, 17 per cent said they did not plan to remain, and 6 per cent said they didn't know.

Reasons for Success

DESC believes the main reasons for the success of their program include the following.

1. The 24/7 staffing by human service professionals who know the tenants and work with them.
2. The approach and attitude of respect and hopefulness that attracts tenants to services that at first they did not express a desire for.

3. The flexible approach to problem solving that is geared to maintaining the tenancy.
4. The planning process, which involved many groups in the community who came together to examine the need and create a model and approach that would work.
5. A clear mandate that the Lyon Building had to be a place the target population would want to be in-and recognition that to accomplish this goal, it was necessary to create a housing program that would accommodate their needs.

Challenges

DESC identified the following challenges to implementing this initiative.

Relationship with AIDS service agencies

It took some time for DESC and AIDS service agencies to clarify their roles and responsibilities. The Lyon Building project was generated from the AIDS service system. In the earlier days of the AIDS crisis, agencies in this system were able to serve their clients and had more resources than most agencies serving people who were homeless. As the face of AIDS was changing, the AIDS service agencies found that their clients' needs were becoming more complex. Many of these agencies saw the Lyon Building as a place where they would be able to send their more "difficult" clients. However, one of the requirements of DESC was that referral agencies would continue to provide support to their clients. Some staff in AIDS service agencies were not keen to continue serving these clients with more complex needs. Then, when the AIDS service agencies' clients moved into the Lyon Building, DESC realized

that many of these individuals could get more appropriate services for their mental health disorders from the mental health service agencies than from the AIDS service agencies. Therefore, over time, the AIDS service agencies became less involved with their clients and the mental health agencies become more involved.

Developing a Greater Understanding of Lyon Building Clients

Through its shelter, DESC developed expertise working with people with severe mental illness and substance use issues. When DESC starting working with the AIDS service agencies, they thought they were discussing a similar client group. However, the AIDS service agencies clients had different types of mental illnesses compared to many of the clients DESC was used to serving. AIDS clients tended to have depression and personality disorders compared to the higher levels of psychotic disorders DESC was used to seeing. While many DESC and AIDS service agencies' clients had substance use issues, because most of the AIDS clients were less disabled by their mental illness than DESC clients, they were higher functioning. DESC found this client group more challenging to work with because they could be more sophisticated in their ability to procure drugs and engage in drug activity. DESC found it necessary to increase its focus on substance use issues. DESC created a position for a Chemical Dependency Specialist and focused more on developing approaches to engage their clients in addressing substance use issues.

Neighbourhood Issues

A property owner across the alley has objected to clients loitering on the sidewalks in an alley and around the building. Sometimes, he blames the Lyon Building for issues not due to Lyon Building tenants.

There was not much opposition to the development of the Lyon Building, in large part due to a series of meetings AHW held with project neighbors during the development of the project.

Lessons Learned

1. The attitude of staff is critical to success. This includes an attitude of hopefulness—that things can work out—and a flexible approach to problem solving that is geared to maintaining the tenancy.
2. The residential program, which integrates property management and support, enables all staff to get to know the tenants as well as possible and to develop effective approaches to working with them. Because staff know the tenants, they can tell if a behaviour is typical or something to follow up on, and can take steps immediately if they observe things that are out of the ordinary.
3. It is necessary to avoid the tendency to force people to make changes. This tendency can creep up on staff working with the target population.

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INNOVATIVE SUPPORTIVE HOUSING THROUGH A HARM REDUCTION APPROACH FOR SUBSTANCE USERS

Case studies



Ottawa, Ontario

Ottawa Inner City Health Project

Background

This case study has been prepared based on an interview with staff from the Ottawa Inner City Health Project (OICHP) and documents they provided (see list at the end).

The Sponsor

Started as a two-year pilot project, the Ottawa Inner City Health Project (OICHP) works in partnership with a number of organizations that offer homelessness services, to provide health care and improve quality of life for persons who are chronically homeless.

Program Goals and History

The project officially began on April 1, 2001, sponsored by the Faculty of Medicine of the University of Ottawa. Funding for the two-year pilot project was provided by the Government of Canada, through the Supporting Communities Partnership Initiative (SCPI). Currently the bulk of the funding comes from the Ontario Ministry of Health and Long Term Care. Contributions also come from community partners and the City of Ottawa.

Three principles guide the work: harm reduction, close integration with existing services, and the inclusion of all cohorts within the homeless population—activities that are sensitive to age, gender, race, language, culture ability and sexual orientation.

Project at a Glance

Sponsor Name

Ottawa Inner City Health Project (OICHP)

Goals

- Manage the health, housing and other needs of people who are chronically homeless
- Target people with complex health needs unable to access mainstream services due to behaviour or lifestyle

Target Population

Chronically homeless complex health need, and challenging behaviours living in the inner core of Ottawa.

Housing Tenure

Full range from short-term to permanent.

Number of Units

-

Factors for Success

- Willingness of partners to take a “leap of faith”

Location

Ottawa, Ontario

Project Start Date

April 2001

The mission of the project is to contribute to ending homelessness in the community by providing health care and improving the quality of life for people who are chronically homeless. Fundamental to this mission is the vision that persons who are chronically homeless have equitable access to the supports and services they require to maintain or improve their health.

The project grew out of a recognition that service providers did not have the capacity to act in a collaborative manner in dealing with homeless persons because of a lack of funding, differing mandates, and lack of co-ordination between sectors. This resulted in movement of clients between systems and disjointed approaches to care.

OICHP has undertaken to work in partnership with many service providers in Ottawa: residential beds are provided for homeless clients of the Mission Hospice; the Special Care Unit of the Salvation Army Booth Centre; and the Management of Alcohol Program at the Shepherds of Good Hope Cornerstone and Aboriginal Women's Support Centre. Each brings differing and specific elements to the project. The collaborative relationships that have been developed have constituted both the major challenges and the major successes of the pilot project.

The partner agencies each had evolved over long periods of time and developed strong organizational cultures. The process of integrating a harm reduction program was especially challenging at the beginning but all were willing to try new things and all realized that they did not have to change their core functioning or values to undertake the work. Nonetheless the organizations did have to adhere to

collective goals that were perhaps different from their organizational goals. The limits of each agency was tested—certain practices were tolerated, even if the agency did not want to do certain things. One example is the issue of abstinence from alcohol on the part of the Salvation Army; they do not accept that alcohol be served on their premises but support a range of treatment options for people with substance abuse and support the Alcohol Management Program which provides in-house wine at set periods of the day. They are particularly committed to supporting injection drug users to stabilize their lives and have been very successful creating safe, supportive environments for active users which creates stability from which the client work towards positive life goals.

The project reflects concern in the broader community about chronically homeless persons—a subgroup in shelters who are in terrible health caught in a situation where their health was getting worse in the shelter system or who could not leave the shelters because of health problems. There also was recognition that same things were being done over and over again without these necessarily being right. In examining what needed to be done to address their health and housing needs, two issues emerged—substance abuse and mental health. The first was of greater concern in part because at the time, the Ministry of Health was in phase 1 of its Mental Health Initiative and it was expected that they would take care of the mental health issue. Furthermore, it was recognized that traditional addiction treatment had failed this group or that they were not interested in pursuing the available approaches offered to them.

Program Description

There are three main residential sites where the services are based: the Mission Hospice that provides palliative care to men, women and couples (15 beds); the Salvation Army Booth Centre that provides convalescence care in its Special Care Unit (20 beds); and the Shepherds of Good Hope that provides the Management of Alcohol Program for adult men and women (20 beds and 5-day program places). Health care also is provided at community beds at sites such as the YMCA and Cornerstone, as well as at clients' homes.

The services and criteria vary according to the partners (for example, have a progressive, end-stage disease for palliative care) but all are for homeless or at-risk adults who are not suited to “mainstream services” due to behaviour or lifestyle; lacking financial or other resources to provide for their own care; and have no suitable caregivers. All have physical needs that usually include substance abuse and mental health problems.

Other services include medical detoxification (the most frequent need identified by clients). Because of their fragile health, amount of substance use, and poor mental health, non-medical detoxification is often unsafe and clients who wish to stop or reduce use need a structured support system. There is a medical detoxification program with 12 beds at the Royal Ottawa Hospital but the wait for admission is eight months and the admission process is inaccessible for OICPH clients because of their lifestyles. OICPH uses medical protocols for detox but this is offered flexibly—clients are supported even if they want to make a small or temporary change and are not required to enter an abstinence-based treatment program following detoxification.

The People

As stated above, the clients are some of the most difficult persons to house. Most clients (93-100 per cent depending on the location of services) have a substance abuse problem and most have both substance abuse and mental health problems (about 70 per cent of the clientele). About 10 per cent of the clients are women however demand from women is increasing rapidly.

The clientele includes people with HIV/AIDS, FAS/FAE, those with physical disabilities, developmental delays and acquired brain injury.

It is estimated that about 120 persons a year will receive services without being registered or admitted to the program. These are persons who do not have access to family medical care and have a medical crisis. OICHP provides them with short-term treatment to bridge the gap to getting to a family doctor, as long as this does not negatively impact on the care of clients.

The Housing

The type of housing varies. Each location has an available combination of dormitory accommodations, single rooms, short-term and longer-term housing. Some clients live in their own units or in shelters.

There was some controversy when the project was initiated about locating services in existing shelters. While it was felt that clients should receive services where they were, there was concern that this would perpetuate the idea that living in a shelter was acceptable. Nonetheless it was recognized that there were cost advantages in terms of shelter, food, and housekeeping services as well as the opportunity to build onto existing

systems. Furthermore there was concern that the needs of very ill clients would tax the shelters services. (Note: The Mission and Shepherds of Good Hope have housing at the same location as the shelter.) A survey of clients for an evaluation in 2002 found that for the most part they were very satisfied with the location of the services.

Access to Housing

There is no set process for referral—people can come from anywhere—other persons, friends, and so on.

Eligibility Criteria

OICHP is a service of last resort.

Clients sign a “consent for admission” form that specifies

- the location where services will be received (for example, palliative care at the Mission Hospice, Special Care at the Booth Centre of the Salvation Army, the Management of Alcohol Program at the Shepherd’s of Good Hope, or another community location)
- acceptance that as health needs change, they could be transferred within the four locations in the project
- that they have the right to give or refuse consent to treatment, including medication, in accordance to the law and that they will be fully informed of the consequences
- that medical care will be provided and co-ordinated by the visiting nurses, with their input and supervised by visiting physicians; that other specialists, including the medical director of the project, may be consulted when appropriate

- daily personal care will be provided by client care workers and that they will be given privacy during care and treatment
- that they accept that documentation and medical records will be kept confidential within the OICHP and partner organizations, and that these can be shared with the health professionals providing care
- that information may be collected for research purposes but that it will not identify the individual

Furthermore, the form confirms that the client understands that

- they can be accepted into the project without a health card but they are expected to apply for one (help is offered)
- that OICHP or partner agencies are not responsible for lost money or valuables
- that OICHP and partner agencies have the right to maintain a therapeutic environment, that failure to comply with policies can result in discharge, that they are to treat staff and other clients with “respect and dignity,” that physical and mental abuse is not tolerated, and that they will report any safety concerns
- that it is their responsibility to appoint Powers of Attorney for medical or legal issues if they require and that assistance can be provided to do this
- that there is a complaint process if they have concerns about services received

Degree of “Housing Readiness”

This is a goal-oriented program and the type of housing (ex. short-term or long-term) depends on what the client wants to do with their life. Goals can change—some people have stopped drinking and found independent housing, and others intend to remain housed within the program for the rest of their lives

Program Expectations

The program operates on a case-by-case basis. For example people are not forced to take medication (for both legal and ethical reasons). However, if there are certain medical conditions, such as an infection, and the client refuses treatment, then it would be concluded that there is no real point to their participation in the program. If people don't want to be assessed, they are not forced to do so if they are manageable. People are sometimes asked to leave if their behaviour is out of control. They can come back into the program but are encouraged to see that they do have control over their behaviour—often people are scared of their own lack of control and once they start to recognize what is happening, they can engage in a behaviour management strategy.

The goals that are set with the clients can be very basic at the beginning, for example sleeping in a bed at night, showering periodically, eating, not hurting others. These goals are set on a weekly basis and three goals are identified—one is always something that the client is already doing (for example, getting up before noon, go down for one meal a day, take a multivitamin). Once there is success in meeting the goals for one week, the client gets into a pattern and the positive achievements are reinforced.

Program Demand

The program tries to take everyone that they can—it's the only place that will have them. There can be waiting lists, for example, the wait for a place in the managed alcohol program is at least a year while usually people can be accommodated fairly quickly in convalescent care.

Harm reduction and substance use

The approach used by OICHP makes a distinction between harm reduction and addiction tolerance. Harm reduction implies that it's not merely management of one problem—the way that a disease like diabetes would be treated for example—but takes the broader context into account and includes other behaviours that create harm in the lives of people.

Because harm reduction is a new approach and in evolution, it took time to have it accepted. For example, clients did not initially believe that OICHP was really working from a harm reduction model and that they would not be excluded for use. Their experience had been that service providers would encourage them to be open about substance use and then exclude them for this. It took time for clients to trust the staff and the approach.

Substance Use

Alcohol and crack cocaine/cocaine are the most common substances used, followed by opiates, non-beverage alcohol and prescription drugs. There is a hierarchy of problems caused by different drugs. For example, alcohol can lead to violent behaviour and injuries although people are usually reasonable and respond well to positive reinforcement of their behaviour. On the other hand, those who take crack cocaine can be “Tasmanian devils,” and are frequently unpredictable,

feel all powerful and unable to respect rules. Opiate users are typically “model citizens” and not much trouble.

One of the major challenges is dealing with people with concurrent disorders. There is a need to observe the cycles of behaviour to understand them—however, often by the time that the patterns are identified the person has been excluded from services and therefore are not eligible for housing. Medication for persons with concurrent disorders is another challenge—the medication for the mental illness must be compatible with drug and/or alcohol use although, this has proven to be less problematic than originally believed.

Other clients that are challenging to help are those with dementia, brain injuries and developmental delays. The systems that exist for these groups are not geared for those who use drugs or alcohol combined with mental illness.

Violent behaviour is another challenge—often leading to a major dilemma: whether to restrain the person chemically or to let them go to jail. The most effective approach is to engage the client in developing a behaviour management strategy which they believe will work with the understanding that if it is not effective the police will have to be involved. This places the onus on the individual to take control of their behaviour with staff in the role of “helper” and removes the dynamic of punishment.

Policies and Approaches Relevant to Housing the Target Group

The OICHP approach is based on getting people to invest in the idea that their lives can be different. Improvements are usually incremental, not dramatic. For example, someone who is now in the managed

alcohol program had almost frozen to death many times while living on the street. This person now eats breakfast, takes medication while still consuming Listerine (alcohol of choice) outside, although in lesser amounts, and then comes back to have a nap and supper. Thus, while the consumption has not ceased, there is a structure to the day, diminished consumption and the person is healthier. Substance use has been reduced; the person manages their diabetes extremely well and cooperates with all expectations for medical care, social integration and civilized behaviour.

Reducing consumption of substances is a goal only if the client identifies it as such. For many, consumption is not regarded initially a problem—even if they have lost everything because of it. The focus is on having the client identify what things are creating harm to them to preventing them from living their lives as they wish and focussing on those issues.

Use of Substances

The level of tolerance varies by partner. For example, wine is given to clients in the Alcohol Management Program but is not served in the Salvation Army Booth Centre.

While illicit drugs are not permitted on the premises at any location, there is room to manage certain drugs such as opiates.

One of the dilemmas that the project has confronted are persons who get permission to consume marijuana for medical reasons, but because there are no pot buying clubs in Ottawa, it remains illegal to acquire. This becomes even more of a problem if the person is too unwell to go out on the street and buy the drug.

Other issues include PICC (Peripherally Inserted Central Catheter) lines and pumps for those in palliative care and their use for illegal drugs (often these are inserted because the clients veins are no longer useable). Some hospitals have refused to put in PICC lines because of the potential abuse. The project has been pushed to deal with the issues that this can represent, however. In one case, the client had a PICC line for antibiotics that had to be administered at precise moments three times a day. In between, he would be disconnected from the pump and he would leave the premises, go to a relative's house to consume crack cocaine and then come back for the next round of antibiotics. Because he had some problems with memory, a system was put into place to remind him to go back for the medical treatment. To date there have been no problems with patients using PICC lines to inject drugs on their own however, the theoretical risk does need to be considered with each case.

There is control of drug paraphernalia for safety issues. Injection drug users are given kits and used needles are put into designated containers—they cannot have used needles on their person. Repeated failure to dispose responsibly of used needles would be a reason to ask a client to leave the program.

Security Measures

Security measures, such as control over who enters the building, are in place. The issue of drug dealers on the premises has caused difficulties in the past—including a resident who offered to share his crack cocaine with others one day and then wanted to be paid the next. He was thrown out but was re-admitted once a behavioural contract was negotiated and in place.

Guests

The policies are set on a case-by-case basis. However, there are policies enforced by some partners—for example, visitors to the Hospice must leave their bags in the office to avoid problems with dealers. If problems seem to be occurring, there may be an imposition of restrictions on visitors to rooms.

Conflicts Among Residents

Conflicts are dealt with on a case-by-case basis. People are generally very tolerant of each other.

Temporary Absence

This is dealt with on a case-by-case basis. For example, if someone is in hospital the space is usually saved for them if there is a reasonable expectation that they will be coming back. Visits with family and friends are important and encouraged as clients re-engage.

Residents Who are Abstinent

There is no requirement that clients consume to stay in the program. What has been observed though, is that goals change when someone is abstinent for a certain period and frequently clients want to move into housing. However, there have been persons who have stayed on who were long-term abstinent but felt they wanted to remain in a community, which they felt, supported and cared for them.

Services	Type of Service Availability	Service Provider	Are Services Available on Site (Yes/No)	Source of Funding: Public Private Charitable
Medical care	Full range – all the way to palliative care	OICHP	yes	Public
Mental health	Case management, ACT, medication	OICHP/Partner agencies	yes	Public, charitable
Substance use	According to the goals of the client and the approach of the partner (e.g. Management of Alcohol program administers in-	house wine at set periods of the day) OICHP/Partner agencies	yes	Public, charitable
Employment assistance (training/finding work)	According to the goals of the client	OICHP/Partner agencies	yes	Public, charitable
Money management	According to the goals of the client – but can include Power of	Attorney Partner agencies	yes	Public, charitable
Assistance with life skills, food, transportation, clothing etc.	According to the goals of the client	Partner agencies	yes	Public, charitable
Social recreational opportunities	Different opportunities offered by partners	Partner agencies	yes	Public, charitable
Medication administration	OICHP and shared by all partners involved in	providing health care OICHP	yes	Public
Needle exchange	Part of harm reduction approach	OICHP	yes	Public
Assistance finding permanent	housing Depending on the goals of the	client OICHP/Partner agencies	yes	Public, charitable
Meal Program	Part of services offered	Partner agencies	yes	Public, charitable

Exits from Housing and/or Programs

Voluntary Move-outs

The length of stay in the program varies by partner organization. For example, the Special Care Unit of the Salvation Army Booth Centre is for short stays—up to three months, although clients can stay on or retain privileges if they are in the process of obtaining housing or there are extenuating circumstances. Five beds in the unit are set aside for clients who have long-term needs and no other options exist (such as mental illness with serious physical health needs or elderly persons). Clients of the Hospice can stay as long as they wish, even if they get too “well”—most consider it home. Clients in the Managed Alcohol Program can participate for as long as they wish.

At times, letting someone stay with OICHP when they are ill, has prevented housing loss and they have been able to return to their homes. In one case a client with mental illness and diabetes was having difficulty managing his diabetes because his mental health was deteriorating. A short stay resulted in stabilization of his mental and physical health and he returned home.

If clients wish to move onto other types of housing and feel ready to move on, they are given support and OICHP services can be provided in clients’ homes. Finding other housing options can pose a considerable challenge, however—there is a lack of affordable housing in Ottawa. Other housing options are not very accessible, for example, most nursing homes will not take this clientele. Others find that some placements have too many rules or are located too far from the downtown and are “too boring.” Proximity to their own community, where they have a sense of belonging, is very important.

However, clients also can decide that they do not want to participate in the program. Often they will ask to come back in—sometimes a cycle that can be repeated a number of times provided that there is a valid reason or goal of service. One of the strategies used in these situations is to create “dissonance” between life in the program and what it is like on their own. People are never told that this is their last chance because this is a program of last resort. They may be told that the program cannot provide services to them but that if the situation changes they can re-apply for admission.

Evictions

Individuals are expected to set goals for their stay—there is a “grace” period that can last for months before goals are set, but this cannot go on indefinitely. Other situations that are not tolerated are abuse to staff or clients. Control over behaviour is a keystone to the project—if people cannot manage their behaviour with the help provided and pose a risk to others, they cannot be there. The clients who fit this profile are often those with FASD who function very poorly in the shelter system and, who are often highly impulsive. The available staffing in the program simply cannot accommodate these individuals safely.

However, being asked to leave is the last resort and is often for a short period. This is seen more as taking a break from the program rather than being barred—no one is barred rather they are “relegated.” Furthermore, it is important that it not be framed as a punishment by staff. However those with mental illness often have a problem of control. The overall approach was summed up by the Executive Director, “Sometimes the people in the greatest need are the most difficult.”

Services

Model of Service Delivery

OICHP uses a case management approach. The nurses at each location are the case managers.

Types of Services

It is important to note that the services that are offered are on multiple levels—the first is health care—the primary goal of OICHP. This includes whatever elements are needed to stabilize and improve the health of the client, which can range from offering safe alcohol to treatment of medical conditions (for example, wounds, HIV/AIDS, diabetes). Other services are based on the goals of the client and can evolve as these change. Partner agencies or others in the community (for example, non-profit housing providers) can then be included to help meet these goals. It is recognized that many clients have lost or never had basic lifeskills and a “quick fix” approach is unsuitable. Long-term support for those with severe or persistent mental illness is available through Canadian Mental Health Association or the ACT programs but many clients do not fit the criteria for long-term support. This is the case for those with chronic health needs such as diabetes.

Changes in Services

The focus in the initial years was on secondary care. However, primary care quickly became a priority as this was lacking in the downtown core and a nurse practitioner was added to the staff. However, as time went on it was clear that more than health issues needed to be addressed. The biggest issue was housing—something that had not been anticipated. Other issues that need to be addressed are improvement of services to women and the

issue of persons who are cognitively impaired—they are often “fly below the radar.”

Connections With Community Programs/agencies

OICHP is based on ties with community partners. A Joint Service Provision Agreement is signed with eight of the main partners. In this document the vision, guiding principles and service philosophy are outlined. The roles and responsibilities are specified and can include

- a minimum number of places for OICHP clients
- joint decision-making for placement of clients within a building
- costs attribution
- provision of a suitable work environment for OICHP staff (for example, storage of confidential medical records and of medications)
- services to be provided by each. For example, on the part of the partner agency this could include a bed, food, laundry services, emergency back up if OICHP client care workers are unexpectedly absent, nighttime care, and so on. On the part of OICHP this could include client care workers on site, nursing and physician services, assessment of the client upon admission, on-call services 24 hours a day for unforeseen situation
- designation of a person to co-ordinate between the partner agency and OICHP and a representative to the OICHP Steering Committee

Other partnerships included CMHA and ACT teams, the Royal Ottawa Hospital outreach team that provides consultation, ongoing support and 1/2 day a week of clinical expertise from a mental health nurse practitioner (program funds are used to hire a 1/2 day per week of consultation and advice on addictions from a physician with expertise in that area).

OICHP has developed a good relationship with the police. For example, if someone is picked up by the police and they are known to be OICHP clients, the police will swing by and pick up the client's medication or in another case the police worked around the dialysis schedule of a client who had not respected a restraining order.

Staffing and Personnel Issues

A major issue is that of staffing and having the right persons in place. Staff are expected to function at a very high level. It is important for the director to be able to trust the staff, although there have been instances where staff attitude was grounded in an approach that used punishment for behaviours. This is not tolerated and people are dismissed. In one instance a staff member working with a client who had suffered a stroke and was paralyzed, was not being compliant with medications. To get them to comply, the staff member turned their chair away from the TV (one of the few pleasures left to the client), then turned the TV off, and the person hit the staff. Because the staff person had not respected the person's right not to take medication and had used punishments—they were fired. The harm reduction philosophy demands adaptability unlike approaches such as behaviour modification that can take a “cookbook” approach. It is acknowledged that this is demanding of staff, as is the process of grief and loss that staff (and clients) go through as people die.

There are a variety of arrangements for staffing.

- direct staff employment – this includes the project director, medical director, clinical physician, outreach nursing, nurse practitioner, administrative co-ordinator, clinical team co-ordinator, IT support
- purchase of service Arrangements – these are with VON Ottawa (nursing an personal care) and the Shepherds of Good Hope (front-line workers)
- direct contribution in kind – organizations that provide staff that work exclusively with the OICHP team include the Mission (Hospice co-ordinator, volunteer co-ordinator, Chaplin), the Booth Centre (special care worker, volunteer co-ordinator, Chaplin), Shepherds of Good Hope (front-line workers), Royal Ottawa Hospital (mental health nurse practitioner)

Staff Burnout

OICHP is starting to look at this issue. There are periodic debriefings—especially around issues of loss and grief. The director is hoping to institute staff retreats but this has been difficult because of unstable funding.

Funding

Funding was very unstable in the early years and short-term funding issues are still being resolved with the Ministry of Health. Plans for long-term funding is underway. One of the initial models that was considered was setting OICHP as a community health centre. Instead, it was sponsored by the University of Ottawa, Faculty of Medicine, which was a very good sponsor—respectful of the community process and lets OICHP do what is needed. As of March 31, 2005 OICHP incorporates and manages the bulk of its operations independently although the relationship with University of Ottawa

continues and, the Ottawa Hospital flows funds from the Ministry of Health to the program through a partnership arrangement.

The estimated bed day costs vary by location

- hospice - \$170/day
- special care unit – \$89/day
- Management of Alcohol Program – \$124/day

The average cost per client of OICHP, exclusive of shelter and other costs is \$51/day.

Annual Revenue

The total budget is \$1.5 million per year. The sources of direct funding are the Ministry of Health and Long Term Care, the City of Ottawa, service partners and private donors. The Community Care Access Centre, Mission, Salvation Army, Royal Ottawa Hospital, Shepherds of Good Hope, Centretown Community Health Centre all provide staff or other resources which are part of the project. The total value of these contributions is 1.3 million annually.

Outcomes, Challenges and Factors for Success

The definition of success is seen as a moving target. Initially the question was whether OICHP could provide health care that was comparable to the Canadian standard at an accessible cost which was achieved during the pilot phase. The definition of success has evolved to a “social inclusion” model whereby success is defined by the clients goals, social participation and the emphasis is now on much broader outcomes than initially.

Sometimes, the changes to clients' lives are incremental. For example, one client with FAS (Fetal Alcohol Syndrome) was used to sleeping outside every night. He has started to come in more often and is now sleeping at the Salvation Army every night. The overarching, long-term goal is that clients will get back into the mainstream—only a few will need to be in the services forever. Nonetheless, the situation of the clients took a long time to develop and it will take a long time to change it.

An evaluation in 2002 of the pilot project estimated that there had been a cost saving of \$3,273,832 per annum to the health care system. Furthermore the study found that there was a decreased use of emergency health services and greater compliance with recommended medical care, and decreased substance use.

Impact of the Program on Residents

Data are collected on a number of outcomes. For example, data for January to March 2004 for a total of 113 clients in four locations (community beds, hospice, management of alcohol, special care) indicate that in terms of Program Outcomes

- 95 complied with recommended medical care
- 90 attend to their own personal health needs
- 103 make appropriate use of health care resources
- 56 obtained and maintained appropriate housing

- 50 reduced risk behaviours
- 101 improved social integration
- 64 set personal goals

In term of health outcomes

- 91 had successful treatment for the condition for which they were admitted
- 96 had primary health care needs and screening for infectious diseases addressed
- 96 established a relationship with health care providers needed to address their health needs on an ongoing basis

The survey of clients undertaken in the 2002 evaluation, found that 78 per cent of clients reported reduction in substance use as a result of participation in the program.

Resident Satisfaction

The evaluation undertaken in 2002 included a survey of clients, as well as service providers within and external to the project. In responding to the statement “My health has improved since becoming a client of the Ottawa Inner City Health Project” 100 per cent of the clients agreed or strongly agreed. This included clients in the Hospice setting who reported feeling better after admission and as their needs for housing, food, health care and pain management were addressed.

Reasons for Success

The reasons for success rest in large part with the collaboration that has been realized and the ability to utilize expertise and resources from a range of service partners.

Challenges

The work in partnership was one challenge that confronted OICHP. All the agencies were keen to have others' policies change but not always their own. In many instances coming to agreements required a “leap of faith” on the part of organizations. Other challenges revolved around the confidence that clients had to develop in the frontline services (although they were familiar with the various agencies). For example, breaking the pattern of going to emergency health services took time as people developed confidence in OICHP. Finally, having OICHP clients using facilities such as shelters that are available to others meant that there were two sets of rules being applied within the same space. Shelters, for example, must operate with consistent rules but the OICHP approach requires greater flexibility and acceptance that different rules would be in used depending on the clients needs.

Lessons Learned

Elements of the project unfolded unexpectedly. What was initially known about the harm reduction approach was based on what had been read—the clients taught and continue to teach OICHP what to do and how to do things differently.

A list of lessons from harm reduction was published in the OICHP Newsletter (Vol. 2, Issue 1). These include

- Assessing risk: before deeming a behaviour harmful the service provider needs a clear understanding of what the client is doing and what is the likely result. Priority needs to be given to the behaviours that are potentially the most harmful (et HIV infection). The assessment must include an understanding of what is being done, the quantity used, the method of use and the environment. Risk may arise from the environment (for example, risk of violence) rather than the substance.
- Alignment with the client: the service provider must engage the clients as partner in the process. Mutually agreed goals and honest and open dialogue facilitate efforts to change behaviour. Care must be taken that the client does not develop a tendency to please the service provider with “good news”: a challenge for the service provider to give as much reinforcement to the client for honesty as for abstinence.
- Support success: harm reduction values gradual or occasional change but especially the client’s capacity to manage their own problems. The assessment needs to identify areas of the client’s life which they are capable of changing (for example, basic improvements in hygiene or nutrition), which make the client feel better and reinforce the belief that they have a capacity for change.
- Expand the range of coping skill: addiction is seen as a coping skill – in spite of the harm it does. A harm reduction approach that supports gradual change gives both the client and the service provider time to develop and use an expanded range of coping skills and tools—eventually giving the client the capacity for variable responses to life’s challenges.
- Harm reduction is not necessarily a continuum: some promote the concept as the first step with an expectation that clients will move closer and closer to abstinence. Many clients have no intention of giving up their habits but may see a benefit in changing the amount or pattern of use.
- Moderation as an acceptable goal: while some service providers accept the idea that if the client has experienced problem drinking or drug use, then they will never be safe from substance use if they use moderately; what little research exists on moderate drinking or drug use does not support this thinking.
- Being inclusive: social isolation contributes to the harm from substance use. As people are less welcome in the “regular world” they spend more time with other addicts, on the streets, and loose social supports. The experience of OICHP does not support the prevailing belief that having people under the influence of drugs or alcohol is dangerous to others. There is great benefit of a supportive environment, diversionary activities, new social experiences and a sense of belonging to a “normal” group.
- Reflecting dissonance: a key role of service providers is to reflect “reality” back to clients and point out the gap between their personal goals and present circumstances. As clients become increasingly uncomfortable with the dissonance between their life goals and their circumstances, service providers are in an ideal position to support positive change.
- Use analytical skills: each situation is different and a “cookbook” approach does not work. To avoid focusing only on the moment and not see the emerging patterns of behaviour, there is a need for close collaboration and communication between staff and clients.

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on the Homeless in Ottawa Ottawa*,
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INNOVATIVE SUPPORTIVE HOUSING THROUGH A HARM REDUCTION APPROACH FOR SUBSTANCE USERS

Case studies



New York City,
New York

Pathways to Housing

Background

This case study has been prepared based on an interview with staff from Pathways to Housing and from documents they provided, as well as published reports (see the list at the end).

The Sponsor

Pathways to Housing, a not-for-profit organization, provides immediate access to independent, permanent housing and support services to homeless persons with severe mental illness and substance use disorders in New York City. It does not require that clients submit to psychiatric or substance abuse treatment before being housed. Most are persons who have been turned away from other programs because of active substance use, refusal to participate in psychiatric programs, histories of violence or incarceration and behavioural problems. A second office, in Washington, opened in 2004.

Program Goals and History

Pathways to Housing started in New York City in 1992. Sam Tsemberis, a clinical and community psychologist working as an outreach worker in New York City in the 1980s kept on hearing chronically homeless people with mental illness asking for the same thing—a place to live, a home. Tsemberis found that clinicians had been taught to interpret what people were saying but not to listen. He found that if one carefully listened to people's stories of their chaotic and traumatic lives, the recurrent theme was about loss of housing and wanting a home. One example was someone who spoke of real estate that they had owned being taken away from them. The particular details of the story perhaps were not accurate, but the essential truth of this story was that he had lost his home. This theme, he found, was repeated over and over again, in people's stories.

Project at a Glance

Sponsor Name

Pathways to Housing

Goals

- Provide immediate and independent housing
- Begin the process of recovery
- Promote integration into the community and work life

Target Population

Chronically homeless persons with mental illness—90% have a substance abuse disorder

Housing Tenure

Permanent housing

Number of Suites

500 tenants in private housing

Factors for Success

- Pathways is research-driven, cost-conscious, and accountable.
- It is cheaper than traditional programs.
- No other solutions that work have been found.
- The homelessness situation is a political embarrassment.
- Both citizens and the business community are complaining about the homeless situation.

Location

New York City (a new project was opened in 2004 in Washington, D.C.)

Project Start Date

1992

At the time, the predominant housing services model that was available was the Continuum of Care, which required clients to proceed through a series of steps to attain permanent housing. Those who implemented this model demanded that participants be clean and sober, and engage in treatment and services prior to receiving housing. The continuum model was based on a number of assumptions, including that the skills needed for independent living could be learned in a transitional, congregate setting, in spite of research on the principles of psychiatric rehabilitation that indicated that the most effective place to teach skills required for a particular environment was in the actual setting. From the client's perspective, the continuum leading to housing was seen as a series of hurdles or barriers that they were often unable or unwilling to overcome.

In the 1990s several thousand units of specialized continuum model housing were built, but some of the mentally ill substance users could not gain access. These individuals said that they did not want to live with others who also had mental illnesses. They preferred to live in real housing, not programs, and got to, treatment rather than live in treatment. Most wanted to live in their own apartments rather than in congregate settings.

The Pathways to Housing program was set up based on the belief that if people with psychiatric symptoms can survive on the streets better than many people without psychiatric problems, such survival skills boded well for their adjustment to life indoors. Many had been mentally ill longer than they had been homeless. Providing a person with their own apartment would create a foundation on

which the process of recovery could begin—having a home of one's own could be enough to act as a motivator for people to refrain from drug and alcohol abuse. In discussing the success of Pathways, Sam Tsemberis, Executive Director stated, “This program—offering people housing first—solves the basic problem. Housing should be a basic right. People with mental illness and addictions should not have to earn their way into housing.” Pathways to Housing was founded to give vulnerable individuals with these challenges housing, and then offer them the possibility and resources to work on their issues.

“In a perfect homeless services world, I think we'd do away with ‘transitional’ services altogether,” says Tsemberis. “There is no need for them.” Homeless people have all lived indoors at one point, he says; they don't need years of training to do it again.”¹

At the heart of Pathways is the philosophy of consumer choice. Clients are encouraged to define their own needs and goals, and if they wish—immediate provision of housing. No requirement of sobriety or psychiatric treatment is imposed but support is offered by ACT teams. Pathways' mission is to take people who are homeless and have psychiatric disabilities directly from the streets, shelters, psychiatric hospitals, and jails and

- provide immediate and independent housing
- provide treatment, support, health, vocational and other services
- promote integration into the community and work life

Pathways to Housing was founded in 1992 with a \$500,000 grant from the New York

State Office of Mental Health to offer housing and services—the fundamental difference was the sequence in which this would be done. In 2005, the budget has grown to over \$12M, serving over 500 clients with a staff of about 100 persons.

Program Description

There are two conditions for participants in the Pathways program—that persons pay 30 per cent of their income for rent through a payee agreement, and that they accept two visits a month from a Pathways assertive community treatment (ACT) team member.

Pathways helps participants get benefits (for example, Supplemental Security Income (SSI), veterans benefits, food stamps, Section 8 housing vouchers, etc.). The program collects the benefits and puts the money in a bank account. Each month the rent money is withdrawn and the remainder can be used at the client's discretion. Budgeting help is given and supplemental funds are offered to fill in the gaps such as setting up house (for example, buying pots, pans, sheets, dishes). Pathways guarantees the rest of the rent due to the landlords.

The second condition is that Pathways participants meet with an ACT team member at least twice a month. Originally this was a less stringent requirement—the agreement with the client stated that they were “asked to agree” to meet with a worker but in 2004 the agreement was modified to state that the client “must meet” with staff. The meetings are an opportunity to chat, run errands but also for staff to keep eye on health and hygiene, encourage participants to take positive steps, and teach living skills (for example, how to

¹ Quoted in *Mother Jones* January/February 2005

cook nutritious food). This is also an opportunity for consumers to set goals and to review them periodically. Goals can range from staying clean, pay bills on time, keep the apartment to learn to read and write, get a degree, get a job, or stay healthy.

The People

Pathway clients have often been homeless for long periods of time. They may be in shelters, in hospitals or on the street. Some persons who have successfully housed were homeless over 20 years. The initial reaction to the suggestion of being housed is disbelief, delight or scepticism. In extreme cases, it can take months to convince someone to look at an apartment. Most of the time it takes about two weeks from the date of admission to be housed. Referrals come from city outreach teams, shelters and drop-in centres. Data from 1999 show that 65 per cent had last lived on the streets, 18 per cent in shelters, and 7 per cent in treatment facilities. More recently, as homeless people are more frequently incarcerated, two teams (East Harlem and West Harlem) have a clientele that has been through the criminal justice system. Some are coming out of prison while others are being diverted out of jail.

The Housing

All of the housing meets minimum standards for safety and security. Most of the housing (about 90 per cent) consists of very good apartments. A few units are not as desirable—not the best neighbourhoods or not in the best state of repair.

Helping participants find apartments at fair market rent is one of the biggest challenges. Pathways has a network of 115 landlords. For these landlords working with Pathways offers a number of advantages.

- the landlord is guaranteed a responsible tenant
- the agency co-signs or sublets to the resident
- the rent is paid on time
- the agency fixes the apartment if it is damage
- the building superintendent (along with the resident) can call on Pathways 7-days-a-week/24-hours-a-day

Pathways does not rent more than 10-15 per cent of the units in any one building to promote community integration and avoid creating a “mental health housing program” feeling in any one building.

Access to Housing

Eligibility Criteria

The eligibility requirements are minimal: clients must be homeless, mentally ill and accept to participate in the program. Approximately 70 per cent of individuals admitted also have a substance addiction, and about 40 per cent have either chronic or acute health problems. Once they are housed, clients are offered a range of support and services such as psychiatric and substance abuse treatment, vocational services, health care, art workshops and family reconnection.

Degree of “Housing Readiness”

There is absolutely no housing readiness requirement at Pathways to Housing. All people are housing-ready. Housing and treatment are separate. Homelessness is treated by providing people with individual apartments, while mental illness is treated by intensive and individualized programs on a 24-hour, 7-day-a-week basis if the client wishes. Refusal of treatment does not have an impact on housing status.

Program Expectations

There are two requirements of clients. They must pay 30 per cent of income for the rent (the source of income is usually Supplemental Security Income—SSI) by participating in a money management program, and they must meet with a staff member at least twice a month.

Each participant is assigned an ACT team

Program Model: Assertive Community Treatment (ACT)

Pathways to Housing uses ACT teams to deliver treatment to clients. Multi-disciplinary services teams comprised of social workers, psychiatrists and specialists in vocational services, addiction recovery and peer services, ACT teams provide in vivo, voluntary mental health, primary health and support services to consumers in the communities where they live. The ratio of staff to clients is between 1:8 and 1:10. Team members work with each client to create and fulfill his individualized service plan and achieve his recovery goals. The only treatment requirement is that the client engage with a team member at least twice per month; however the vast majority of clients chose to meet much more frequently—usually at least once weekly.

Harm Reduction and Substance Use

Substance Use

There is a high incidence of crack cocaine although most clients rarely use only one substance—most use multiple substances—alcohol, marijuana, heroin, PCPs, cocaine. The range in substance use among the clients is quite broad: there are light users and heavy users, and program directors estimate that about 15 per cent are actively using drugs or alcohol dysfunctionally at any one time.

Policies and Approaches Relating to Substance Use and Abstinence

Use of Substances

Pathways adheres to a harm reduction philosophy. One of the observations is that this approach does not work as well in congregate settings because one person's relapse can challenge the whole community's recovery. Relapses are normal and should be expected, but they impact everyone.

Independent, scattered units are more compatible with promoting recovery from substance addiction because it limits the impact that one person's relapse can have on another's precarious sobriety.

Security Measures

These vary according to the units and locations.

Guests

The participants have full control over their units. However, some participants, for example, people who have just left prison, can find themselves vulnerable to the influence of others who ask to be "put up" in participants' apartments. ACT team members do not forbid this with rules, rather, they teach participants how to say "no," inform them of the unwanted consequences that may result from "taking in" guests who are not truly welcome. Sometimes having guests in one's apartment is a healthy part of recovery and normal life in the community, other times it is a hindrance to wellness. Team members help clients make their own healthy decisions about guests, and vigorously support their efforts to follow through on these decisions. ACT team members will even advise clients to claim to unwanted guests that Pathways has "rules" against guests as an excuse to refuse their imposition.

Conflicts Among Residents

These are treated on a case-by-case basis.

Temporary Absence

Pathways makes a promise to its clients that "you will not be homeless again." Even if people are put into prison or a long-term hospital, when they are about to be discharged, they will be at the "top of the list" for housing and an apartment will be found.

Residents Who are Abstinent

Residents who are abstinent are not a problem. Residents who are not abstinent or who are actively using or who are actively psychotic are not excluded from the program. In fact this is the *raison d'être* of this harm reduction program; provide people with these two co-occurring housing as a matter of right and work with their clinical crises after they are housed. Once housed, clients who are using are offered support to decrease or stop consumption by the ACT team.

There are insufficient detox facilities for drug use for this client group.

Legal Issues

A few Pathways clients do get arrested for drug use. Pathways currently operates a program for individuals with psychiatric disabilities who are either facing jail time or have served sentences. There is a constant communication with lawyers, probation officers and court case managers concerning the status of these clients.

The great majority of legal issues concern landlord tenant court and the on-going effort to avoid evictions or other proceedings related to maintaining the clients residential stability.

Exits from Housing and/or Programs

Voluntary Move-outs

People do move out or graduate from the program. For example, one client who went through job training is currently working as a peer-counsellor at another agency but plans to apply for a job at Pathways. The plan is now to get this person out of the Pathways program—they no longer need the clinical support of ACT and could move onto community services. Their housing has been subsidized but they will be moved onto a regular lease and help will be given to budget for non-subsidized housing.

Evictions

ACT team members will intervene if there is the threat of an eviction by the landlord. The teams do not discharge any individual even if they are evicted by a landlord, the team will work with the client to find new housing. There have only been a handful of clients discharged from the ACT team in the past 10 years. The situations are dealt with on a case-by-case basis.

Services

Model of Service Delivery

Clients of Pathways are offered support from the ACT team, made up of social workers, nurses, psychiatrists, vocational and substance abuse counsellors, and peer specialists who are available 7 days a week, 24 hours a day. Unlike with traditional ACT teams, clients can choose the frequency and type of services they receive. Furthermore, the standard ACT model was modified by Pathways to include a nurse practitioner, to address the considerable health problems of clients, and

a housing specialist to co-ordinate housing services. More recent changes include integration of vocational services and a job developer into the ACT team.

While housing and treatment are closely linked, they are considered separate and clients may accept housing and refuse clinical services, without impact on their housing.

Types of Services

Changes in Services

Changes in funding in the last year (such as, fee-for-service billing) have resulted in a reduced budget for social and recreational activities. This is a loss for Pathways clients who, for the most part, were living in institutional settings before getting their own apartments and are used to dormitory conditions, surrounded by people and in highly structured settings. When Pathways clients move into their own independent apartment, many do not know how to use their days: social activities (such as, movies, outings) are important. It is felt that this reduction in social activities on the part of Pathways is a transitional phase as the focus is shifted to activities available in the community.

Pathways has developed job-training services (two job developers are on staff) and vocational counsellors are part of the ACT teams. This is a response to what was seen as inadequate state job programs.

Connections With Community Programs/agencies

Where possible, clients are encouraged to use community services. Changes to recreational and social activities at Pathways will require greater reliance on outside services than in the past.

Services	Type of Service Availability	Service Provider	Are Services Available on Site (Yes/No)	Source of Funding: Public Private Charitable
Medical care	24/7 part of ACT	ACT Team	Yes	Public
Mental health	24/7 part of ACT	ACT Team	Yes	Public
Substance use	24/7 part of ACT	ACT Team	Yes	Public
Employment assistance (training/finding work)	Through ACT 35 part-time workers at Pathways are clients	ACT Team	Yes	Public
Money management	One of the requirements—related to payment of 30%	of income on rent Pathways—required	Yes	
Assistance with life skills, food, transportation, clothing etc.	According to client's goals	Pathways	Yes	
Social recreational opportunities	The shift in funding in the last year has meant that fewer funds are available for social activities. There is now a shift to activities in the community.	Community services	No	
Medication administration	Yes if client wants/needs it	ACT Team	YES	Public
Needle exchange	Yes, assistance provided	ACT Team	No	Medicaid - public
Assistance finding permanent housing	1st stage of involvement with Pathways	ACT Team	Yes	Public
Meal program	N/A-Clients cook meals in their own apartments. Can get help if needed	ACT Team	Yes	Public

Staffing and Personnel Issues

As of June 30th 2004, Pathways had a staff of 117 persons (a 19 per cent increase over the previous year) organized into seven teams. These include social workers, substance abuse counsellors, peer counsellors, psychiatrists and nurses. There are 35 part-time positions held by clients.

Funding of Pathways ACT teams changed in 2004. Funds had been provided through a contract with the state based on the number of tenants enrolled in Pathways. Changes now allow the ACT teams to become licensed and be reimbursed by Medicaid. The clinicians have now become certified as mental health professionals (60 per cent of the clinical staff is now certified). This has meant that the number of peer specialists on the teams has been reduced to comply with certification guidelines. Each team now has been required to undertake more administrative duties. An impact of this change has been the necessity of prioritization of clients and programs needs, based on fiscal limitations.

The housing department is made up of nine employees (seven full-time and more are to be hired). It is responsible for finding apartments, working with landlords, maintenance, cleaning, moving assistance and representing tenants at housing court. A housing staff person is assigned to each ACT team. The housing shortage and increased rental cost are considerable challenges. Pathways clients also are faced with more stringent criteria from landlords for pre-qualification (such as, not only credit checks but background checks as well). The housing department is currently devising marketing strategies to sell the program to prospective new landlords, and to convince existing landlords not to place the rents beyond reach of clients at lease renewal.

In 2004 the vocational department (with 25 tenants competitively employed and 60 in the tenant worker program) was eliminated and ACT teams took on closer supervision and integration of the vocational services.

Staff Burnout

The staff turnover is quite low—probably much better than other organizations. This is attributed to the spirit, mission and philosophy that keep people working at Pathways.

Policies for Hiring Formerly Homeless Individuals

There are 35 part-time positions held by clients. These positions include office work, reception and maintenance, and are part of the job-training program. Some people have started working with Pathways and have moved onto other work. Each team hires a “peer counselor” a person who has been previously homeless and institutionalized as a full-time employee. Peers are best able to understand consumer-driven services and also serve as role models for the other clients and staff.

Funding

The overall annual budget for 2004 was \$12,362,000 (an increase of 12 per cent over the previous year).

Pathways has begun to bill Medicaid for ACT team services (such as fee-for-service billing rather than contract-based billing). Other sources of income include contracts with HUD to provide housing and support services to 50 persons with serious psychiatric diagnosis who are homeless and being released, diverted or contemplating jail.

Annual Revenue

Source of Revenue	Amount
Medicaid	\$ 2,352,000
Office of Mental Health	\$ 6,834,936
New York City Department of Mental Health	\$ 560,140
Housing and Urban Development	\$ 1,925,325
Total	\$11,672,401

Costs	Amount
Total	\$11,672,401

Outcomes, Challenges and Factors for Success

One of the strengths of Pathways has been the documentation and research that has accompanied the practice. The project was set up in such a way that there would be data to demonstrate outcomes. It was recognized that anecdotes would illustrate successes but it was through data that people would be convinced of the approach.

Research has demonstrated that Pathways has a retention rate of clients that is between 80 per cent to 88 per cent. For example, between 1993 and 1997, 88 per cent of Pathways clients remained in their housing, compared to 47 per cent of those who went through the New York City treatment system (Psychiatric Services, April, 2000). Furthermore, studies have revealed no differences in substance use between Pathways clients and those in traditional continuum services.

In spite of the demonstrated success, Sam Tsemberis is very clear on what the program has accomplished. Pathways in New York has only 500 units. “This is not a program to end homelessness. We have demonstrated

that people with mental illness and substance abuse can live in the community with everyone else. To end homelessness we need affordable housing.” One solution that Tsemberis proposes is that more affordable housing could be developed with a proportion set aside for special needs. Private real estate could get involved as well and having 10-15 per cent of units set aside for special needs would have a considerable impact.

A two-year study of Pathways to Housing consisted of randomly assigning 225 participants to two groups: Pathways and to Continuum of Care programs.

Participants were interviewed every six months. (Tsemberis et al. 2004, American Journal of Public Health, April, 2004.)

Persons assigned to Pathways were found to have been housed earlier, spent more time stably housed and spent fewer days hospitalized over the 24-month period.

While traditional thinking holds that giving people housing too early, “sets them up for failure,” the study found no indication of this.

The results suggest that people with disruptive behaviours and who use substances may do better in private apartments than in congregate settings where their behaviour directly impinges on others.

Furthermore, giving clients the treatment that they want may allow them to select treatment they need.

Impact of the Program on Residents

Pathways has demonstrated considerable success in stabilizing formerly homeless persons with mental illnesses and substance abuse problems.

Resident Satisfaction

A survey was undertaken of resident satisfaction in 2004 (80 per cent of tenants completed the survey). Preliminary analysis indicated overall satisfaction with the program and the level of choice. One area that seems to need improvement is the response rate to repairs on the part of landlords or Pathway teams.

Reasons for Success

Tsemberis believes that there are a number of reasons for the success of Pathways and the “Housing First” approach.

- It is cheaper. For example it is estimated that the cost of ER, prisons, shelters and other services for people with mental illness and living on the street costs the government about \$40,500/person/year. The cost of Pathways is about \$22,000 a year—much of this already allotted through government benefits programs.
- It is research-driven, cost-conscious, and accountable.
- No other solutions that work have been found.

- Treatment programs are not working.
- Homelessness is a political embarrassment.
- Both citizens and the business community are complaining about the situation.

There have been suggestions that Pathways’ success is unique to New York City. However a Washington D.C. office opened in 2004 and it is planned to move 75 mentally ill homeless persons into apartments in 2005 with a projected 375 people over the next five years—if funding can be found. There has also been strong support for the Pathways model of Housing first on the part of Philip Mangano, Executive Director of the federal Interagency Council on Homelessness (ICH). A 2003 initiative awarded \$35M to almost 12 locations, including Philadelphia, San Francisco and Denver, to implement innovative approaches, including housing first.

The major obstacles are the limited number of Section 8 vouchers from HUD (for example, the rent supplement). There have been no new vouchers since 2001 and there have been attempts to cut back on the program. Another challenge is finding ways to pay for behavioural and other services—some states are better positioned than others to bill Medicaid for ACT services.

Lessons Learned

It is critical that all staff are trained to know and understand exactly what the drug laws require from them.

Working with other agencies, for example the police, is important.

The larger organization needs to understand the work and the goals of the project.

The lessons and recommendations are presented separately for the areas of program and clinical issues, and housing.

Program/Clinical Issues

1. The most important and exciting discovery of operating the Pathways Program is that individuals who are homeless, living on the streets, parks and other public places, who have severe psychiatric disabilities and/or substance abuse problems can be successfully housed in independent apartments with the right support services.
2. The relationship between psychopathology, substance abuse and level of functioning is not as strong as assumed by most clinicians and housing providers. Skills for living in an apartment can be learned effectively by people with a host of psychiatric symptomatology including delusions and hallucinations as well as those who use alcohol and drugs.
3. Treatment and housing are more effective and achieve desired outcomes when the client determines the conditions under which to participate.
4. The Assertive Community Treatment (ACT) team model serves as an excellent clinical and case management structure for this supported housing program. The team should operate with the values and principles consistent with the empowerment philosophy of the Pathways program.
5. Staff composition should include approximately 50 per cent consumer representation (peer counsellors, people in recovery, and so on) to serve as role models and embody the empowerment model espoused by the program. All staff must be in strong support of the program philosophy, and have the personal values and flexibility required by this program approach.
6. Vocational rehabilitation is an essential program component if independence and community integration is the long-term goal. Tenants are more motivated to seek paid work rather than treatment. Meaningful, paid employment improves mental health, social skills and self esteem.
7. Harm reduction and other substance models that allow for prevention rather than insist on abstinence are effective treatment strategies.
8. Recreational/educational/social events are an essential program component for fostering support and developing relationships.

9. Fear of psychiatric hospitals and what happens to people when they are hospitalized is much greater than anticipated. The team members, especially the psychiatrist, must emphasize to tenants that the treatment is simply being offered and the tenant has the right to refuse.

10. The engagement process takes longer than one would expect given that immediate access to housing is offered with no strings attached. People who have survived for years on the streets will not readily accept any offer for services until trust is established.

Housing

1. Housing and treatment are separate issues. Treatment criteria should not be used to evaluate housing status. The program should be operated as collaboratively as possible but always keep housing issues, rents, leases, repairs, etc., distinct from the case management and clinical functions. However, it should not be assumed that because some people have successfully survived the hardships of life on the streets, that these same people will not need a great deal of assistance in managing their new household.
2. It is useful to have several transitional apartments (or the local YMCA) that are operated in a manner that is consistent with the Pathways CPIL philosophy, in order to provide immediate access to safe and comfortable housing for eligible tenants while they await a place of their own.

3. The scatter site model has several important advantages: a) landlords are surprisingly welcoming of program tenants because they are assured of regular rent payments; b) there is no required bureaucracy, for example, no community board approval, zoning, and so on; and c) it is most effective at community integration when no more than 15 per cent of the units in any building are rented by program tenants.
4. Having tenants sign a lease to their own apartment is a powerful intervention in and of itself; it provides tenants with the self-respect and dignity that comes with control over your environment.

Publications

Fitzpatrick, Colleen 2004 'Housing First' Becoming the standard model for homeless populations *Alcoholism and Drug Abuse Weekly* Vol. 16 Issue 41 10/25/2004

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INNOVATIVE SUPPORTIVE HOUSING THROUGH A HARM REDUCTION APPROACH FOR SUBSTANCE USERS

Case studies



Vancouver,
British Columbia

Princess Rooms Transitional Housing Demonstration Project: Sponsored by Triage Emergency Services and Care Society

Background

This case study has been prepared based on an interview with staff from Triage Emergency Services & Care Society (Triage), additional written information provided by Triage, and a resident survey.

The Sponsor

Triage is a non-profit organization located in Vancouver's downtown eastside. It was established in 1990 to provide quality housing and support services to marginalized populations. Triage's vision is "a home for every person." Its mission is to shelter and support homeless people with mental health and/or substance use issues in a safe, supportive environment, while working with them to develop and implement a plan for the future. Triage aims to treat each individual with dignity, respect, care and compassion.

In addition to emergency, transitional and long-term housing, Triage provides support services such as: nursing care, a medication day program, financial administration, low-cost meals, Internet access, drop-in services, intensive outreach for homeless individuals with concurrent disorders, and concurrent disorders support groups for people in the community.

Project at a Glance

Sponsor Name

Triage Emergency Services and Care Society

Goals

- Break cycle of homelessness
- Emphasize recovery and opportunities
- Demonstrate effectiveness of an innovative, evidence-based transitional housing model

Target Population

Chronically homeless with high rates of repeat shelter use, complex health needs, challenging behaviours and histories of evictions. Most have a mental health diagnosis, substance use issues and a concurrent disorder.

Housing Tenure

Transitional housing

Number of Units

45

Factors for Success

- High-tolerance policies
- Specialized client-centred service model focusing on strengths, harm reduction, rehabilitation and motivation
- Assertive advocacy
- Committed staff

Location

Vancouver, British Columbia

Project Start Date

November 2002

Program Goals and History

In April 2001, Triage received a grant from Human Resources Development Canada (HRDC), through the Supporting Communities Partnership Initiative (SCPI) to purchase the Princess Rooms hotel. Triage initiated the demonstration project in November 2002.

High rates of repeat shelter use at its emergency shelter was the prime motivation for Triage to pursue this demonstration project. Triage was seeing individuals who were chronically homeless, engaged in high-risk activities and had multiple challenges. They had a history of evictions from SROs, non-profit and market housing, and were considered too hard to house by most supportive housing providers. Triage wanted to break the cycle of homelessness, shelter use, poor health, and high-risk lifestyle, by helping their shelter clients stabilize their lives and access quality permanent housing.

Equally as important, Triage saw a need for a housing program that would offer more than just a high-tolerance living environment. They wanted to offer a comprehensive range of services, using a specialized service model, and place a strong emphasis on recovery and opportunities.

Finally, Triage wanted to demonstrate the effectiveness of an innovative, evidence-based transitional housing model in breaking the cycle of homelessness for individuals who have challenging behaviours and complex health needs.

Specific objectives

1. Provide accommodation to individuals who have difficulty accessing housing due to a history of highly challenging behaviours and complex health needs.
2. Provide safety, security, and immediate crisis intervention for all residents of the Princess Rooms.
3. Build the capacity of Princess Rooms residents to enjoy and participate in normal, non-street-related environments, while emphasizing growth and dignity.
4. Assist Princess Rooms residents to establish improved health and stability.
5. Ensure Princess Rooms residents' transition into good quality, safe, affordable housing that meets their needs.
6. Improve the service delivery model to better meet the needs of Triage's target population.
7. Increase capacity within the service community to meet the needs of homeless/at-risk individuals with challenging behaviours and complex health needs.

Program Description

The People

The Princess Rooms Transitional Housing Demonstration Project is targeted to individuals who have been chronically homeless, have high rates of repeat shelter use, complex health needs (most typically concurrent disorders), challenging behaviours and histories of evictions.

As many as 45 individuals can be housed at any one time, but 95 individuals were housed in the Princess Rooms during the period from November 2002 – September 2004. All the residents are single individuals. About two-thirds of the residents were from 35 to 64 years of age, and the rest were from 18 to 34 years old. The average age was 39 years old. Two thirds of the residents were male, and one third were female. All residents were poor and almost everyone received income assistance (disability assistance rates) as their main source of income. The residents average income was about \$725 per month.

About three quarters of the residents at the Princess Rooms were Caucasian. Close to 15 per cent were Aboriginal, and 6 per cent were Black. The remaining residents had a variety of backgrounds (for example, South and Southeast Asian, Japanese, Arab/West Asian and Latin American).

As noted in the following table, almost all the residents at Princess Rooms from November 2002 – September 2004 had a mental health diagnosis (91 per cent), and most (82 per cent) had substance use issues. Three quarters of all residents had a concurrent disorder (both a mental health diagnosis and substance use). Almost half the residents with a mental health diagnosis had schizophrenia, and almost one third had a diagnosis of depression. Other diagnoses that were more common among residents included anxiety, bipolar disorder, post traumatic stress disorder and brain injury. In terms of physical health issues, diagnoses included Hepatitis C, HIV, a non-specified illness, and a physical disability.

Types of Issues	Number of clients	Per cent of client
Mental health diagnosis	86	91%
Substance use issue	78	82%
Concurrent disorder (mental health and substance use)	71	75%
Physical health diagnosis	45	47%
Total clients	95	

The Housing

The Princess Rooms is an old hotel with 45 rooms. Each room has its own kitchenette. Residents share washrooms and an activity room. Although this housing is designated as “transitional,” residents may stay as long as needed. Some residents do not want to stay for a long time because of the nature of the housing (SRO format) and “liveliness” of the residents. Others, however, do not want to leave—most likely because of the measure of safety and stability they have achieved. Residents do not sign a lease with Triage, and the housing is not governed by the *Residential Tenancies Act*.

Access to Housing

Applicants to the Princess Rooms are referred from shelters, outreach workers, mental health teams and other agencies. In fact, most referrals are from Triage’s emergency shelter. Staff at the Princess Rooms review information about each applicant to determine if they meet the basic eligibility criteria (as outlined below) and arrange for an interview. A team of staff at the Princess Rooms decides if an applicant should be housed. Residents do not have a role in tenant selection because

too much confidential health-related information is part of the decision-making process. Very few walk-in applicants meet the program’s mandate and eligibility criteria

Eligibility Criteria

To be eligible for housing in the Princess Rooms, applicants must

- have a history of chronic homelessness, particularly chronic shelter use
- have a mental illness, either formally diagnosed or not
- be able to live in an environment with active drug use and active street culture

Potential residents will be denied access to housing in the Princess Rooms if they

- do not meet the above criteria
- pose an extreme risk for safety (for example, fire-starting, extreme repeated violence, etc.)
- have a mobility impairment (because there is no wheelchair access or elevator in the building)
- have physical and mental health needs that exceed what can be provided in the program (for example, they require hospitalization)

Degree of “Housing Readiness”

The demonstration project is designed to serve individuals who have challenging behaviours. The goal is to help these individuals become more stable and “housing ready” for permanent housing.¹ According to Triage, most housing providers—particularly those outside Vancouver’s downtown eastside—require applicants/tenants to be “housing ready.” Triage considers the Princess Rooms to be following a “housing first” approach because individuals who are homeless and have

multiple challenges have direct access to stable housing—even if it is not “permanent.”

Triage decided to adopt this approach because their target population is rarely able to access safe, affordable housing. If they do obtain housing, they usually lose it within a short period of time. In addition, Triage believes housing is a right, particularly for those with health issues. Triage also believes that people have the right to make their own treatment choices. They think the burden should be on providers to design programs that meet the needs of tenants, not for tenants to meet the standards and expectations of housing providers.

Program Expectations

Princess Rooms residents are not required to participate in any program or activity as a condition of their housing. They do not need to have a plan regarding their use of substances, nor are they required to take any medication. However, Princess Rooms staff do work with residents to enhance their motivation to participate in substance use or mental health treatment, take medications, link with other community services, or make other changes to their lives that they choose. Residents are not required to meet with a case manager, but staff duties include assertive measures to maintain regular contact. The only expectation for residents is that they accept good quality, appropriate housing placements when they are offered.

Program Demand

Triage generally maintains a very short-term waiting list of between six and ten people who have been accepted into their program. The waiting period can vary between two weeks and several months, based on turnover. Priority is based on need. Triage does not maintain a long-term waiting list. Demand

¹ The concept of housing readiness means meeting the standards and expectations of most housing providers.

remains high. Despite their initiative at the Princess Rooms, the number of repeat users at Triage's emergency shelter has not diminished. Triage believes this indicates that despite being able to accommodate 4 new residents each month, there remains more need for this type of housing than the Princess Rooms alone can provide.

Harm reduction and substance use

Triage uses harm reduction as a set of beliefs, principles and pragmatic strategies to help residents minimize the harm associated with high-risk behaviours.

Most of their target population actively uses and is not interested in abstinence. According to Triage, these individuals are used to having service providers judge them for their use. They believe service providers often set an agenda of abstinence. Sometimes, this agenda is overt, for example, abstinence is a requirement for service. Other times, the expectation is more subtle, via an unwelcoming stance and reluctance to fully engage and offer assistance for users, which changes when the client begins to discuss abstinence. Triage believes this attitude dramatically impedes the creation of effective relationships and distorts attempts to create effective service plans.

Triage has found that harm reduction allows them to build more honest relationships with their clients, and create more effective service plans that clients want and are motivated to implement. They believe harm reduction policies enable them to provide housing and support services to people who are not willing to be abstinent at the time they are seeking services. And most importantly, the use of harm reduction strategies allows Triage to assist clients in leading safer lives and living longer.

Some specific harm reduction strategies used at the Princess Rooms include

- on-site needle exchange as well as sharps containers in the building and some rooms
- availability of condoms and lubricants and so on
- distribution within the building of information on drugs, overdose prevention, and safe using techniques
- staff training so they can provide safe using and safe sex information
- policies that facilitate access/remove barriers to services
- focus on relationships rather than rules, particularly regarding substance use and challenging behaviour
- unconditional acceptance of residents' choices regarding substance use and high-risk behaviour

Substance Use

Among the Princess Rooms residents who used substances between November 2002 and September 2004, just over half used crack, 40 per cent used cocaine, and one third used marijuana. The next most commonly used substances were heroin and alcohol. Intravenous (IV) drug use was reported by about 10 per cent of residents. A few reported use of methamphetamines, solvents and hallucinogens.

Triage has noticed that the type of substances used by people seeking housing has changed somewhat over the past few years. There is less use of heroin, somewhat less IV use, more crack use, and Triage suspects more use of crystal methamphetamine. Triage believes that availability and the cost of drugs are likely contributing factors.

Triage has found that the use of stimulants can be extremely difficult to manage, as these substances increase agitation and violence. In response to this, Triage added another shift in the evening to increase staff, resident and community safety.

Triage has also found that persons with concurrent disorders pose different kinds of challenges. It is more difficult for these individuals to obtain treatment or service. Very few programs are designed to handle their specialized needs. The complexity of the issues associated with concurrent disorders requires more intensive service provision, and a more skilled, knowledgeable workforce. In response to this, Triage, in partnership with the Justice Institute of B.C., has created a specialized certificate program titled "Supporting Marginalized Populations." The program has a heavy emphasis on concurrent disorders and is offered free of charge to all Triage regular staff.

Individuals with borderline personality disorder or brain injury are also especially challenging.

Policies and Approaches Relevant to Housing the Target Group

Triage's approach to substance use is primarily geared to helping residents use substances more safely. Triage also works with residents to help them move to less harmful substances and to reduce their use. Triage will also support residents wishing to enter substance use treatment, and about 10 per cent of residents who left Triage between November 2002 and September 2004 were discharged to detox or treatment.

Use of Substances

Residents are permitted to use alcohol or drugs in their private living space, but not in any common areas inside the building. Selling drugs on the property is not permitted,

although it happens. In these situations, Triage asks dealers to leave and calls police if they don't agree. In situations where residents engage in behaviour that might disturb other residents, Triage handles each incident on a case-by-case basis, and looks to identify and address underlying causes.

Security Measures

Triage has implemented several security measures to promote the safety and security of residents. These include installing door alarms, cameras, lighting, fencing, daily room checks, key fob², staff panic alarms, 24-hours staff, and Non-Violent Crises Intervention training.

Guests

Guests are not permitted in the building except for immediate family. Other individuals are asked to leave, and staff will call the police if they don't agree. Residents who work in the sex trade are not permitted to bring clients into the building, though this policy is under review.

Conflicts Among Residents

Triage usually tries to help residents resolve conflict themselves.

Temporary Absence

If a resident is temporarily absent from his/her unit (for example, enters a residential treatment program or is hospitalized), Triage can keep their unit as long as rent is paid, usually up to three months, though a few times more than six months. In these cases, the Ministry of Human Resources has covered the rent payments. Triage is not funded for vacancies.

Residents Who are Abstinent

Residents who become or wish to become abstinent typically give up their room and are discharged to a treatment facility. Some have moved to other housing, and Triage provides support for this transition. It is difficult to find appropriate housing options for individuals after treatment, particularly if they have a mental health issue. A few residents have continued to live in the Princess Rooms and staff support them with interventions appropriate for early stage recovery. Triage is developing a program specifically for individuals with a mental illness who are in recovery from substance use, and is in the process of applying for a development permit to build housing for this target group.

Role of Staff in Working with Residents

Triage's primary goal, and the foundation of its work, is to establish an open, non-judgmental relationship with each resident. As such, the program is based on relationship, not policy. Triage particularly avoids rules and policies that create barriers to effective relationships. Harm reduction facilitates this process by respecting the client's right to choose to use substances, and to build a relationship based on clients' safety and self-determination.

The amount of contact staff have with each resident varies. It can range from several times a day to once a week. The level of intensity of each contact varies widely. Staff keep records to monitor if they have seen each resident a minimum of once per day. Triage also monitors their clients for signs of decompensation³, medication use, indications of being subjected to violence, etc.

Staff work to engage clients and encourage participation in service planning, external treatment and service use, internal activity programming, needle exchange, the medication program and other activities. Participation is always voluntary. Health and lifeskills work is done informally and is often embedded in activities that include fun and food. Triage believes that "clients should drive the process," but staff have a role in helping to facilitate change. Motivational interviewing is one approach that can help achieve this balance, and Triage is training its staff in this method.⁴ The goal is to help clients address their ambivalence related to behaviour changes, particular changes related to substance use, and to help clients establish their own goals. Triage believes this approach helps avoid two traps: the trap of an "anything goes" passivity that can creep into harm reduction programs; and two, the trap of the service providers setting an implicit abstinence agenda for the client.

Legal Issues

Triage has not experienced any particular legal conflicts arising from providing housing to individuals who use substances. However, because their residents buy drugs, this attracts drug dealers and can increase levels of drug activity around the building. To address this issue, Triage has increased security measures. The police sometimes treat their residents well, often not. This has been improving as the program gets more established and the police understand what Triage is trying to achieve.

2 A key fob is an electronic access system that replaces conventional keys.

3 For signs of a return or worsening of mental health symptoms.

4 According to Meuser et al. 2003, "motivational interviewing is a counseling approach designed to help clients become aware of their substance abuse problems and to develop motivation to overcome these problems through the process of articulating and pursuing their own personal goals." P.31.

Exits from Housing and/or Programs

Voluntary Move-outs

There are several reasons why residents might move out of the Princess Rooms. One reason is the structure of the program itself. The goal is to provide transitional housing and help individuals transition to higher quality and permanent housing. However, residents are not required to move out, even if Triage has secured what they consider to be a good housing option. Triage does not enforce arbitrary time limits. Residents may also stay in the Princess Rooms long after they have stabilized because of the lack of appropriate housing to transition into.

The most common reason why residents left the Princess Rooms between November 2002 and September 2004 was because they found appropriate accommodation elsewhere (40 per cent). Other reasons included entering a substance use recovery program, hospitalization (for physical or mental health reasons), moved out of region, client wanted to move, client was evicted, and deceased.

Close to 30 per cent of the residents moved to a self-contained apartment. One fifth moved to a hotel—with or without cooking facilities. Other residents were admitted to hospital (for a physical or mental health reason); entered a substance use recovery program or detox; or moved in with friends, relatives, or shared accommodation. A few residents went to jail, an emergency shelter, or an unknown location.

Evictions

Triage will do everything possible to avoid evictions and homelessness. The prime strategy is to develop a good quality relationship with each resident. In addition, Triage tries to consider underlying issues or problems that might affect a tenancy. For example, at the intake process, Triage tries to identify potential issues and takes steps to prevent problems from developing. If problems do arise, some strategies include

- providing respite care in the shelters
- mediation between residents
- advocating for administration of a resident's financial affairs
- advocating for mental health treatment or hospitalization
- changing the style of interaction with a resident

To date, reasons for ending a tenancy are

- multiple months of not paying rent
- repeated instances of unprovoked violence that are unresponsive to Triage's interventions, that cannot be eliminated with improved treatment, and that Triage believes may occur again.

During the demonstration project between November 2002 and September 2004, Triage evicted a total of four residents. Two individuals were evicted for violence and two were evicted for non-payment of rent.

In the event an eviction becomes necessary, Triage tries to work with other housing providers to ensure the person stays within the continuum of care.

Services

Model of Service Delivery

Triage uses a model of service delivery that incorporates components of the integrated treatment model for concurrent disorders. This includes structuring service using the Assertive Community Treatment (ACT) model, and incorporating harm reduction, motivational interviewing, the strengths model (which focuses on clients' resources and abilities), psychosocial rehabilitation, stage-wise case management, comprehensiveness, lifeskills and social skills, and so on. Most of these services are provided on site, though staff will take residents off-site for one-to-one meetings (and are provided with funds for this), appointments/meetings with other service providers, or recreational opportunities.

Triage is still working to improve its service delivery model to better meet the needs of its target population based on Triage's own values and experience. The goal is to develop a clearly defined model that is both innovative and specific to this program, and thoroughly informed by current best practices literature.

The development of this model is being supported by a customized certificate program created by Triage and the Justice Institute, which provides 15 two-day courses to Triage staff.

Coordination is done on an individual basis and includes regular liaison with particular workers as well as case conferencing.

Types of Services

Residents of the Princess Rooms receive the services set out below.

Changes in Services

Over the past few years, Triage has been able to increase the level of staffing for the Princess Rooms. This has enabled Triage to provide more case management, more assistance with lifeskills assistance, a medication administration program, nightly social recreational activities and a needle exchange.

Most Effective Services

Triage believes that the provision of housing—with a high level of tolerance—is the most effective service in promoting stability for the population served in the Princess Rooms. Intensive case management (Triage uses a version of the ACT model); medication support; meal support; and high-quality recreational opportunities are also considered most effective.

Connections With Community Programs/agencies

Triage has informal relationships with other service providers, but believes these relationships could be improved. As the program matures, Triage wants to strengthen relationships with other providers and ensure that they are informed of Triage's services.

Triage has both formal and informal arrangements with other programs that are available in the community.

Formal:

- With BC Housing's Health Service Program which provides priority access to BC Housing's subsidized units.

Services	Type of Service Availability	Service Provider	Are Services Available on Site (Yes/No)	Source of Funding: Public Private Charitable
Medical care	Medical Clinic 7 days per week, 8:30 a.m. – 8:30 p.m.	Downtown Community Health Clinic / St Paul's Hospital	No	Public
Mental health	Community mental health teams and private practitioners, M-F	Vancouver Community Mental Health services/ Private Psychiatrists	No	Public
Substance use	Addiction counselor; Dual diagnosis program Detox Treatment	Downtown Community Health Clinic, Dual diagnosis program	No	Public
Employment assistance (training/finding work)				
Money management	Financial administration	Triage's head office, St James, Ministry of Human Resources	No	Public
Assistance with life skills, food, transportation, clothing etc.	Some 24 hours per day, some daytime only.	Princess Rooms staff	Yes	Public/Private
Social recreational opportunities	Almost every evening	Princess Rooms staff	Yes	Public/Private
Medication administration	24 hours per day	Princess Rooms staff	Yes	Public/Private
Needle exchange	24 hours per day	Princess Rooms staff	Yes	Public/Private
Assistance finding permanent housing	24 hours per day	Princess Rooms staff	Yes	Public/Private
Meal program	Twice daily	Triage main building	No	Public
Case management	24 hours per day	Princess Rooms staff	Yes	Public/Private

- preliminary discussions are underway to enter into a formal arrangement with another mental health housing provider to access their units on a priority basis.
- Triage's Supported Housing Program gives individuals from Princess Rooms priority access to their housing units.

Informal

- Work closely with Triage Centre Emergency Shelter: taking referrals from them, using the shelter's day programs to provide additional supports, and using the shelter beds for respite care.
- Work extensively with Strathcona Mental Health Team, Hospitals, Downtown Community Health Clinic (HIV Care, HIV medications, addictions counselors, mental health counselors, primary care), the neighbourhood pharmacy, Living Room Mental Health Drop-in, Ministry of Human Resources and skills, and other Downtown Eastside service providers.

Staffing and Personnel Issues

The table below shows the current staffing at Triage compared to the ideal level of staffing they would like to have.

Current Staffing	Ideal Staffing
<ul style="list-style-type: none">■ 4.2 front desk staff (24 hour coverage)■ 1.4 FTE activity programming■ .8 FTE case management■ 1.0 FTE supervisor <p>Total of 7.4 FTE</p>	<ul style="list-style-type: none">■ 5.6 FTE front desk staff, including peer support workers■ 3.8 case managers■ 1.0 Master's level addictions clinician■ 1.4 FTE recreational therapist■ 1.0 full-time manager <p>Total of 12.8 FTE</p>

Triage believes that adequate 24-hour staff is crucial. This is supported by residents who have reported several benefits, such as less drug dealing in the building, someone to talk to in the middle of the night, fewer people banging on windows and coming in late at night, and fewer people “sneaking” into the building.⁵ Triage also believes that given the target population and the location of the building, having a single staff on duty overnight does not allow for a high enough level of safety, support and crisis intervention; nor does this provide enough support for staff to learn from and mentor each other.

Triage uses the 24-hour and activity staff to assist with case management, and estimates the total case management hours to be approximately 48 hours/week with a case management ratio of approximately 1.2 case managers for 45 clients. With these marginal levels of staffing, Triage believes they are unable to provide adequate service for all residents. The result is that some residents do not stabilize or simply leave the Princess Rooms without really engaging with the program.

Recruiting experienced staff has been difficult, delaying the maturity of the program. There are no training programs that adequately prepare workers for this program. Triage has created its own training program, which has been very time intensive and expensive.

On the other hand, Triage believes their staff are “fabulous,” and have endured the growing pains of trying to attempt something new, often without adequate resources. They are kind, committed and smart.

Staff Burnout

Triage has found that “burnout” is an issue with the staff. For much of the duration of the demonstration project, staff worked alone and the level of crises and responsibility was huge. Two staff went on medical leave for stress, and in the winter of 2003-2004, two new employees quit after orientation, refusing to work in the Princess Rooms environment. The stress largely comes from chronic crises and hostility, but also from secondary trauma from witnessing violence, listening to stories of abuse, discussing terminal illnesses, deaths, etc.

Supports for staff include

- mandated debriefings at shift change
- extensive training programs to increase staff ability to competently handle stressful situations
- debriefings and check in's at staff meetings
- free counselling for all staff
- professional group debriefing after critical incidents
- nine day/fortnight schedule to provide regular three-day weekends
- job sharing provisions with union to shorten work weeks for stressful positions
- regular one-to-one meetings for full-time staff with the program supervisor

5 Summary of Results, Princess Rooms Tenant Survey: February 13-14, 2003

Policies for Hiring Formerly Homeless Individuals

Triage does not have any formal policies regarding hiring individuals who have been homeless or who have had a history of substance use, though they do have staff who have experienced both issues. These individuals are hired for regular health care worker positions, and meet the qualifications stated in the job descriptions.

Funding

Triage received a grant of \$1.2 million from HRDC's SCPI program to purchase the Princess Rooms.

Annual Budget 2004

Sources of Revenue	Amount
Rental income	\$196,000
Vancouver Coastal Health	\$324,440
Private foundation	\$120,000
Total	\$640,440

Costs	Amount
Labour	\$464,320
Operating	\$183,265
Total	\$640,440
Per diem on total	\$39 per client per day
Subsidy required	\$640,440 (total expenses) minus 196,000 (rental income) = 444,440
Per diem on subsidy	\$27 per client per day

Residents pay \$325 per month for a single room (37 rooms), and \$400 for a one-bedroom unit (8 units).

Triage notes that the Princess Rooms is funded at rates far below a group home for mental health consumers, despite housing a group with more difficult behaviours and more complex care needs. In group homes,

typical per diem rates are around \$130 per day per client; current funding to subsidize the Princess Rooms is about \$27 per day per client.

Outcomes, Challenges and Factors for Success

Triage believes the Princess Rooms Transitional Housing Demonstration Project has achieved the goals originally intended. They have provided housing for a particularly challenging population, built good relationships with

the residents, linked the residents to services, and helped them to stabilize and transition to high-quality housing. During the first 18 months of the demonstration project, many residents achieved stability.

Impact of the Program on Residents

Triage reports that the Princess Rooms Transitional Housing Demonstration Project has had the following outcomes and impacts on the residents.

Measures of success	Outcomes (for residents November 2002—September 2004)
Residential stability (e.g. length of time housed)	The average length of stay was 11.3 months.
Discharge to good quality, appropriate housing	About 40% found appropriate supported and unsupported accommodation and close to 30% obtained a self-contained apartment.
Reduced substance use and increased safety re use	About 10% of residents left the Princess Rooms to enter a substance use recovery program.
Increased participation in employment, volunteer or other community activities	Six residents volunteered at programs in the community. Residents participated in a range of activities, such as women-only meetings and outings, men's group, community kitchen, baking group, movies and games. They also went to special programs and events e.g. skating, professional soccer games, baseball games, the Folk Festival, movies, parks, etc.
Income	More residents obtained disability benefits through income assistance. Incomes increased for 19% of residents after intake to the program.
Improved self-care and reduced high-risk behaviour	Many residents improved their personal hygiene, improved their social and home management skills, and engaged in less high-risk behaviours.
Personal networks (e.g. more contact with family, new friends)	Some residents reconnected with family. A sense of community is developing within the building.
Improved use of mental health services and primary health care	Comparing the use of services at intake with current/discharge usages, links with mental health services increased 7%, links with physical health services increased 25%, and links with community services increased 35%.

Resident Satisfaction

A survey of 15 Princess Rooms residents in February 2003, found that the residents had many positive comments about living at the Princess Rooms.⁶ Eleven survey participants reported that they felt safe living there, two reported that they felt somewhat safe, and two reported that they did not feel safe. Residents commented on several benefits to having 24-hour staff, and most participants in the survey reported that their lives have changed for the better since moving into the Princess Rooms. Some of the benefits that were noted included

- counseling and communication with staff—"they help organize my life"
- life has leveled out
- "Now I bathe/eat/sleep regularly. Now I have the will to live"
- better living conditions
- met lots of new people
- more positive attitude for example, motivation to get on with life, carry on relationships, get educated
- health has improved

On the other hand, some residents who participated in the survey complained about the lack of private bathrooms and inadequate cooking facilities. They also reported dealing with major depression.

When asked if living in the Princess Rooms has helped them to achieve any personal goals, most participants in the survey said "yes." Some of the comments from the resident survey included

- on the right path now to be able to make changes
- made inroads to finding employment
- helped get medications on track
- keeping appointments, organizing for upcoming court date
- does own cooking and cleaning

Some residents who participated in the survey expressed the view that staff were too busy to help them meet their goals.

Eight of the survey participants expressed positive comments about the way in which staff deal with issues around their drug use. In general, the comments demonstrated that the residents appreciated the non-judgmental way in which they are treated. Three residents felt "OK" about the way in which staff deal with issues around drug use.

Almost all the respondents (14/15) reported that they felt supported by Princess Rooms staff. For example, residents appreciated the help they received with medications, appointments, preparing for court, meals, conversation and buying clothes. They also appreciated that staff were caring and willing to listen, treated them like an equal, supported them in their decisions, helped with practical day-to-day living issues, and helped them deal with emotions.

Reasons for Success

Triage believes the top two-three reasons for the success of their program include the following.

1. The high-tolerance policies.
2. The specialized client-centred model, which focuses on strengths, harm reduction, rehabilitation and motivation. Triage believes this approach makes it possible to accommodate people with difficult behaviours. The focus on developing a relationship helps to provide hope, optimism and real opportunities for recovery and moving beyond homelessness.
3. Assertive advocacy, which works to create broad-based supports for each client for example, ensuring community-based treatment plans are effective.
4. The commitment of flexible, kind and intelligent staff.

Triage believes they have been remarkably successful given the resources and various challenges they have faced. They believe they could do much more in a better building and with a better staff-to-client ratio. They expressed concern that many residents are not well served, and remain unstable due to insufficient staffing and unmet case management needs.

Challenges

Triage has identified the following challenges to implementing this initiative, as well as their strategies for addressing these challenges.

⁶ Summary of Results, Princess Rooms Tenant Survey: February 13-14, 2003.

Funding

It has been a challenge for Triage to secure adequate and stable funding. High staffing levels are required to be able to provide the necessary services. The bulk of funding is annualized, but a significant portion was received through a private donor, and this funding ended in September 2004. Vancouver Coastal Health has provided one-time funding to replace this, and discussions about future funding are on-going.

Triage has been persistent in their efforts to pursue funding and have conducted program evaluations to establish the program's credibility.⁷ Nevertheless, a funding crisis is looming and Triage has not yet found alternative sources of revenue.

Triage believes the lack of investment in resources for this population is why people remain chronically homeless, unstable and at-risk.

Staffing

It has been difficult to recruit experienced staff for this project. One of the ways Triage addressed this issue was to increase the level of staffing so that staff rarely have to work alone. This has made it easier to recruit and retain staff. Triage also provides extensive staff training.

Living Environment

With 45 residents, high levels of drug use, street activities, and untreated psychosis, the living environment can be quite stressful for some residents and counter the goals of the program. To help address this issue, Triage instituted a "no guest policy," improved the security of the building, and at times selects less disruptive residents to

allow the living environment to settle down.

Triage is also exploring renovations to improve the suites and reduce the number of suites to achieve a more manageable and effective staff-to-client ratio.

Triage believes that the living environment could be improved further with greater support from the mental health system to reduce the level of psychosis in the building; and more support from police. The street level drug trade is extremely intense in this area, disrupting the program's ability to provide a safe, secure environment.

Lack of Housing to Transition to

Another significant challenge to this program has been the lack of units for residents to transition to. Princess Rooms residents receive priority access to permanent housing units within Triage's portfolio. Triage has also created a partnership with BC Housing's Health Services Program and initiated discussions with another mental health supportive housing provider, to give Princess Room residents priority access to subsidized and supported units. Nonetheless, after 18 months of operating the demonstration project, a number of residents have stabilized and are ready to move on to supportive housing, but Triage is unable to access sufficient supported units for them.

Lessons Learned

1. If serving the same population with multiple challenges and complex health needs, don't underestimate the amount of staff needed to be effective. Try to get intensive levels of staff from the beginning.
2. Ideally, projects for specialized populations should be small-no more than 25 units. A building of this size requires at least two front-line workers on duty 24/7. On the other hand, larger projects are more cost effective. However, they would require additional support staff beyond the two on duty 24/7, resulting in lower per diems but larger overall budgets.⁸ Given a choice between a smaller building and not enough funding for staff, or a larger building (for example, 50 clients) with sufficient staff, Triage believes it may be best to opt for a larger building.
3. Try to phase in the initial rent-up of a building so staff can work with a few clients at a time and help them stabilize. Once the initial residents are stabilized, you can bring in more residents.
4. Research service models and get your model in place before hiring staff and operating the project. Use components of the ACT model, harm reduction, psychosocial rehabilitation, strengths model, stage-wise case management and motivational strategies.

⁷ Princess Rooms Transitional Housing Demonstration Project, Evaluation Report – Phase I, March 2003.

5. Hire staff who will be able to focus on and build relationships with very challenging people without getting caught up in trying to control their behaviour.
6. Support staff as much as possible.
7. If possible, build for your program.
The physical design of the building should support the objectives of the program. With the target population served by Triage, it is important that the physical environment helps to maintain safety and security, and community.
8. Create partnerships with community resources during the design phase to ensure the program is properly supported. Residents should be able to access treatment. If you are providing transitional housing, establish connections with permanent housing providers. You have to be able to offer people-viable housing options to transition to.

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INNOVATIVE SUPPORTIVE HOUSING THROUGH A HARM REDUCTION APPROACH FOR SUBSTANCE USERS

Case studies



Minneapolis,
Minnesota, U.S.A.

Anishinabe Wakiagun: Operated by the American Indian Community Development Corporation

Background

This case study was prepared based on interviews with staff at Anishinabe Wakiagun (Wakiagun) and written information that they supplied.

The Sponsor

Anishinabe Wakiagun is a 40-unit, purpose-built facility owned and operated by the American Indian Community Development Corporation (AICDC). This non-profit organization provides housing and undertakes community development activities in the Phillips neighbourhood of Minneapolis, Minnesota. It is an outgrowth of the American Indian Task Force on Housing and Homelessness, which was formed in Minneapolis in the early 1990s to identify housing needs for the city's homeless American Indians.

Program Goals and History

Anishinabe Wakiagun means *The People's Home* in the Ojibwe language. The top priority of the facility is to keep people housed and off the street. Its goal is to provide a permanent, stable, culturally appropriate, supportive housing environment for late stage chronically alcoholic homeless men and women. Sobriety is encouraged, but is not a program requirement. Case management at Wakiagun is designed to minimize the negative consequences of the residents' drinking patterns. As well, Wakiagun aims to lower the public cost of serving this population by reducing use of emergency rooms and detox facilities.

Project at a Glance

Sponsor Name

American Indian Community Development Corporation

Goals

- Provide stable culturally appropriate supportive housing
- Minimize the negative consequences of the drinking pattern
- Reduce the public cost by reducing detox and emergency room visits

Target Population

- Predominately chronically homeless American Indian single adults affected by late stage chronic alcoholism. Most residents come from the streets or detox facilities
- Also people who are not American Indians

Housing Tenure

Permanent housing

Number of Units

40

Factors for Success

- Excellent staff
- Building relationships with residents
- Stable funding
- The facility is not too large

Location

Minneapolis, Minnesota U.S.A.

Project Start Date

1996

Two agencies partnered in the development of Wakiagun

- AICDC¹
- Project for Pride Living

Project Pride in Living was founded in 1972 by a group of volunteers to renovate rundown houses in two Minneapolis neighbourhoods. It now offers affordable housing and support services to people in poverty, and owns and manages more than 800 affordable housing units.

In the early 1990s, Wilder Research of St. Paul, Minnesota conducted one of its periodic state homeless surveys, in which it identified 81 American Indians as living on the street in Minneapolis. The American Indian Task Force on Homelessness considered this to be an undercount. Estimates were that 10 per cent of the Indian population of Hennepin and Ramsey Counties (covering Minneapolis and St. Paul) were homeless, on the streets and invisible. This could have represented a figure as high as 2,000 people. According to staff at Wakiagun, few American Indians access shelters because they do not feel comfortable in racially mixed facilities. They feel unsafe and report experiences of racism, assaults and theft. Instead of shelters, they are either in detox facilities, sleeping outside or doubling up with friends.

The Task Force discovered that survey volunteers had not canvassed either of the two Minneapolis detox facilities and, for safety reasons, were instructed not to talk to intoxicated people on the street. The Task Force then attempted to address concerns arising from the count, including abuse at detox facilities, the liveability of camps where homeless people slept, the high detox recidivism rates (50 per cent of

individual who had been in detox more than 20 times were American Indians), drinking on the streets, and the use of detox as a shelter. The Task Force's position was that homeless individuals who were Native American were not being well served. One response to this lack of appropriate service was to develop Wakiagun. Talks about the housing model began in 1991. The American Indian Housing Corporation was incorporated in 1992 and Wakiagun began operation in 1996.

Before construction, Wakiagun consulted with people on the streets and held focus groups concerning the design of the building. It wanted people who were homeless to feel that they were active participants in the facility's development.

Program Description

The People

Wakiagun is targeted predominately to chronically homeless American Indian single adults affected by late stage chronic alcoholism. The facility also houses non-

American Indians—on average 1 or 2 at any one time out of 40 residents. Most residents come to Wakiagun directly from the streets or from detox centres.

Residents at Wakiagun do not have a high self-identified need to be housed. By their own assessment, they were doing relatively well on the street, and take pride in their record of survival. They typically enter Wakiagun only when survival on the street becomes too difficult. Over 50 per cent have never been employed in a permanent position, and a similar percentage have never had a permanent home. During 2003-2004, Wakiagun housed 60-70 people. Some of those who leave will return. There are currently 34 men and 6 women in the facility. Some of these may be couples, although they live in separate rooms. The current mix reflects the population of Wakiagun over the last 3 to 5 years. Recently the average age was calculated at 47 years. This is an increase from an average age of 43 a few years ago, though residents have been as young as 30 year of age.

Types of Issues	Number or proportion of residents
Substance use – Alcohol	100%
Mental illness. Formal diagnosis and/or connected to mental health team/services	2 or 3 at any one time
Mental illness. No formal diagnosis or connection to a mental health team/services	At least a third, maybe higher; no real way to determine
HIV/AIDS	3 or 4 people, also no way of determining
Domestic violence	100% of women
Involvement in the criminal justice system	100% (all have been picked up at least for public drinking)
Behavioural issues	Yes

¹ When Anishinabe Wakiagun was established, the founding organization was called the American Indian Housing Corporation (AIHC). Later the organization changed its name to the American Indian Housing and Community Development Corporation (AIHCDC). It is currently called the American Indian Community Development Corporation (AICDC).

The Housing

The 40 units at Wakiagun are each 142-square-foot, single-occupancy rooms. Residents share common bathrooms. The facility serves three meals a day and snacks. It also offers rooms for socializing, arts and crafts and laundry, as well as offices and a small apartment for the use of relatives and others visiting Wakiagun. Entry to the facility is supervised 24 hours a day, 7 days a week and video cameras monitor the halls, the entryway and common spaces.

Windows in the residents' rooms are shaped like a shallow bay to try to avoid comparisons with windows at residential schools and jails, and to provide as much light as possible, since people who have been living on the street are used to light. As well, the facility's kitchen and dining room are deliberately larger than required, to accommodate both daily socializing and the number of American Indian festivals that involve sharing food such as "Manomin Day," which celebrates the traditional harvest of wild rice. As a result of staff experiences with food services in shelters and detox facilities, where crowded dining rooms led to altercations and fights, the dining room at Wakiagun was designed to accommodate all residents without crowding.

There is no limit to the length of stay at Wakiagun. For some residents, Wakiagun will become their permanent home.

Access to Housing

Potential residents at Wakiagun have an initial interview with the case manager and complete an application form in which they self-report criminal history, substance use, number of times they have been in detox, etc. The interview allows the case manager to interact with the individuals and assess if they meet the facility's eligibility requirements. As well, the applicant signs a release-of-information form to allow Wakiagun to check on the applicants' detox and treatment record and most recent assessment regarding their substance use.

When Wakiagun opened, referrals came by word of mouth and through contacts staff had with individuals on the streets. For example, Kelby Grovender, AICDC's Director of Chemical Services, has had many years of experience working with the homeless population in Minneapolis. Currently the majority of residents come through detox facilities. Some residents come through street case management programs such as the Kola Street Case Management Project located in the basement of Wakiagun.

Eligibility Criteria

Wakiagun is housing of last resort. It is designed for people who cannot live elsewhere, and who inevitably would lose their housing due to their addiction. Wakiagun's target population either lives at Wakiagun or will live on the street.

Residents are expected to meet at least three of the following requirements to be housed at Wakiagun

- twenty or more admissions to detox in the last three years
- two or more attempts at chemical dependency treatment
- evidence of police intervention due to alcohol use
- use of emergency room services due to alcohol use
- physical deterioration due to alcohol use
- have been homeless for the most of the last five years
- show evidence that they are incapable of self management due to alcohol use and a danger to themselves
- failure to obtain necessary food, clothing or medical care due to alcohol use

Having a concurrent disorder neither qualifies nor disqualifies an applicant. Tenants sign a month-to-month lease with Wakiagun, which includes signing over that portion of their General Assistance²/Supplemental Security Income (SSI)³/Social Security Disability Insurance (SSDI) benefits that is not set aside for personal use.

Degree of "Housing Readiness"

Wakiagun considers a person who is "housing ready" as too high-functioning for its facility. As well, someone whose alcohol addiction is deemed not to be at the chronic or recidivist stage would also be ineligible.

Two conditions that would preclude an otherwise potential resident from access to Wakiagun are primary addiction related to drug use, and/or extended history of criminal violence or drug dealing.

² General Assistance programs are funded by the state, county or local governments designed for low-income persons who are either ineligible for or awaiting federally funded cash assistance.

³ Supplemental Security Income (SSI) is a U.S. Federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind and people with disabilities; who have little or no income and it provides cash to meet basic needs for food, clothing and shelter.

Program Expectations

Residents of Wakiagun are encouraged but not required to participate in programs and/or to reduce their use of alcohol. Wakiagun considers itself a relational project (building relationships between residents and staff that assist the resident) and not one that relies on programs. Despite being offered in the building, case management at Wakiagun is described as being similar to street outreach. Residents meet with the case manager on an as-needed basis. Staff are always available to listen to a resident. Staff will remind residents about their medications and the facility offers medication storage and daily distribution. If residents refuse their medications they do not automatically lose their housing. However, the behavioural results of not taking the medication may lead to losing the housing and therefore staff will attempt to help the resident understand the consequences of their refusal and will encourage them to take appropriate action.

There are a number of house rules. For example, residents can remain at Wakiagun so long as they refrain from violence or damage to the building, and as long as they treat people with respect most of the time. As well, there are rules regarding drinking (see below).

Program Demand

Wakiagun has an eligibility list comprised of people who have had an interview when there was no vacancy. There is no “average” wait. Wakiagun usually has about two vacancies a month. Some people are accepted into the program within a week of their interview while others are on the eligibility list for months because they do not stay in contact with staff and cannot be found when a vacancy occurs.

Harm Reduction and Substance Use

When planning began for Wakiagun, there were only two similar programs in the United States, both in the Minneapolis area. Wakiagun did not initially call itself a “harm reduction” facility. People who came to view the program ascribed this term to its approach.

Some have accused the approach as enabling people in their addictions. In response, Wakiagun points out that if its residents were basic functioning alcoholics then, yes, the program would be enabling them. But with Wakiagun’s population, enabling is a non-issue. These are individuals who are past being shielded from the consequences of their substance use, such as loss of job, loss of relationships and deteriorating health. Wakiagun considers itself to be shielding its residents from death.

The founding organization’s experience with the target population of Wakiagun led to the conclusion that only an approach now commonly known as “harm reduction” would result in (1) bringing people off the street into a safe and monitored environment, and (2) keeping them there.

Policies and Approaches Relevant to Housing the Target Group

Use of Substances

Wakiagun residents may drink in their own rooms, but they may not drink in any of the building’s public spaces or outside on the grounds, and they are not permitted to drink with friends who come to visit. The use of drugs in the building can result in immediate discharge and Wakiagun does not permit possession, use or distribution of illegal drugs. They will talk to the resident or they will call the police. A user can be banned from the building.

Security Measures

There is someone at the front desk 24 hours a day, 7 days a week. The hallways, entryway and common areas are video monitored. There has been only one incident in eight years where a resident pulled a weapon on a staff member.

Guests

A maximum of two guests per resident are allowed, unless the resident makes prior arrangements, and residents must accompany guests at all times. Visitors and guests may not drink with the residents. Guests are allowed in the building from 8 a.m. to 10:30 p.m. and they must sign in and out at the front desk. Wakiagun has the right to refuse entry to guests who are seen as inappropriate or potentially dangerous to the facility’s residents

Conflicts Among Residents

Conflicts between residents are handled on a case-by-case basis. The primary guideline for residents is: Do not hit anyone. Dangerous behaviour that threatens the safety of other residents or staff is prohibited.

Temporary Absence

The county maintains rules that will lead to discontinued funding for an individual who has been away from their unit for more than 18 days. However there is some flexibility in applying the rule.

Residents Who are Abstinent

A resident who becomes abstinent is not required to leave. Any action taken is on a case-by-case basis. Sometimes Wakiagun encourages the person to move on, but staff wait until the person has been sober for a year or more before suggesting this possibility. The expectation is that sobriety will cause the person to move himself to a different lifestyle, such as seeking new activities of his own volition instead of watching TV much of the day. “You don’t need to push people to do things; they will move out when they are sober because it may not be fun to live with 39 drunks.”

Role of Staff in Working with Residents

All staff at Wakiagun, including cooks and front desk staff, are trained to listen to residents describe their needs and to try to help them understand how their behaviours are preventing them from attaining what they need. The most effective staff are those who are good listeners and can make non-judgmental comments. The least effective staff member would be one who makes assumptions about what residents should or should not do, or who takes residents’ decisions and behaviours personally. As well, all staff monitor residents on a daily basis to ensure that needs such as required medical interventions are attended to.

Legal Issues

There have been no legal issues with Wakiagun’s harm reduction approach. Relations with the Minneapolis Police Department have been excellent. The Police Department operates the City’s detox van, which is staffed by off-duty police who understand both the target population and the Wakiagun program, and who regard the facility as a resource. When they pick up a Wakiagun resident on the street, they have a home to bring that person to where the person will be cared for. As well, returning residents to Wakiagun requires much less paperwork than delivering them to detox centres.

Exits from Housing and/or Programs

Voluntary Move-outs

Some residents leave voluntarily, but most leave due to medical problems requiring admission to a hospital, nursing home, or residential treatment program. Some move to these facilities for a few months’ break and then return to Wakiagun. One hundred and eighty-seven people have left since the facility opened, but many have returned. Those who do leave voluntarily have either found alternative housing that they prefer or have decided that they would rather be on the street. For many residents, their time at Wakiagun is usually the longest they have stayed in one place since going out on the street.

Evictions

A resident may be evicted for

- violent behaviour (this usually escalates over time)
- damaging the building
- constantly stirring up other residents.

Victimization of others triggers the most severe consequences, and leads to the greatest possibility of eviction. However eviction is a last resort, and is handled on a case-by-case basis. Staff counsel residents about the consequences of their inappropriate behaviours and try to suggest alternatives to alleviate the situation. Eviction, however, does not preclude the person returning to Wakiagun at a later date, although that person must present a good case for why they should be allowed to return.

Staff may suggest that a person exhibiting behaviour leading to eviction might need a stay in detox as a way to manage the anger or inappropriate behaviour.

Services

Model of Service Delivery

The goals of service at Wakiagun are to provide an environment where chronic public inebriates can maintain stable housing, meet basic needs and improve quality of life, reduce dependency on detoxification centres and hospital emergency rooms, and reduce behaviours that are detrimental to the neighbourhood.

Chronic alcoholics suffer from many diseases and conditions related to their prolonged drinking including liver disease, pancreatitis and oesophageal varices. As well, many have suffered physical injuries either

accidentally while intoxicated or inflicted by another person. Medical assistance is available both from a doctor who comes two afternoons a week to an office set up at Wakiagun and a doctor who attends patients at the Kola drop-in centre in Wakiagun's basement. The Kola doctor sees both Wakiagun residents and homeless individuals who access the centre. AICDC is currently designing an Outpatient Treatment Program, based on the philosophy that one type of treatment is not appropriate for everyone. The new program will include components that are designed for both an American Indian population who are chronic inebriates and those who are not. The program's component for chronic inebriates will be less "reading and writing" oriented and more experiential. It will be based on a harm reduction philosophy, paying attention to the "Felt Needs" of the individual and giving them greater decision-making power in the design of their own recovery plan.

The Kola drop-in centre also offers food, clothing, showers, personal effects storage and laundry services for the homeless. It stays open from 7 a.m. to 11 a.m. and its major focus is to attract homeless individuals to have their medical needs attended to.⁴ Wakiagun residents go downstairs to Kola to socialize with those coming into the centre and may use some of the services themselves.

Aspects of Wakiagun's program and services are specifically designed to reflect the values of Aboriginal people. These include respecting an individual's right to choose, considering each person's values and establishing a separate apartment for visiting relatives. It also attempts to facilitate healthy spirituality. Some residents participate in the 12-Step program (Christian) or are taken to sweat

lodges. At the same time, Wakiagun has established itself as a comfortable barrier between the residents and some of the cultural underpinnings of Native Americans that can be difficult to manage. One example is the concept of sharing everything, including one's space.

Types of Services

Case Management

Case management at Wakiagun focuses largely on health and medical issues. The case manager is in contact with local and out-of-state agencies and chemical dependency programs to assist clients in finding the most appropriate option. The case manager is, himself, a recovered alcoholic who was once homeless, and therefore understands and relates well to the residents. He is available for assistance on site and has a regular Monday through Friday workday. Other staff assist the residents when the case manager is unavailable.

According to Wakiagun's case manager, the way to relate to residents is to build trust. He and other staff socialize with the residents, eat with them, and have a smoke together. Residents are often forthcoming and ask the case manager or staff to check on another resident if they believe that person is sick or has injured himself.

Changes in Services

The amount and type of activity programming depends on who is in residence at the time and their interests. Core services have steadily grown. Wakiagun has added and strengthened the medical clinic, as well as adding the Kola program and the psychologist. Funding for services

at Wakiagun has been stable. Programs available at the nearby Indian Centre, however, have been curtailed by a loss of funding. There were some potential threats a few years ago from legislators opposed to Wakiagun's approach, but this was dispelled by pointing out that programs such as Wakiagun save the state money. Residents at Wakiagun have shown a 90 per cent decline in detox admissions, translating into a savings of \$250,000 per year.

Most Effective Services

Three of the most effective services at Wakiagun are:

1. A bed to sleep in, in a room where the resident can lock the door;
2. Three meals a day; and
3. Case management support and services, i.e. crisis intervention and attending to problems between residents.

Other important services are the medical services and a front desk that is continuously staffed. Wakiagun could not function with less than full coverage because residents do not trust their own or others' behaviours, and without supervision, there is concern that residents' behaviour would spiral out of control. Two staff are on duty in the building at all times. For example, the janitor will sit at the front desk if the program aide who works there is involved in a crisis intervention.

Connections With Community Programs/agencies

Formal:

There is a formal arrangement between Wakiagun and the Community Health

⁴ At one time, the county funded Kola for outreach work on the streets. Kola was expected to concentrate on high detox and emergency room users and reduce their use of these services. However, serving such a narrow population is not the Indian way, according to Wakiagun. The wider population served by Wakiagun diluted the statistical results the county was looking for and the county eliminated its funding.

Services	Type of Service Availability	Service Provider	Are Services Available on Site (Yes/No)	Source of Funding: Public Private Charitable
Medical care	Doctors come to the main part of the building and to Kola drop-in centre in Wakiagun's basement. Resident can also attend outside clinics as necessary	University Health Care Center; Kola Medical Outreach Program	Yes	Public
Mental health	Psychiatrist or MH worker	University Health Care Center or community mental health services	Yes	Currently: through the public Detox program and a private foundation. Wakiagun is seeking more permanent funding.
	If a resident has no documented history of a mental health diagnosis, but exhibits behaviour that may be clinical, Wakiagun will try to get a doctor from its clinic to assist the resident.	University Health Care Center	Yes	Public
	A psychologist offers mental health services one day/wk to residents and others who come through Kola and detox facilities. She also provides services to staff in stress management, critical incident circumstances, and coping with death, ⁵ and is developing a culturally appropriate outpatient treatment program, focused on the Native American community.	Kola Program	Yes	AICDC
Substance use	Referrals to programs such as the Hennepin County Chemical Health, and the Minnesota Indian Women's Resource Center		No	Public
Employment assistance	Referrals to the American Indian Opportunities and Industrialization Program		No	
Money management	Facilities for safekeeping of money Wakiagun will work with a resident who receives extra funds (as, for example, from an inheritance).	Wakiagun	Yes	Representative Payee (Public) if residents receiving SSI. Wakiagun is representative for the four people getting SSI.
Assistance with life skills, food, transportation, clothing etc.	Case management, limited transportation	Wakiagun	Yes	Wakiagun
Social/recreational opportunities	Recreational activities	Provided in conjunction with Kola Street Case Management Project	Some yes, some no	AICDC
Medication administration	Staff remind residents about their medications, and the facility offers medication storage	Wakiagun	Yes	Wakiagun
Meal program	3 meals/day served to residents	Wakiagun	Yes	Wakiagun
Case management	Offered by resident case manager, as well as rest of staff. Someone available 24 hours a day, 7 days a week.	Wakiagun	Yes	Wakiagun
Other	Spiritual Activities Plant care ⁶ Depends on interest of resident. Residents must be sober when participating in events.	Provided in conjunction with Kola Street Case Management Project	Some yes, some no	AICDC

⁵ There have been approximately five deaths a year at Wakiagun.

⁶ Project for Pride Living brings bedding plant donations to the building for a gardening day each spring, and plants them with the help of residents.

Centre for the services of a doctor, and a contract with the Hennepin County Chemical Health Division, one of Wakiagun's funders.

Informal:

There are also a number of informal arrangements. Wakiagun is approved by the state as a group residential provider to qualify residents to receive financial benefits. Wakiagun also works closely with medical, chemical health and mental health providers through a monthly "Special Needs" meeting as well as having close contact with the area detox centres and the Hennepin County Street Case Management Project.

Staffing and Personnel Issues

When Wakiagun opened it had two case managers. Once operational, it discovered that case management services required by residents were quite limited and that with the support of other staff, the facility could function well with a single case manager. There are now 13 staff at Wakiagun: the case manager, 3 kitchen staff, 2 janitors, the director of chemical services (who works half-time at Wakiagun and half-time on other duties related to his position with AICDC), and 6 program aides.

Staff at Wakiagun must be

- non-judgmental
- cannot think they are going to fix the residents
- tolerant of unpleasant behaviour related to drunkenness
- aware they are there to serve residents

There has been good staff retention at the facility. Five of the 13 staff have been at Wakiagun since it began. All program staff have been employed for more than two years. The most likely turnover is with janitorial and kitchen staff.

Staff Burnout

Recognizing the potential for staff burnout, AICDC has hired a psychologist who will also attend to needs of the staff.

Policies for Hiring Formerly Homeless Individuals

Wakiagun has hired people who used to live in the facility. Before being hired, a former resident must have lived in their own housing for one year and maintained sobriety.

Funding

Capital Costs

Capital costs of development were approximately \$4.1 million. Grants and forgivable loans covered the entire capital costs of the project. There is no mortgage. Funding sources included:

Wakiagun also received pre-development funding from the Corporation for Supportive Housing. This included a recoverable grant of \$25,000 and a loan of \$103,732.

Sources	Amount
Forgivable loans	
Minnesota Housing Finance Agency ⁷	\$875,000
Neighborhood Revitalization Program	\$195,000
Family Housing Fund ⁸	\$300,000
Minneapolis Community Development Agency HOME Loans	\$265,000
Total Forgivable loans	\$1,635,000
Capital Grants	
General Partner Capital	\$700,000
National Equity Fund (NEF95 Net Equity) ⁹	\$1,754,959
Total of Capital Grants	\$2,454,959
Total cost of development	\$4,089,979

Operating Budget 2004

Source of Revenue	Amount
State of Minnesota Group Residential Housing Funds ¹⁰	\$600,000
Hennepin County Grant	\$40,000
HUD Supportive Housing Grant	\$80,000
Total	\$720,000
Costs	Amount
Labour	\$372,000
Operating	\$348,000
Total	\$720,000
Per diem cost	\$49.32

7 The Minnesota Housing Finance Agency provides funding for a variety of housing needs, such as building affordable transitional and supportive housing; www.mhfa.state.mn.us/

8 The Family Housing Fund is a non-profit that preserves and produces affordable housing, including supportive housing, for those with low and moderate incomes. www.fhfund.org/

9 The National Equity Fund takes advantage of a U.S. federal program called Low-Income Housing Tax Credits. Investors put funds into the project and get tax credits. Wakiagun must comply with strict guidelines for 15 years in order to remain in compliance. www.nefinc.org/

10 The Group Residential Housing (GRH) program is a Minnesota funded program that provides monthly income supplements for rent and food for people at risk of institutional placement or homelessness.

Residents also receive their own spending money of \$74 per month through the Minnesota Group Residential Housing Program. Those residents who also receive Supplemental Security Income get an additional \$20 per month.

Outcomes, Challenges and Factors for Success

Wakiagun's contract with the Hennepin County Chemical Health Division states that:

- Residents are to reduce their detox and emergency room use by 20%.
- 60% of the clients would stay longer than 60 days at Wakiagun.

In a 2001 report for the county, it was observed that:

- The average length of stay per person was 368 days, though this was not always on a continuous basis. The average length of stay without interruption was 244 days.
- Only 15% of residents in the first four years of operation did not stay at least 60 days. This exceeds the above contracted expectations.
- Older residents stayed longer.¹¹

A 2003 report for Hennepin County noted that Wakiagun had also exceeded contractual expectations for lowered detox use. Before coming to live at Wakiagun, residents had, on average, 20.7 annual detox visits. Afterwards, this fell to 2.3 visits/year. (It was noted that individuals who left Wakiagun to go back to living on the streets returned to their pre-Wakiagun level of detox use.) In 2003, detox cost \$300 per visit in Hennepin County. For

the 40 residents this represents a decline in expenditures from \$248,400 per year to \$27,600, which saves the county \$220,000 annually. As well, the detox van estimated that it made 450 trips a year to return intoxicated residents to Wakiagun and another county facility (the number of trips to Wakiagun alone was not separated out). Without housing, these individuals would have been taken to detox centres or an emergency room to sober up. The report also surmised that allowing residents to drink in the facility meant that when

intoxicated the residents weren't generating 911 calls leading to pickups off the street and delivery to expensive public services.

The impact on emergency room use was not as dramatic. Emergency room visits fell from an annual average of 8.8 before housing at Wakiagun to 8 while at the facility. However the nature of the visits changed from severe intoxication and injuries to illnesses. There was a decline of \$4,000 per year in the median cost of health care per resident.

Impact of the Program on Residents

Measures of Success	Outcomes
Residential stability (e.g. length of time housed)	Residents are now staying for longer periods of time than they did when Wakiagun began.
Increased participation in employment	Negligible
Income	Increase, since residents get an allowance from the state program that funds their stay.
Improved self care	Residents keep themselves cleaner than when they lived on the street and they usually gain
weight.	family, new friends)
Personal networks (e.g. more contact with	No discernible pattern. Residents may have
more contact with family than before but this depends on the individual.	The mental health issues of some residents appear more often in residence than on the street. Their symptoms become more apparent once they are stabilized. However they receive help in the facility and feel more comfortable with themselves after they have
Improved use of mental health services	
been living at Wakiagun.	The 2003 Hennepin County report concluded that the decline in the number of emergency room visits was not significant, (see above) but that there was a significant decline in median medical costs due to residents having medical conditions requiring less expensive care.
Improved use of primary health care	
Other	At the beginning, discharge was most often due to behaviour. Now it is most often due to medical conditions.

11 Thornquist, Lisa, *Wakiagun Residents' Use of Emergency Services in Hennepin County, Minnesota*, prepared for the Adult Services Chemical Health Division, Hennepin County, March 2001,

Resident Satisfaction

Wakiagun has not conducted a resident satisfaction survey.

Reasons for Success

Wakiagun defines success as having the tenant remain housed and not going back onto the street. Hennepin County defines success as also reducing visits to detox centres and emergency rooms. The program has met or exceeded its own primary objective. It has lowered detox visits and while it has not reduced emergency room use, it has resulted in lower median medical costs by residents.

Reasons for success include

- the staff—the way in which they have come to accept and practice Wakiagun's philosophy of service provision and that they treat residents with respect
- the case manager—he was once homeless and an alcoholic, and has a good understanding of Wakiagun's population
- the principle that Wakiagun relies on building relationships between staff and residents and not on set programs
- stable funding—Not having to expend time and energy worrying about funding, staff can devote more to program work and service for the residents
- not overly large facility—this reduces the potential for the building to have an institutional atmosphere

Challenges

- “The whole program is a challenge.” In that respect there were no surprises.
- Development of the facility was delayed 1 1/2 to 2 years due to NIMBY

problems with the neighbourhood. Zoning was interpreted more stringently than for other programs.

- Several years ago the fire department was unhappy with the facility and in particular one captain challenged the harm reduction approach and continuously threatened Wakiagun with infractions.

The challenges were addressed in the following manner.

- NIMBY: Once Wakiagun was operational, objections diminished. During construction, Wakiagun initiated a Community Advisory Committee to allow neighbourhood concerns to be voiced and addressed. Five or six people would attend meetings. After construction, this number rapidly dwindled to zero, and the committee was disbanded. Some time after opening, a staff member went around the immediate neighbourhood to ascertain opinions on the project. Some neighbours didn't know Wakiagun existed and thought the building was an apartment house. Some said the project was doing well. A handful expressed continued opposition.
- Fire Department: Wakiagun met with local fire stations and explained why harm reduction was chosen as an approach for the facility's residents. As well, since Fire Department staff are first medical responders, Wakiagun asked them: *Would you rather treat someone who is a resident in a facility, where you will be handed the person's medical history and taken to his room to provide the emergency care, or would you rather respond in all weather and types of geographical conditions (such as down a river bank) to a call about someone living outside?*

Lessons Learned

- Staff must be non-judgmental, friendly and empathetic without being enablers of the lifestyle of the residents. To work at Wakiagun it is most important that staff understand (even first hand) the lifestyle of the residents. They also must be able to read and write well enough to fill out the logbook for each shift.
- Trust the people you are serving. Set up the correct situation and options, and they will make the choices they need for themselves. Their choice may not be the ones you wish they would make, but will be their choices. For example:
 - One resident decided that he drank too much at Wakiagun compared to living on the streets, and left the facility.
 - One former resident has been sober for five years. He remained at the facility almost three years after he began sobriety, and was not pushed out. He finally decided on his own to leave, and has continued to remain sober.

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Appendix B
Interviews with Residents/Individuals
using the Programs Provided by the
Case Study Agencies

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Participants' backgrounds

The researchers conducted face-to-face interviews with 33 individuals who participated in this study. Thirty participants were residents or

individuals receiving services from each of the 10 projects where on-site interviews took place. Three additional interviews were conducted with individuals who had lived in a project that was subsequently not documented as a case study.¹

Table 1. Number of interviews conducted at each case study location

Project	Number of participant interviews
Canadian	
1. Princess Rooms, Vancouver	3
2. Eva's Satellite, Toronto	3
3. Canadian Mental Health Association, Ottawa	3
4. Ottawa Inner City Health Project, Ottawa	3
5. Services à la Communauté (CDC), Montreal	3
6. Chambreclerc II, Montreal	3
U.S.	
7. Lyon Building, Seattle	3
8. Supportive Housing and Managed Care Pilot (SHMCP), Minneapolis	3
9. Anishnabe Wakiagun, Minneapolis	3
10. Pathways to Housing, New York	3
European Projects	
11. Heavy Drinkers Project, Manchester	
12. In Partnership Project, Manchester	
Planned Project	
13. Situation Appropriate Supportive Housing (SASH), Halifax	
14. O'Neil Crack Cocaine Project, Seaton House, Toronto*	3
Total number of interviews	33

* Not documented as a case study

Some participants lived in housing that was owned and operated by the case study agency, and also received services provided by these agencies.² Others lived in housing owned and operated by private landlords or non-profit societies. Participants in this housing received

support from the case study agencies. In fact, the case study agencies had helped the participants secure their housing and provided ongoing support to help them maintain it.³

1 The researchers had originally intended to document the O'Neil Crack Cocaine Project, a former initiative of Seaton House in Toronto. Interviews were conducted, but it was subsequently decided that the researchers would not prepare a case study for this project. Nevertheless, since the interviews with former residents had been completed, it was decided that their input should be retained.

2 These include participants living in the Princess Rooms, Eva's Satellite, Seaton House, Chambreclerc, Lyon Building, Anishnabe Wakiagun, and tenants renting condominium units owned by the Canadian Mental Health Association.

3 These include individuals receiving services from the Ottawa Inner City Health Project, Dollard Cormier, the Supportive Housing and Managed Care Pilot, Pathways to Housing, and Canadian Mental Health Association (renting units from private landlords and non-profit housing societies).

Prior housing/homelessness

All the participants had been homeless or had unstable housing histories prior to becoming involved with the case study agencies. More than half the participants (20) had been homeless—some for a few years. They had lived out on the street—sleeping on the sidewalk, in a park, or in a car. Some had also couch surfed with friends/family and spent some time in shelters.

The other participants had very short term/tenuous housing arrangements. One had been in and out of several relationships. He was housed during the relationships and homeless when they ended.

Two participants had lived in rooms or shared accommodation. Three participants had lived in a house or apartment—which they lost—before coming to one of the shelters.

Characteristics

About three-quarters of the participants (24) were male and nine were female. They ranged in age from 22 to 63 years old, but most were in their 30s and 40s.

Participants were asked about their ethnic or cultural background. They identified themselves as follows:

Table 2. Ethnic/cultural background of participants	
Self-identified ethnic/cultural background	Number
Canadian—including Italian-Canadian, Irish-Canadian, and Canadian-born in the U.S.A.	8
Aboriginal—including Native American (3), First Nations (1), and Northern Cheyenne (1)	6
Caucasian	5
French Canadian/Québécois	5
Black	4
Slavic	3
Other European	3
Did not wish to answer	1
Total	35*

*Numbers don't add up to 33 because some individuals identified two categories.

Where from

Most participants (26) were from the same country where the interview took place, while seven were from another country. Only five of the individuals were born in the city where the interview took place. They had come to the city for several reasons (e.g., to be with friends and family, for better opportunities and health reasons).

How they became involved with the program

There were several different ways that the participants came to be involved with the case study agencies. Some found out about the program while in an emergency shelter, others heard of it through “word of mouth”—from a friend or stranger, while others were referred by another

program/agency. Some participants were approached by an outreach worker or staff from the program. For example, one person was living outside the building. A staff person came out and asked her if she would like to live inside.

One participant told the interviewer how a police officer helped him get to the case study agency. An outreach worker had told the participant about a program that would get him an apartment. The participant asked a police officer if he knew about the program, and the officer suggested that he check it out. When the participant told the officer he didn’t have any money to get to the agency office, the officer gave him bus fare, put him on the bus, and off he went.

Current housing

About three-quarters of the participants (24) were living in permanent housing, six were in an emergency shelter, and three were living in

transitional housing. As can be seen 10 of the 24 individuals in permanent housing had been in their housing for two years or more, and five of them had been housed for four to six years.

Table 3. Length of time participants were in their current housing

Length of time in current housing	Emergency	Transitional	Permanent	Total participants
Less than one year	4		8	12
1 year		2	6	8
2 years			4	4
3 years	2*	1	1	4
4 years or more			5	5
Total	6	3	24	33

* May have been “on and off” during this time.

Most participants (26) were living in buildings dedicated to the target group or a similar clientele. Another seven were living in units that are integrated within non-profit or private rental buildings that serve a mix of tenants (e.g., scattered sites). Nineteen participants lived in accommodation where some of the living space is shared (e.g., bathrooms or cooking facilities). Almost all of these participants had a private bedroom. In the permanent housing, two participants shared a bedroom. Fourteen participants had their own self-contained units.

Most of the participants were satisfied with their housing. Twenty were very satisfied and nine were satisfied. Only a small number, (4) were not satisfied. One participant said “sometimes I look at my apartment, standing between the living room and the bedroom, and I think, man, I’ve got a good apartment.”

There did not seem to be any correlation between the type of housing and level of satisfaction among participants.

When asked what they liked most about the place where they are living, participants provided the following comments:

Location

- Close to services, places to get free food, public transportation, parks, shopping, and church etc.
- In a quiet neighbourhood

Housing

- Affordable rent
- Housing quality and cleanliness of the building
- Having own self-contained apartment
- Privacy, safety and security

Staff

- Supportive, responsive and available

Opportunities to socialize

- Comraderie with the other residents
- Group activities/programs, e.g., movies, breakfast meetings and parties
- Space in the building to socialize with others
- Meals provided by staff/community suppers—"Good food and lots of it"

Just the fact of having their own apartment or private room seemed to provide a great deal of satisfaction. One person said, "At last I'm home." This person appreciated the security of having a place—"a roof over my head." Someone else's room was very personalized—it appeared that a great deal of effort had gone into decorating it, and another talked about how she enjoyed taking care of her plants. One person stated, "It's the best thing that ever happened to me."

When asked what they liked least about the place where they are living, participants who lived in dedicated buildings complained mostly about some of the other residents. Some expressed concerns about new residents, who (at the time of the interview) seemed to be causing problems such as violence, banging on doors and screaming in the hallway. Some participants also complained about living with other residents who have serious mental illness, poor hygiene, and can be mean, vindictive, selfish, tough, rude or cruel. Some participants expressed concern that residents can be terrorized by an individual on anti-psychotic drugs who goes off their meds. Other residents in dedicated buildings also expressed concerns

about arguments between residents who are drunk, other residents who bother them when they are drunk (e.g., pound on the door), and other residents who use drugs—which can lead to temptation.

Participants also raised concerns about the following:

Location

- Too close to people who sell drugs, liquor store, heavy traffic and noise; not close enough to transportation and amenities

Housing

- Units need to be painted; not clean enough, problems with rats and repairs not done
- Rules restricting guests
- Too many people together
- Don't like sharing—especially the bathroom
- Would prefer a subsidy so could live anywhere

Program/Services

- Food—could be better
- Timing for the administration of medications
- Not enough money for bus fare
- Not enough focus on spiritual needs
- Doesn't like having to leave at 8:30 a.m.

Staff

- Sometimes staff can be quick to judge
- Residents should be treated with more respect by staff

Housing rules

Participants were asked if there were any rules for living in their housing and what they thought of these rules.

Scattered site housing

In the scattered site units, tenants were required to sign a standard lease. Aside from this, one participant lived in an “adults only” building, another was required to inform the caretaker if a guest would be staying for more than three days and two lived in buildings where no pets were allowed. One of the agencies also required that each participant receive a visit from their worker each month. Participants did not indicate any concerns with these rules.

Dedicated buildings

Visitors/guests. In the dedicated buildings, the most common rule involved regulating visitors or guests. Some participants said that no guests or visitors were permitted (with the exception of immediate family) in their building, while others indicated that guests were permitted, under certain conditions. Some housing providers required guests to sign in and to have ID. There were also rules regarding visiting hours, overnight guests and about not leaving guests alone in the building. Most participants said they supported the rules about guests and said it was “good,” and provided for the safety and protection of tenants. One person said that the “no guests” policy had put an end to fighting, stealing, dealers and sex trade workers on the premises. Another comment was that this policy had made it easier to set boundaries with

friends. On the other hand, one person said he would like to have more visitors and another commented that it can be irritating if you want to run to the store late at night and your guest has to come with you.

Use of substances. A few participants noted that drinking or using drugs was not permitted anywhere on the property (rooms, grounds or common areas). They did not object to this rule, but pointed out that it needed to be enforced consistently. One participant expressed concern that she had chosen to live in housing that was “sober living,” but the lack of enforcement made it difficult to stay clean because everyone else around was using. Others noted that drinking or using drugs was not permitted in any common areas, however, residents were permitted to consume in their own unit/room.

No violence. One participant stated that there was a rule about no violence or hitting another resident. He stated that while this was OK, some people take advantage. For example, they may borrow money and not repay it because they know there’s nothing you can do about it.

Other rules that were mentioned included:

- Guests from outside are not permitted to come in and drink with a resident;
- Clients (sex trade) are not permitted in any rooms;
- Residents must take turns cleaning the common areas;
- Attendance at residents meetings is required;
- No noise is permitted after certain hours; and
- Residents must respect each other.

Activities

Participants were asked about a typical day and about different programs and activities they are involved with.

Health care. Ten participants talked about taking care of their mental or physical health issues. This included attending appointments to see a counsellor, psychotherapist, psychiatrist, case manager, school counsellor, social worker, and/or doctor. One person was undergoing a series of tests in preparation for an operation.

Community activities. Ten participants said they access services in the community. Some go to a gym, library, drop-in centre, soup kitchen, community centre, or church, and some participate in social activities offered by non-profit groups. One participant sits on the board of a housing project where she had once lived.

Programs offered by the case study agency. Eleven participants said that they spend time socializing with other residents or people who participate in day programs on site. Some participate in group activities, such as bowling, swimming, BBQs, mini-putt, mini-golf, going to movies and picnics with other residents. Some go to breakfast or meal programs in the building. Two participants commented specifically on how they really like it when staff provide meals. One participant discussed how she enjoys helping out in the kitchen or dining room. One participant started up a food bank in the building. She gets food from a local day center and distributes it every 15 days. One participant commented that there used to be more weekend trips but because of financial cuts, these don't happen any more. He was disappointed about this and said that he sometimes gets

bored—particularly on weekends.

Five participants said that they do not participate in the activities provided by the case study agency—or they do not participate very often. One person said he has his own circle of friends, and so is not very interested. Another said he likes to be solitary and doesn't like to be around others who talk about drugs and drinking. Another participant said he does not like being with the other residents.

Substance use. Six participants are involved in a drug treatment/counselling program. These include AA meetings, chemical dependency classes and drug counselling. One of these participants was involved in a concurrent disorder group, and another has been participating in a harm reduction therapy group for three years.

Two participants said that they spent much of their time getting money to buy drugs, obtaining drugs and doing drugs.

Volunteer initiatives. Six participants were involved in volunteer initiatives. Three were volunteering in community outreach programs. Two participants stated that they used to do some work for a community agency—two hours a day, but that ended when the centre lost funding for such work. Another person said he used to give haircuts to other residents.

Employment/vocational initiatives. Four participants are employed on a part-time or temporary basis. Two of them work for their service agency about four hours a day. Their duties include running errands (e.g., pick up things from the pharmacy) and answering the phones. Another participant works with a temp agency, and when not on a temp assignment, is looking

for full-time work. Another participant does some work “under the table.” He takes care of repairs for some other tenants in the building. Three other participants talked about looking for work. One participant had enrolled in an adult high school program—which had just started on the day of the interview, and another participant was planning to go back to school.

Child care. Three parents talked about looking after their children. Two of them had school-aged children and talked about getting them off to school each day.

Other. Other activities in a typical day included walking around the neighbourhood, going to the park, going for breakfast, going to a café, having coffee, finding a cigarette, watching TV (in the room or lounge) or watching movies on the VCR/DVD, reading and listening to music. Participants also talked about taking care of their apartment and keeping it clean, watering the plants, buying food and doing laundry. Three participants talked about visiting their children, mother or friends. One person (who is dealing with major depression) said he sleeps a lot. Another who is in a shelter spent his days trying to find permanent housing.

Previous situation and how changed

Health

Physical/mental health. Participants were asked about what their health was like before they became involved with the case study agency. While 10 participants stated that their health

was OK or good before becoming involved in the program, most had some health concerns, as noted in the table below. Participants were also

asked about how coming to the program had affected their physical health. Most participants (23) stated that their health improved after becoming involved with the case study agency. They are feeling better, eating better, sleeping better, less stressed, and taking medication for HIV.

Before	After
<ul style="list-style-type: none"> • Terrible—HIV positive and doing very badly. Weighed about 90 lb. • HIV positive but no infections. • Schizophrenia and HIV positive. • HIV positive for 2.5 years. Very skinny. • Bad psoriasis. • Would catch colds easily. • Depressed. Wanted to sleep all the time. • Not bad except when fell and bruised or broke some ribs. • Was beaten up sometimes and ended up in hospital or detox. • Not good. Doing many drugs (speed and ecstasy) and not eating well. • Had leg problems and blocked arteries and had a heart attack. • Deteriorating. • Not good. Became aggressive with alcohol use. • Miserable. Had hallucinations—schizophrenia. • Infection in arms where was injecting drugs. • Was very weak. 	<ul style="list-style-type: none"> • Feeling better—stronger physically and intellectually. • More relaxed and confident. • Can concentrate. • Physical health is much better. • Taking meds for HIV. Gaining weight (was 125 lb. when arrived and now 198). • Good meals really help. • Eating better. Feeling better. Have put on some weight. • Go to bed early and sleep well. • Can sleep with “both eyes shut.” • Less stress. None of the stress of living on the street. • Less hospital use. • Just starting to work out. Methadone makes you retain water. Starting to diet. • Service agency took good care of her. Salt and bandages and TLC. Fed her well. • Doesn’t get beaten up all the time anymore. • Is on his last legs. Diabetic, thyroid problem, Hep B and C • Was told by doctor he had three months to live when moved into the facility. At time of interview, had been there 4.5 months. • Health is better than ever—but still a problem—in a wheelchair. • Better than ever now that here.

Substance use. All the participants, except one, stated that they had substance use issues before they became involved with the case study agency. This included using alcohol, marijuana, speed, crack, cocaine, heroin, morphine, ecstasy and crystal meth. Some participants used a combination of drugs and alcohol—whatever they could, while others were loyal to only one substance (alcohol, heroine or crystal meth). The amount of drug use varied. Some had used drugs daily. One person stated that she had been using drugs 24/7. A few had not used much or had been abstinent (more or less) for a period of time before becoming involved with the case study agency.

About two-thirds of the participants (22) stated that they were using less or had stopped since they had been housed. Participants gave several reasons for this. One person said “I don’t need it as much as before.” Another person who used to use drugs every day said, “today drugs are second, not first.” This person had regulated her use to certain days of the week. One person said she has grown out of some of her drug use. She said

she doesn’t need to do drugs as much because her life is so much better. Another said that he didn’t want anything to jeopardize his housing.

A few participants gave examples of how they were using less drugs and/or alcohol. One person, who used to use drugs “pretty much every day,” was using only a few times a month at the time of the interview. Another participant, who at one time drank a fifth of bourbon every day, was consuming this much per week at the time of the interview. Another participant had been sober for 27 days prior to the interview.

Two participants stated that their drug use had decreased but they were drinking more. One person had recently switched from using crystal meth daily to heroin twice a day. He was trying to taper down his use. On the other hand, two individuals mentioned that they had relapsed a few times after being housed.

The following table shows how substance use among the participants changed since they were housed with the case study agency.

Table 4. Change in substance use since housed	
Drug use	Number
Using less	18
Stopped	4
Less harmful	1
Less drugs more alcohol	2
No significant change	3
Never used	1
Don’t know	4
Total	33

More than half the participants (18) had been to a treatment program before becoming involved with the case study agency. Among those who went to a program, six said that they found it helpful. One person said that they talked about important issues and he stopped using for a while. Another person was sent to a program through the criminal justice system. The program was in the country and she liked it. She said that treatment helped her think more, and she had to write about her feelings. Another participant, who had been in treatment about 10 times, said that once in the 1980s it made a difference and he stayed sober for a year, going to AA meetings five times a week. Two others had tried AA. One said that it helped in the beginning. Another said that it helped—but not enough. The sixth person had completed an intensive program and had been sober for three years. Then she relapsed and was on the street. Some time later, she tried a 12-step program but relapsed very quickly afterwards. All these individuals were using substances when they became involved with the case study agency.

Among those who tried a treatment program, three mentioned that treatment facilities were often a place to stay or a way to “get out of the cold.” Another participant said he went to treatment, “but only if beaten up and he ended up in hospital or detox.” He wouldn’t go into treatment until he got hurt and needed a place to heal. One person, who never went to treatment said, “ain’t needed but a place to stay.”

Some who went to a treatment program said that they didn’t like the program. Others said that they simply weren’t ready to give up drugs or stop drinking. “Old habits die hard.” A few had some specific complaints. For example:

- One person said he didn’t complete the program because he was very tired and wanted to sleep all the time. He felt unable to do the chores. Someone screamed at him for not doing the chores. He got angry and slammed the door, and had to leave.
- Another person complained that the treatment facility he went to was not receptive to gay men. He had to keep being gay “very hush hush.” For him, part of using was being gay. He felt that he couldn’t address his issues if he couldn’t talk about being gay.
- Another person left after four days. He said the staff wouldn’t let him take meds for depression or sleep. He couldn’t go to the gym or to the library and he didn’t want to sit around all day.

Two participants were involved in treatment groups at the time of the interview, and were happy with these programs. One individual in a concurrent disorder group stated that it was a very supportive and understanding group. She was never judged, and was treated as “just a regular person.” Another individual had been participating in a harm reduction therapy group for three years. He likes it and likes talking to the people. He says that they help you look at your addiction realistically.

Income

Seven participants stated that their income was the same since they had become involved with the case study agency, another seven said that their income was more regular because their funds were administered by the agency. Another seven said that they were better off. Reasons included having more disposable funds because they were paying less rent, able to access disability benefits

after securing permanent housing, and working more. At the same time, some participants said that their income was less compared to a previous time in their lives when they had been working. Four participants did not discuss how their income had changed since becoming involved with the case study agency but commented that their income was not enough to live on.

Table 5. Comments about income

Comments about income	Number
Same	7
Regular—some said because funds are administered by the agency	7
Better off—more disposable funds because get more—pay less rent. One got on disability. One working more.	7
Less income—because they had more money when they used to work	4
Not enough	4
Fluctuates depending on whether they are working	1
Don't know	3
Total	33

Feelings about life

Most participants (23) indicated that becoming involved with the case study agency had a positive impact on the way they feel about life. They talked about developing self-esteem; having a brighter outlook on life; having hope; less stress; feeling more confident, secure, relaxed, happy, safe, optimistic, and less isolated; and how their life is better and has “turned around.” A few specific comments were:

- “I feel good about myself. I look forward to another day and to years to come.”
- “I wasn't suicidal, but I really didn't think I'd live very long - now I can see myself in 10 years.”
- “I feel wonderful, I enjoy living.”

- “Being a father has made me really happy—I haven't been able to accept happiness until now.”

One participant said that the program had given her hope and the ability to function as a human being. Another said she had increased hope in the future for her and her son. Another said she felt less isolated because there were always people to talk to. She said that, “while I don't especially like sharing, maybe I need the other people around to keep me stable.” Another participant said that he is starting to deal with his depression, while another commented that her anti-depressants were working now that she wasn't using drugs. Another said that he is more mellow—not as nervous (has panic attacks and is agoraphobic). He had stopped liking music but was learning to like it again.

Four participants indicated that they were not feeling very positive about their lives. One participant was struggling with depression and noted that while he had been able to put some issues to rest that he had been struggling with while couch surfing, he was now dealing with some of the other/deeper issues in his life. Another participant said he felt a bit more depressed because he was not working. A third participant said, “I’m home but also have a tendency towards isolation.” A fourth participant said he had less trust in people after living with so many people with addictions.

Two participants said there had been no change. As one of them said, “its a “day-by-day thing.”

Family

More than half the participants (18) said they were in touch with members of their family. Three participants indicated that they have regular visits with their families or a family member. One participant said he is close to his family. Another said his family cares about where he is and is happy he has a fixed location. One mother said that her 22 year old daughter “calls me up and talks about things that are bothering her.” Four participants indicated that being involved in the program had helped with their family relationships. One of them had recently got in touch with her family after seven years. Another said that the program helped her maintain contact with her family, a third said that her relationships with her children were getting better, and a fourth said that his relationships with his parents had improved since he had been living apart from them. Later in the interview, when asked about their goals, three participants said they wanted to strengthen their relationships with their families. One woman was hoping to be re-united with her children.

On the other hand, three participants said that they have no contact with their families. One said that his family has had no contact with him since he acknowledged his addictions. Another has no interest in connecting with family, and a third participant said he has no family.

Friends

About half the participants (17) talked about having friends. Six of them talked about friends they had in the drop-in center, the building, or the program. One participant, a very lively woman, goes to the same café every day and knows lots of people there. Two women said they had boyfriends. One of them said, “I’m seeing a guy - a computer geek - we go out, see movies.” When participants were talking about their friends, it was not always clear if they were talking about “old” friends or “new” friends. At least five participants talked about maintaining their friends—or still being in contact with their friends.

Four participants said they had no friends. One said this was because a lot of the people around used drugs and alcohol and he didn’t want to. Another said he was not interested. Three participants mentioned that they did not want to be in touch with their old friends. One said he wanted to stay away from old friends from “drug days.” Another said she was staying away from the people she used to know. Another said “I don’t want to hang out—don’t want to get involved in use—used to know the wrong people.” One person had split up with his girlfriend, and this seemed to be a very painful part of his life at the time of the interview.

Factors responsible for changes

When asked about the factors most responsible for the changes in their lives, one participant said that it was due to the program as a whole. Others mentioned several factors.

Housing

Ten participants commented that having a place to live was responsible for the changes in their lives. One person said it was having her own room where she could lock the door. Three commented on having a roof over their head, and not being homeless. As one of these persons said “especially because I’m not on the street anymore—it’s hard not being in one’s place.” Two participants said that having a place to live made it easier to stop using drugs and alcohol. One of them said, “having steady housing has changed things—I’ve cut down on my drinking—my drinking is my biggest problem.” One participant said that having his apartment and being able to afford it had taught him to be responsible and increased his self-esteem. Another participant talked about the building as a whole—that the building is like a community. She said that people get along and support each other both in the building and outside on the street.

Support

Seven participants talked about how the support they received from the case study agency was responsible for the changes in their lives. Participants commented on the nature of their relationship with their case manager or the support team. One participant said that the service agency shows him respect. He doesn’t feel like a number, but is treated as a person.

He said the service agency is non-judgmental about his addiction or lifestyle when he makes mistakes and that team members are great motivators and responsive to his needs. This person said that he feels the team genuinely cares about him. This has boosted his spirits, and he doesn’t want to do anything to jeopardize his housing. Other participants provided the following comments about how the support agency has helped them:

- Makes sure she gets to appointments. There is always someone to support her. Her case manager is like her own mother. (The participant had known her for three years).
- Support agency has given her faith in the system. She feels safer because she has something—her case manager to fall back on. This participant also said that the support agency had let her son go to the school he wanted. She says, “I wouldn’t be able to manage without the support” provided by the case study agency.
- Counsellors have helped him kick around ideas of what he might do.
- Is able to relate to the case manager as a friend.
- Staff at the program were good and helped him. He felt supported from both staff and clients.
- Felt better about himself while at the program, and feels worse since out of the program.

Medication

Three participants felt that life had improved because their medication was working better. A fourth commented on the relationship between her meds and drug use and noted that her meds were working better when she didn’t use drugs.

Substance use

Two participants stated that stopping or reducing their drug use made them feel better. One person had stopped smoking pot because it had made him feel paranoid. He said he used drugs to make him happy. But since becoming involved with the case study agency, he feels better, so is using less drugs. He is thinking more about his life and what he wants. Another participant said that he has learned to control his substance use and was able to work. (He was working on a housing renovation at the time of the interview.)

Other

- Seeing people who have been damaged by drug use and wanting to stop before things happen to her.
- Growing up—getting older and wiser.
- Ability to socialize with others in the building.

Goals

When asked about the kind of changes they would like to see for themselves over the next year, if any, participants identified the following goals.

Move to better housing. Nine participants said they would like to move somewhere else. Four participants who were in a shelter said they would like to get their own place. Another participant (who shared a bathroom/kitchen), said she would like to have her own place “and then never move again.” Another said he wanted to move, but acknowledged that he wasn’t ready. Another expressed a desire to live in the country where she could have a garden and fresh air. Another said he wanted to move to a different area where people aren’t using drugs or alcohol. Another was on a waiting list for accessible housing.

Employment and education. Eight participants said they wanted to get a job. Those who specified the type of work they were interested in mentioned working in a food store, working with animals, working with computers, and making and selling buckskin shirts. Five participants said they wanted to go back to school or finish school.

Getting off drugs. Two participants said that they wanted to stop using drugs. A third participant said he wanted to taper off his use of heroin. Two others who had stopped using drugs said they wanted to be able to stay clean. As one person stated, he wanted “more emotional balance and clean time.” Another said he doesn’t want to get back into hard drugs again.

Mental health. Four participants discussed their mental health. One said he wanted to “get out of his funk.” Another was hoping to attend some therapy for agoraphobia. Another person was

hoping to become more content with himself, while another was hoping for “absolute stability and contentment—to be able to take a breath.”

Strengthen family. Three participants said they wanted to improve their relationships with family. One said he would like to visit his brother, another expressed a wish to be reunited with her kids and another wanted to move closer to his family.

Physical health. Two participants were dealing with significant health issues. One was waiting for an operation, after which she hoped her health would improve. Another was dealing with stomach cancer, which he felt could be treated. A third participant was hoping to stop smoking.

Other. Participants expressed a variety of other goals. These included:

- Doing music or photography—something creative;
- Buying things for themselves;
- Being independent;
- Going on vacation (Europe, Italy, France, “where the food is good”);
- Going out into the world;
- Winning the lottery;
- Painting the apartment;
- Being a better father—a better human; and
- Making friends.

No goals. Three participants did not have any goals that they shared with the interviewer. One person said he had no thoughts like this—he lives day-to-day, another said he hadn’t thought of any. A third person said “I’m pretty happy.” Two did not answer the question.

Participants' recommendations

Participants were asked if they had any words of wisdom or advice for any other organization that might be interested in doing a similar project to the one like their case study agency. They were also asked to provide more comments about what features of the program they thought should be different and what should definitely stay the same. In reviewing the comments, the following themes emerge about what is important to the participants.

Staff

It was clear from the interviews that staff, and the way they related to the participants, was critical to them. Eighteen participants discussed what was important to them in terms of staffing. They raised the following issues:

Qualities of staff. The participants valued staff who were friendly, caring, supportive, responsive, helpful, compassionate and patient. They appreciated staff who helped them with practical things (e.g., getting paper and pens for drawing and helping to replace lost ID). They also appreciated that if something in the building needed to be fixed, staff would take care of it right away. Participants appreciated staff who they felt cared about them. One participant had this to say about the staff from the case study agency: "People are concerned about you—they know you need help. They worry if they don't see you. If you need help, they're there—even on weekends."

How they are treated. Participants appreciated being treated "like a person." As one participant said, "the personal touch is so important. Being treated like a person rather than a client makes all the difference. 'I've called her at 5 a.m. And

she's listened to me.'" Another participant said, "always remember to treat clients as people no matter their affliction. Take time to listen and say, 'Okay, how do we fix that?'"

Participants also want to be treated with respect. They appreciated staff who were non-judgmental and accepting—good staff—not the ones who would "talk down to you." One participant pointed out that the people in her building are "vibrant and wonderful. It is important to recognize this."

Training, experience and skills. Participants said that staff need to be well-trained. They need to understand about the nature of mental illness, addictions, different kinds of drugs (and how they affect you), and they need to be knowledgeable about harm reduction. One participant pointed out the importance of trained people who can recognize both mental health and substance use issues. He said that often, the mental health issue is not recognized because of the drug use. He said "you have to recognize this and get people into housing and make sure they get the support they need." Another participant said it was important to have staff who can "talk to you when you are coming down from crack because they know what they are doing."

Participants also felt that experience is important. This includes experience working with the target population and also real-life experience. One participant said he feels much more comfortable talking with staff who have life experience similar to his—rather than "green college kids." He wants to hear from a peer rather than someone who is "book smart." Another participant also said he thinks it is good to have staff who went through the substance abuse themselves. By being sober, they can show the residents it can be done.

For programs serving Aboriginal people, participants said they should employ other Aboriginal people, who have first-hand knowledge of the issues the residents have faced.

Participants also said it was critical that staff have the necessary people skills and communication skills. They need to understand the population they are working with. One participant cautioned that staff sometimes have their own issues and take things too personally.

Availability of staff. Participants said that there should always be someone on call. They appreciated staff being available 24/7. They also pointed out that some participants may need constant contact with staff “so they don’t fall off the wagon.” Participants wanted staff to be available when needed and wanted.

“Give love, lots of love, for the clients. Keep love and faith together. Stick with it....”

Housing

Sixteen participants discussed what was important to them in terms of their housing. They raised the following issues:

Affordability. Rent should be affordable

Location. Housing should be in communities away from drug dealing, in quiet neighbourhoods, accessible to public transportation, amenities and services.

Privacy. Residents should have their own room that they can lock. Sharing can be problematic—particularly sharing a bedroom or bathroom.

On the other hand, two participants mentioned tendencies to isolation and one person acknowledged that maybe she needed other people around.

Scattered site housing vs dedicated building.

One participant expressed a preference for scattered sites. He didn’t think people should be grouped together. Another would prefer an apartment-like building where residents can bring guests. On the other hand, some participants liked the sense of community that can be achieved in dedicated projects. One participant said she has made good friends in the building, and appreciated the sense of community.

Housing choice. One participant talked about housing choice, and said, “If you’re going to house someone, show them the apartment, and let them walk around the neighbourhood to see if they would really like to live there.” This person had been shown two apartments, and appreciated having a choice.

Alcohol and drug-free housing. A need was identified for housing options for people who don’t use alcohol and drugs. Some participants had stopped using drugs and/or alcohol identified a need for housing options that were “away” from these influences.

Housing quality matters. Buildings should be clean and well-maintained (e.g., units are painted and repairs are done). Good insulation between units is also important. For new buildings, it is important to follow the work of the contractor closely to make sure they do the work they are supposed to do.

Building size. Shouldn't be too large. One participant said that a program of 20–25 people is just right.

Units/rooms. It is good to have furniture included.

Transitional housing. There should be other buildings close by where residents could move once they no longer need transitional housing.

Rules. If there are rules, these need to be enforced consistently.

Safety and security. Are important.

Food

Fifteen participants talked about food. Six participants said that they appreciated communal meals. “When people eat together it’s a very bonding experience.” Another said that meals provided by staff make him “feel good.” Two participants said they enjoyed the collective kitchen. The quality of food is important. Where food was good, participants said so, and where they didn’t like the food, they said so. They wanted “good food and lots of it.”

Treatment

Three participants talked about harm reduction. One said that more instruction was needed, another thought this approach should be continued, and another commented that programs that have a harm reduction approach can save lives. One participant pointed out that programs should not have unrealistic rules about quitting substances. It is important to understand that people must be ready—and when they are, they will need support.

For people who are ready, treatment should be available on demand. One participant suggested that treatment facilities should have a few beds dedicated to housing programs such as described in this study.

Activities

Three participants talked about the need for more organized activities. One thought there should be a program seven days a week. He said, “You really need something on Sundays.” Another participant also identified a need for a day program and weekend program. He used to enjoy a breakfast program on weekends and when the organization used to show movies. A third participant also said how he used to enjoy it when the organization used to take them places, such as movies and plays.

On the other hand, some residents said that they did not feel comfortable participating in group activities, and one participant said that they should be able to say “no” to outings.

Shelter

Three participants in shelters said they would like more flexible rules re coming and going e.g., hours when residents have to leave and be back.

Community connections

Some participants noted that it is good to have good connections with the community and good links between various organizations. For example, one participant suggested that staff from other organizations should be on site to help residents find housing and work.

Access to health care was also noted as an issue. One participant said that the ability to see a doctor had helped him. He can be sober more often now due to a drug that helps him sleep and cope with the anxiety that occurs when he is withdrawing.

Religion and spirituality

Two participants mentioned the need for programs to be able to address spiritual needs. For Aboriginal people, it was suggested that the program bring in people who are familiar with different kinds of native religions. Another said that spirituality should be addressed in a general way.

Appendix C:A Review of the Literature

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Introduction

Stable Housing for Substance Users (Drugs and Alcohol): Lessons for Housing Providers

Literature Review

The purpose of this literature review is to:

- Provide an overview of interventions which promote access to and maintenance of stable housing for people who are homeless and who have addictions or “concurrent disorders;”
- Provide an overview of evaluations of such interventions with special attention to the differences that exist between conventional and alternative (e.g., harm reduction) approaches; and
- Summarize the state of research regarding housing stability for the identified population and identify areas of consensus, differences of opinion and areas where further investigation is required.

As the literature was reviewed, a number of issues emerged that will be important in guiding subsequent phases of this research project. These include the application of the harm reduction philosophy (e.g., tolerance of consumption versus active engagement in abstinence-based treatment) as well as differences in application of the harm approach to alcohol, which appears to be more easily acceptable, especially among certain populations such as elderly chronically homeless persons, versus the approach to drug use. As the Wintercomfort example in England illustrates

(described below), the harm reduction approach for drug use can raise important legal issues. Furthermore, underlying the issue of stabilization of homeless persons is the question of what approach to housing provision is the most effective. Two major tendencies are found in the literature. The first is the continuum (e.g., the U.S.) or staircase (e.g., Sweden) models, which move persons through clear stages of shelter and housing. The Swedish example appears to be at one extreme of rigidity in the application of the model whereby housing is seen as a potential instrument to change undesirable behaviours, such as substance use. The other approach that is revealed in the literature is one where housing is seen as a critical factor in stabilizing substance use, rather than a consequence or reward for control or abstinence. The American “housing first” approach is a good illustration of this.

Other issues, not dealt with explicitly in this literature review, but that may be important in the study are questions of location of projects. For example, there are strong indications that moving persons away from sources of drugs and the drug consumption milieu may be desirable if not essential to the development of new capacities and relationships (Mercier, Corin, and Alaire 1999). NIMBY can be another factor in the development of new projects. This was an important issue for Birchmount Residence in Toronto (Serge and Gnaedinger 2003) and appears to have been a major factor in the location of the Sirkkulanpuisto Community in Finland, which was built on the outskirts of a city to avoid problems with neighbours. (See below).

In carrying out this literature review, the researchers focused on materials published in Canada and the United States since 1990. This included materials written in English and French. The researchers searched major medical,

health and social science indexes and databases through the University of British Columbia and other library systems. We also reviewed several Canadian, U.S. and European sites available online. For Canada, some of the sites included Canada Mortgage and Housing Corporation, Raising the Roof, the Canadian Harm Reduction Network, Canadian Centre on Substance Abuse, and National Homeless Initiative website. Some of the U.S. sites included the National Institute on Alcohol Abuse and Alcoholism (NIAAA), Department of Housing and Urban Development (HUD), and National Alliance to End Homelessness.

In the U.K., sources of information included DrugScope, the London Drug and Alcohol Network, and the National Treatment Agency for Substance Misuse as well as sites such as Homeless London (which lists good practices in the provision of services for people with drug problems) and several government websites.¹ The search for materials from Europe included reports available from the European Federation of National Organizations Working with the Homeless (FEANTSA), European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the Qualitative European Drug Research Network and the International Harm Reduction Association (IHRA). Other European sites included the A-Clinic Foundation in Finland, the Observatoire Français Drogues et des Toxicomanies, and l'Observatoire du SAMU (Service d'Aide Médicale Urgente) Social de Paris.

The researchers searched combinations of words relating to housing, homelessness, substance use/abuse) and harm reduction. While some of the indexes for journals yielded close to 19,000 citations for articles on substance abuse, 9,000 for articles on housing, 4,000 for articles on homelessness and 800 for articles on harm reduction, the search for articles dealing with a combination of these yielded much fewer citations. A search for housing and substance abuse yielded about 400 citations. Much has been written about housing in relation to addictions treatment, particularly with regard to individuals with a dual diagnosis (co-occurring mental illness and substance use disorders). There is also a significant body of research emerging with regard to harm reduction and addictions. A search for harm reduction and substance abuse yielded about 130 citations. However, a search for harm reduction and housing yielded about eight citations, and a search for housing, harm reduction and substance abuse yielded virtually no articles. Only a few journal articles or books discussed the concept of “wet”² or “damp”³ housing. Thus, it became clear early on in the literature search that the term “harm reduction” has not generally been used in the context of housing for people with addictions. However, the literature does address new approaches to providing housing that are consistent with harm reduction goals.

1 These include the Greater Glasgow NHS Board website, the City of Liverpool Homelessness Strategy site, the Social Exclusion Unit and the cross-government national drug strategy website.

2 Wet house—a facility where substance use is tolerated and not considered a reason to bar or discharge anybody.

3 Damp house—where substance use is tolerated “off-site” and on-site support is provided to help the person transition to abstinence in a non-threatening way.

Overview of Harm Reduction

Concerns with the traditional approach to treatment

One of the issues addressed in this literature review is the concept of harm reduction in dealing with substance use issues. This section provides an overview of harm reduction because it is discussed in the literature from all the countries included in this study.

The traditional approach to the treatment of addictions was based on abstinence, and relied heavily on a client's willingness to accept lifelong abstinence as a goal (Denning 2001).²

However, during the 1980s, there was a growing sense that this zero tolerance approach did not work well, especially for many homeless persons. Studies in the U.S. found that 12-step programs, which account for more than 90 per cent of all alcohol and other drug treatment programs in the U.S., had a success rate of between five and 39 per cent (Denning 2004). It was also estimated that 80 per cent of clients failed to complete traditional treatments (Denning 2004 and Brocato and Wagner 2003). There was a growing belief that the zero-tolerance approach to drugs and alcohol was a barrier that prevented these people from seeking/accessing programs and services (Brocato and Wagner 2003 and Marlatt et al. 2001).

These findings are consistent with a Toronto study that found substance users were reluctant to seek out conventional addiction treatment

services, including 12-step programs, detoxification and rehabilitation, that required people to abstain from using drugs or alcohol (Steering Committee for the Study Project on Homelessness and Alternative Addiction Treatment 1999). According to one service provider, "the model where users "just say no to drugs" does not work." (Steering Committee for the Study Project on Homelessness and Alternative Addiction Treatment 1999). The Toronto study found that while traditional services have been successful for some people, abstinence-based programs have little chance of attracting or retaining people who are homeless. "For many homeless people who use drugs, quitting is not a decision they choose to make or can make... nor is it a realistic option, at least in the short term. Without basic supports in place, such as housing, food, a job and supportive family or friends, abstinence can be impossible." (Steering Committee for the Study Project on Homelessness and Alternative Addiction Treatment 1999) Some participants in the Toronto study described traditional approaches as a "revolving door," which involves entering a detox facility or a 30-day residential program, returning to a life of homelessness and joblessness, resuming alcohol or drug use, and returning to a detox facility or other program that requires abstinence (Steering Committee for the Study Project on Homelessness and Alternative Addiction Treatment 1999).

In summary, during the 1980s and 90s, according to the literature review, increasing numbers of practitioners came to believe that new approaches to substance abuse treatment were desperately

² However, Rozier and Vanasse (2000) point out that drug consumption only became an issue in the 19th century with an increase in users and the perception that this was a threat to productivity and social cohesion and that the era of social tolerance ended with the La Haye international agreement of in the early 1900s. They identify huge increases in policing and prisons as one of the consequences and emphasize that many of the negative impacts of drug abuse (e.g., crime, prostitution, health care costs, overdoses, etc.) stem from the context under which the drugs are used.

needed for individuals who were not prepared to abstain but who might be willing to moderate their use of substances or eventually choose to quit.

Emergence of harm reduction

In parallel to the growing realization that abstinence programs did not work for everyone and that the elimination of use was perhaps not a realistic goal (Rozier and Vanasse 2000), the emergence of HIV/AIDS and the link to drug use through sharing of injection equipment brought the issue of drug use into the realm of public health, with impacts that went far beyond a small and marginalized population. Many countries began to take the public health-based perspective that the dangers of the spread of AIDS among drug users and from drug users to the general population posed a greater threat to health than the dangers of drug use itself (Cheung 2000 and Riley et al. 1999).

Many of these approaches began in Europe, including Switzerland where drug addiction is viewed as a temporary phase in an individual's life, the Netherlands with tolerance of "soft drugs," and the Mersyside approach with the integration of harm reduction interventions and police actions. (These are described below.)

As interest in the harm reduction approach has grown, several conferences have been held since 1990 to address the issue, including one in Toronto in 1994. A goal of the 1999 conference held in San Francisco was to improve standards of care and develop best practice principles to be followed in integrating harm reduction approaches into traditional substance abuse services.

Definition of harm reduction

The literature includes a variety of definitions of harm reduction (Brocato and Wagner 2003, Majoor and Rivera 2003, *Drogues, santé et société* June 2003, Anne Wright and Associates 2002, Cheung 2000, Rozier and Vanasse 2000, Riley et al. 1999, and MacCoun 1998 and Brisson 1997. These can be summed up as follows:

Harm reduction is an approach, strategy, set of interventions, policy or program aimed at reducing the risks and harmful effects associated with substance use, and addictive behaviours, for the person, the community and society as a whole, without requiring abstinence.

One of the Quebec sources (Rozier and Vanasse 2000) speaks of a "hierarchization" of objectives that includes:

- In the short term, reducing the negative consequences of substance use (e.g., needle exchanges);
- In the medium term, moving onto more secure use of substances (e.g., controlled alcohol use, methadone, etc); and
- In the long run, the possibility of eventual abstinence.

Although harm reduction does not require abstinence, it does not rule out abstinence in the longer term either. In fact, harm reduction approaches are often the first step toward the eventual cessation of drug use (Riley et al. 1999 and Allan and Nolte 2001).

One of the main benefits of harm reduction is that it facilitates access to services (Allan and Nolte 2001). With a harm reduction approach, therapy/service is provided even when people continue to use drugs and are unwilling to enter traditional substance abuse treatment programs that require abstinence. A harm reduction approach can enable access to services such as safe housing, health care, psychological help, and safer means of drug use to people who would not normally seek traditional substance abuse treatment.

A key element of harm reduction is to provide a “client-centred” approach to working with people “where they are” rather than “where they should be” as dictated by treatment providers. With this approach, clients are allowed to set their own goals while receiving support and assistance (Denning 2001 and Little 2001).

A literature review of approaches to homeless persons with multiple problems found that the best approach was a client-centred one. Success depended on the ability to respond to different needs and provide individualized services adapted to the daily reality of clients. Flexibility, tolerance and addressing the concrete problems expressed by the persons are also important (Comité aviseur itinérance multiproblématique de la Régie régionale de la Santé et des Services sociaux de Montréal-Centre 1994).

Harm reduction also embodies the concept of “low threshold,” which means removing traditional barriers to treatment that insist on a

commitment to abstinence as a requirement of admission and as the only acceptable goal (Tsui 2000). Examples of “low threshold” approaches to accessing services might include street-outreach, drop-in centres or information groups that allow people who are actively using drugs to take part in treatment activities on site (Marlatt 1996, Little 2001, and Denning 2001). Low threshold programs could also include “wet” shelters or housing that does not require abstinence.

Harm reduction programs can be any program that incorporates harm reduction practices or principles to reduce one’s exposure to harm (Anne Wright and Associates 2002). Examples of some harm-reduction programs that have been well-documented include:

- Needle exchange programs;
- Methadone maintenance;
- Education and outreach programs that tell users how to reduce the risks associated with using drugs;
- Law enforcement policies that place priority on the enforcement of laws against drug trafficking while using a “cautioning” policy toward drug use; and
- Tolerance areas e.g., injection rooms, health rooms, centres where drug users can get together and obtain clean injection equipment, condoms, advice, and/or medical attention.

Clinicians who work with dually diagnosed clients have expressed support for the harm reduction approach. For example, one study that included four focus groups with clinicians who were nominated by their peers as experienced and/or experts in treating persons with substance use and psychiatric disorders found that while abstinence was the preferred goal, they expressed a pragmatic flexibility and other views consistent with the principles of harm reduction (Carey 2000). Some clinicians who work with dually diagnosed individuals have also acknowledged that requiring abstinence as a condition of entering or continuing treatment may be too high a threshold for people who believe that they receive real benefits from drug and alcohol use. These individuals may be willing to enter treatment but not to be abstinent. Reasons for continuing to use drugs and alcohol are often more compelling than reasons to stop. Nevertheless, dually diagnosed clients may be interested in other benefits of treatment, such as attending to their psychological and emotional problems. They may also be interested, as a goal of treatment, in changing or reducing their use of substances (Little 2001).

Some researchers have noted that harm reduction programs are more likely to attract active drug users, to motivate them to begin to make changes in their behaviour, to retain these individuals longer in treatment and to minimize attrition and dropout rates (Cheung 2000).

Literature from Canada

Connection between substance use and homelessness

Several studies in Canada have attempted to determine the percentage of the homeless population with substance use issues. A snapshot of shelter users in B.C. in 1999 estimated that about one-third had substance use issues. Substance misuse, either alone or in combination with other health issues, was the largest single health issue facing shelter clients (32 per cent) followed by mental illness (22 per cent). It was estimated that about 10 per cent of shelter users had both substance use and mental health issues (Eberle et al. 2001).

In urban centres, such as the Vancouver Lower Mainland, Victoria, Ottawa, Calgary, Edmonton and Montréal, it has also been estimated that approximately 30 to 40 per cent of shelter clients have substance abuse issues (Eberle et al. 2001). In Montréal a study of the clientele of 12 facilities dealing with persons with multiple problems found that 85 per cent had mental health problems, 75 per cent were homeless, 65 per cent had problems with alcohol and 53 per cent had problems with drugs. (Comité avisier itinérance multiproblématique de la Régie régionale de la Santé et des Services sociaux de Montréal-Centre 1994).

A review of the literature in Toronto regarding its homeless population found that alcoholism was the most pervasive health and mental health issue among homeless adult males (Springer, Mars and Dennison 1998). Toronto has estimated that up to 20 per cent of its homeless population suffers from severe mental illness and addictions (City of Toronto Mayor's Homelessness Action

Task Force 1999). Substance abuse has also been noted as a significant cause of death among the homeless. Between May and December 1999, the Office of the Chief Coroner in Toronto recorded 27 deaths of homeless people. Alcohol and/or drugs was a contributing factor in 16 of these deaths (City of Toronto 2001).

A report from Toronto cites several reasons why the risk of homelessness is higher for people with substance use issues. People with addictions may become so focused on acquiring and using drug or alcohol that this affects their social and family relationships, ability to work, go to school or manage their finances. The more isolated the person becomes, the greater the effect of the addiction and the faster the decline towards instability and homelessness. People with money, stable housing and supportive family or friends can often maintain stability in their life for long periods of time while being addicted. However, people with addictions who are unemployed, poor or disabled may soon find themselves unable to pay rent and may end up homeless (City of Toronto Mayor's Homelessness Action Task Force 1999).

It has been noted that people with both mental health and addiction problems are disproportionately at risk of homelessness. Some of the issues noted in a Toronto study are that most mental health facilities are unable or unwilling to work with people who have an addiction. At the same time, addiction treatment facilities are not equipped to deal with people with a serious mental illness (City of Toronto Mayor's Homelessness Action Task Force 1999). A Montréal study found that the problem of access to care was especially difficult for 18–25 year olds (Comité avisier itinérance multiproblématique de la Régie régionale de la Santé et des Services sociaux de Montréal-Centre 1994).

Intervention strategies for people who are homeless and substance users

Since the 1970s, abstinence has been the main approach to treatment in Canada (Rozier and Vanasse 2000). Canada's drug strategy focuses on the effectiveness of specific treatment approaches and sets out best practice guidelines to address the needs of various special populations (Roberts et al. 1999). This does not include guidelines for people who are homeless. Nevertheless, some best practice guidelines are recommended for people with co-occurring substance use and mental health problems. Best Practice Guideline 17 provides that:

While evidence is limited, it appears that providing integrated services for people with co-occurring substance use and mental health problems holds more promise than offering services in sequence or parallel. Close liaison and coordination to enhance referral and case management need to occur among the respective specialized services and informal street-level agencies in a community. Training appears crucial, not only for staff of respective specialized services, but also for social services and correctional staff where these clients often present themselves. Excluding people with mental health problems from addictions treatment and excluding those with alcohol or drug problems from mental health treatment should be discouraged. (Roberts et al. 1999)

The best practices report also sets out elements of a substance abuse treatment system that would include the following:

- Information and referral
- Outreach

- Detoxification
- Comprehensive assessment
- Case management
- Outpatient treatment
- Short-and long-term residential treatment
- After-care/continuing care

In terms of addressing homelessness, the National Secretariat on Homelessness has taken a lead role in developing national objectives. The Supporting Communities Partnership Initiative (SCPI) is the largest component of the National Homelessness Initiative. It is based on the premise that communities are best placed to devise effective strategies to both prevent and reduce homelessness locally and SCPI is designed to support communities in building the capacity, resources and incentives to develop and implement comprehensive strategies.

The Secretariat supports a continuum-of-care model to ensure that a full range of services is provided by community agencies to move homeless persons from the street or shelter to a stable and secure life (Raising the Roof 2001). SCPI defines a continuum of supports as "a holistic approach to addressing the needs of homeless individuals within a community plan. It includes all supports and services that would be needed to assist a homeless person or someone at risk of becoming homeless to become self-sufficient, where possible." The continuum includes homelessness prevention services, emergency shelter, outreach, transitional housing and support services. Addiction services are also included in the continuum. Some communities (e.g., Greater Vancouver, SPARC BC 2003) have identified this continuum to include:

- Sobering centres;

- Detoxification facilities;
- Residential treatment;
- Supportive recovery homes,
- Counselling;
- Methadone treatment;
- Needle exchange; and
- Medium-and long-term permanent supportive housing.

Community agencies and individuals have also identified a need for housing that provides alcohol- and drug-free environments to accommodate individuals who are in treatment or recovery. At the same time, a need has been identified for housing where use is permitted, to meet the needs of homeless people who are not ready to enter treatment (SPARC BC 2003 and Raising the Roof 2001).

One of the more comprehensive Canadian studies was that undertaken in Montréal to identify the trajectory of reinsertion of homeless persons who were alcoholic or drug users and to identify the indicators of progress and stabilization from the perspective of the users (Mercier, Corin, & Alaire 1999). Two interviews, nine months apart, were held with both 15 men and 15 women clients of a substance abuse program (which uses a harm reduction approach) and their therapists. The study found that individuals did not identify themselves as homeless but rather the homeless state was indicative of “hitting bottom.” Housing, it was concluded, is the cornerstone for stabilization and its lack reinforces a lifestyle linked to addiction in terms of persons and places visited, and continued investment in drugs/alcohol as a means to deal with very difficult conditions.

The study also found that a structured

environment was essential to stabilization, including elements that ranged from access to therapists to supervised housing, group homes or shared apartments. Indicators of change and stabilization included less frequent relapses, less frequent consumption, shorter relapses, better controlled relapses (i.e., not “demolished” by relapse), and not losing what was gained during a relapse (e.g., housing, friends). The researchers recommended that given the relationship between consumption and housing, housing stabilization should be prioritized and provided early on in the intervention. Nonetheless there is a need for other support, including budget management, occupation of time and space (i.e., need to replace consumption activity) and development of a relationship to a significant person (e.g., therapist).

Harm reduction approaches and housing

Literature from several communities across Canada indicates a growing interest in using a harm reduction approach to address the needs of homeless substance users. For example, working groups have been established in both Ottawa and Toronto. In Ottawa, the Working Group on Addictions in the Homeless Population produced a background paper to support the development of a continuum of services for homeless persons with addictions, based on a harm reduction model. One of the recommendations calls for decreased reliance on shelters by increasing progressive housing options from transitional to supportive housing with an emphasis on achieving permanency (Allan and Nolte 2001).

In Toronto, the Harm Reduction Facilities Working Group developed a “continuum model” to describe facilities that use harm

reduction principles, including shelters, drop-in centres and housing (City of Toronto 2001). In addition, the Steering Committee for the Study on Homelessness and Alternative Addiction Treatment produced a report *From the Revolving Door to the Open Door*. This research project included a community forum, literature review, individual interviews and focus group discussions with service users and providers and an educational forum. One of the key findings was that “without exception, study participants identified affordable housing, including supportive housing, transition housing and co-operative housing, as the top priority in helping people control and overcome substance use.” The report recommended that a harm reduction facility be established on a pilot project basis for people who are homeless and substance users. Other key recommendations called for:

- Integrating harm reduction approaches into traditional drug and alcohol treatment programs;
- Improving detoxification services;
- Expanding and providing alternative services for substance users, such as healing circles, learning circles, art therapy and acupuncture;
- Expanding and establishing new community economic development programs to improve job skills and increase employment opportunities for people who are homeless;
- Improving accessibility to services;
- Changing policies and attitudes to drug use; and
- Building partnerships to provide for better linkages among agencies and services to meet the multi-faceted needs of people who are homeless and substance users.

There appears to be growing interest in Canada to provide emergency shelters using a harm reduction approach. **The Seaton House Annex**

Harm Reduction Program is a “wet” shelter program that provides a safe place to stay for men who usually avoid the shelter system and social service sector due to alcohol or dual diagnosis issues. The mandate is to provide an “exceptionally tolerant and low-demand environment,” known as a harm reduction approach. The shelter is open from 8 p.m. to 8 a.m. and has room for 38 to 40 men per night. The men store their bottles when they come in and take them when they leave. If needed, they are able to have a drink during the night. All non-palatable alcohol is exchanged for wine or sherry provided by the shelter. A methadone program is also available. This shelter avoids the situation where men would either sleep outside because they didn’t want to give up their bottles, or would drink an entire bottle before arriving at the shelter.

In Ottawa, the Inner City Health Project also offers a range of harm reduction programs. Working with three main residential sites, services range from a hospice providing palliative care (the Union Mission), convalescence care for adult men (the Salvation Army Booth Centre), and the Management of Alcohol Program (the Shepherds of Good Hope), which has 20 beds for adult men and women with additional health needs. This latter project, for “chronic alcohol” clients, serves a limited amount of homemade wine that is increasingly diluted so that the amount of alcohol served is reduced gradually over the long term. Support is provided to obtain health and medical care. The agency also offers counselling, encourages clients to get involved in community activities, renew family ties, participate in day programs and create new relationships in the community (National Homelessness Initiative website).

Community groups in other cities, including Halifax, Peterborough and Victoria, have also conducted research and expressed interest in

providing shelters that incorporate a harm reduction approach.

A number of other projects with a harm reduction approach or one not requiring abstinence were identified in a recent CMHC study (Serge and Gnaedinger 2003). Some, like the Pioneer Inn in Whitehorse, allow residents to continue to consume alcohol on the premises (about half of the clients have alcohol use problems), while others such as the Hospice for the Homeless operated by the Union Mission in Ottawa or the Seaton House Infirmary in Toronto have explicit harm reduction philosophies.

The literature identified a few initiatives in Canada that promote access to and maintenance of stable housing. Some of these specifically report that they are using harm reduction, while other initiatives are consistent with harm reduction objectives.

The **Portland Hotel** in Vancouver provides transitional housing (without time limits) to individuals who are considered hard to house. The primary objective is to create stability for tenants who need support because of mental illness, substance use, affordability problems or any other reason. The Portland's approach to their tenants is based on a harm reduction model. The staff operate under the assumption that eviction is a last option. The Portland has achieved measurable success stabilizing residents housing. The average length of stay for about 35 to 40 per cent of the residents is 10 years. For the remaining tenants, the average length of stay is two to four years.

Also in Vancouver, the **Dual-Diagnosis Assertive Community Outreach Team** was an initiative that operated for six months from November 2001 to May 2002. It was funded by the federal government through SCPI and by the Vancouver Coastal Health Authority. Four outreach workers provided comprehensive outreach services to 50 homeless/at-risk individuals, at least 30 of whom had a dual diagnosis of mental illness and substance use. The goal was to enable chronically homeless/at risk individuals with a dual diagnosis of mental illness and addictions to acquire and retain safe, affordable and stable housing and receive appropriate treatment. Through this intervention, better housing was found for almost all clients.

One of the lessons learned from this initiative was that the Assertive Community Treatment (ACT) model provides a more effective framework for working with this population than do generalist outreach approaches. The intensity of involvement, consumer-oriented philosophies and shared case management responsibilities were found to be indispensable components of an effective, creative and stable service delivery. Another finding was that appropriate housing plays a critical role in the stabilization, quality of life and initiation of treatment for homeless dually diagnosed individuals. In addition, there is a need for specialized housing that can meet the needs of this group without requiring lifestyle changes. The housing needs to be designed to accept the client as they are (Triage Emergency Services and Care Society 2002).³

3 Triage Emergency Services and Care Society received additional funding to continue this project for a 12-month period from April 1, 2004 to March 31, 2005.

In Ottawa, the Canadian Mental Health Association (CMHA) received SCPI funding for its Direct Services Program. The goal of this program was to prevent and end homelessness among persons with serious mental illnesses, many of whom also had substance use issues, by creating stable community living situations. Program objectives were to help clients obtain and maintain appropriate community housing of their choice, divert clients from the criminal justice system through treatment and follow-up in the community and provide clients with individualized long-term support according to their own priorities and needs. These objectives were met primarily through casework and client advocacy by social workers, and secondarily by referrals to other agencies. As a result of this program, 80 per cent of the clients who were housed were able to retain their housing for six months or more. One of the lessons learned was that the ‘housing first’ model was effective. The provision of stable and appropriate housing for persons with serious mental illness significantly increased their ability to function, and provided a stable base for their lives and for obtaining various kinds of assistance. Another lesson learned was that working with both non-profit and private sector landlords was an important part of stabilizing housing for this population (Raising the Roof, Shared Learnings on Homelessness).

Literature from the United States

Connection between substance use and homelessness

In the U.S., it has been estimated that about 30–40 per cent of homeless persons abuse alcohol and another 10–15 per cent abuse drugs (McCarty 1991). It has also been estimated that about one-third of people who are homeless have serious mental illnesses and that between 50 and 70 per cent of homeless adults with serious mental illness have a co-occurring alcohol or other drug use disorder (Rickards et al. 1999, Conrad 1993, Tsemberis et al. 2003, and Gulcur 2003). It has also been estimated that about 10–20 per cent of homeless people in the U.S. are dually diagnosed (National Health Care for the Homeless 1998).

It has been suggested in the literature that the relationship between abuse of alcohol and drugs and homelessness is bi-directional. “Although alcohol and drug abuse can increase the risk of homelessness, displacement and loss of shelter can also increase the use and abuse of alcohol and other drugs” (Rickards et al. 1999).

Individuals with a dual diagnosis are believed to be among the most visible and vulnerable of the homeless population (National Health Care for the Homeless 1998). For them, the connection with homelessness is believed to be quite direct. The literature reports that people with a dual diagnosis are most at risk of becoming homeless (Tsemberis and Eisenberg 2000). They have been found to have greater rates of psychotic symptoms, non-compliance with treatment, psychiatric hospitalizations, higher rates of

relapse and violent, disruptive behaviour, than persons with mental illness only, which makes it difficult for them to access housing and easier for them to lose their housing. Frequent and long periods of hospitalization may also result in a loss of housing, particularly in areas where there is a shortage of affordable housing and waiting lists are common. Another problem is that persons with dual diagnoses may be unable to manage income or benefits, particularly if such funds are used to purchase drugs or alcohol.

Once they are homeless, and because of their disability, it is extremely difficult for individuals with a dual diagnosis to access fragmented treatment services, benefits and housing. Most clients are unable to navigate the separate system of mental health and substance abuse treatment. Often they are excluded from services in one system because of the other disorder and are told to return when the other problem is under control. The result is that they are more likely to remain homeless than other subgroups of homeless persons (Dixon and Osher 1995, Drake et al. 2001, Drake et al. 1997, and Rickards et al. 1999).

Intervention strategies for people who are homeless and substance users

Demonstration Programs in the U.S.— lessons learned

In the U.S., the Stewart B. McKinney Homelessness Assistance Act, 1987 provided the legislative framework for the first comprehensive federal initiative to help protect and improve the lives and safety of homeless people. Section 613 authorized the National Institute on Alcohol Abuse and Alcoholism (NIAAA), in consultation

with the National Institute on Drug Abuse (NIDA) to establish a demonstration program for homeless persons with alcohol/or drug problems, (formally known as the NIAAA/NIDA Community Demonstration Grant Projects for Alcohol and Drug Abuse Treatment of Homeless Individuals). One of the goals was to systematically assess the nature and effectiveness of a variety of interventions through site-level outcome evaluations and a national evaluation of the full demonstration program.

The first set of initiatives funded through the demonstration program received \$9.2 million in the fiscal year 1988 and an additional \$4.5 million in 1989. The purpose of the program was to:

- Decrease levels of alcohol and/or other drug use;
- Increase co-operation and formal linkages among alcohol treatment, drug treatment, and other supportive services for the target population;
- Improve access to shelter and housing (including alcohol- and drug-free living environments);
- Enhance economic status; and
- Improve quality of life.

Grants were awarded on a competitive basis to nine projects. Each program was different, depending on community needs and the target population to be served. Services included outreach, sobering-up stations, detoxification, residential services, housing and case management. The development of alcohol- and drug-free housing was emphasized in all project cities and each program recognized that the greatest need among the homeless was having a safe place to live (Stahler and Stimmel, eds. 1995, McCarty et al. 1990, Kraus 2001).

In 1990, NIAAA/NIDA funded 14 new projects with varying target populations and intervention strategies. This program's mission was also to support and evaluate the effectiveness of interventions for homeless persons with alcohol and other drug problems. (Stahler and Stimmel, eds. 1995). The primary goals of the program were to:

- Reduce the consumption of alcohol and other drugs;
- Increase levels of shelter and residential stability; and
- Enhance the participants economic or employment status.

In reviewing the various demonstration projects, Conrad states that the traditional substance abuse provider response is that if they can get the addiction under control, "it will buy the needed time" to address other problems, such as housing and income (Conrad 1993).

However, an alternative view presented in a program for substance users in Seattle was that while the individual's addiction was an important problem, his/her homelessness status was more critical and needed to be dealt with before treating the addiction, and "must be handled in an unconditional manner (i.e., housing and other services must continue regardless of the client's drinking or treatment status)." (Conrad 1993).

Some of the key findings or lessons learned from the two demonstration programs were that:

- Treatment programs need to focus not only on addiction but must also address the tangible needs of homeless clients, particularly housing, income support and employment.
- It is extremely difficult to help most of the chemically dependent homeless without providing them with a secure, comfortable and supervised place to live. For individuals in treatment, that place must be supportive of sobriety (Conrad 1993).
- A major barrier to the success of the projects is the lack of permanent housing available to the poor even if the goals of sobriety, employment and improved mental health have been achieved.
- For independence to be maintained, it is necessary to have established an income through employment and/or benefits.
- Maintaining sobriety usually requires participation in self-help groups and/or ongoing participation in program activities. These interventions facilitate the development and ongoing maintenance of a continuum of treatment and recovery services and a spectrum of housing services in the community.
- One of the most important client variables for successful treatment is the level of the participant's motivation and readiness for treatment (Stahler and Stimmel eds. 1995).
- Since motivation for treatment seems to be positively related to retention and outcomes, there is a need to develop flexible, low demand interventions that can accommodate clients who are not willing initially to commit to more extended care. It is hoped that clients can be gradually brought into more intensive treatment when their motivation increases (Stahler and Stimmel eds. 1995).
- Treatment outcomes appear to be particularly positive after treatment, but seem to diminish over time.

In summary, a review of all the demonstration programs did not find a “silver bullet” to address the needs of homeless people with addictions. Particularly troubling was the finding that the positive outcomes from treatment seemed to diminish over time. As one book reviewer stated: “There is much food for thought in the accounts, but taken as a whole, this expensive programme is curiously frustrating. At the end of it all there is simply not a strong enough sense that real practical progress has been made showing effective ways of tackling the dual problem of homelessness and substance abuse.” (Cook 1999).

In 1996, the Center for Mental Health Services and the Center for Substance Abuse Treatment in the U.S. launched a two-phased, three-year initiative to document and evaluate the effectiveness of homelessness prevention interventions for adults with serious mental illnesses and/or substance use disorders who are formerly homeless or at risk of homelessness.⁴ One of the main questions to be addressed was the relative effectiveness of alternative models for preventing homelessness in the target population (Rickards et al. 1999). Several significant risk factors were identified as pathways to homelessness for persons with psychiatric and/or substance use disorders.

⁴ The name of this program was Cooperative Agreements for CMHS/CSAT Collaborative Program to Prevent Homelessness.

These included:

- Housing instability or eviction from housing (loss of housing);
- Poor management or misuse of financial resources;
- Exhaustion of the family support system and the lack of family respite services;
- Ineffective linkage to community-based treatment, housing and support services for individuals exiting institutional systems;
- Inappropriate and/or insufficient services; and
- Lack of systems integration.

Identification of the pathways to homelessness led to the development of conceptual strategies to address causes and risks as follows:

- Service-based treatment approaches: psychotherapy, cognitive therapy, group therapy, assertive community treatment (ACT) and case management approaches.
- Service-based support approaches: skills training, family support and respite care services, representative payee programs, socialization programs and job training preparation
- Structural interventions: jail diversion programs, improved access to services (e.g., improved discharge planning or service integration activities) and housing and support services (Rickards et al. 1999).

Eight projects were funded under this homelessness prevention program. They focused on three broad prevention approaches: housing, resource management and representative payee interventions and family education and respite care (Hanrahan et al. 1999). The program

identified the following critical components in preventing homelessness:

- Provision of a range of affordable, safe housing options;
- Flexible case management with varying degrees of intensity;
- Links to mental health and/or substance abuse treatment;
- Money management; and
- A range of community support services.

A series of articles was written describing each of the initiatives two years after the project was first implemented (Hanrahan et al. 1999). At that time, however, the amount of information available made it premature to evaluate any outcomes.

Approaches for successful interventions

General approaches

The literature from the U.S. points to several themes about what is needed to promote access to and maintenance of stable housing options for people who are homeless and who have addictions or “concurrent disorders.” One recent study conducted for the National Health Care for the Homeless Council, which included a review of the literature and case studies of six different programs that provide “model” treatment to homeless people with substance related disorders concluded that “effective treatment for homeless people with substance use disorders appears to be fundamentally related to providing comprehensive, highly integrated, and client-centred services, as well as stable housing.” (Kraybill et al. 2003).

Key elements of a successful strategy are described below.

1. **Comprehensive services.** For people experiencing homelessness, substance use disorders cannot be treated apart from the concerns of the whole person. Comprehensive services are needed to address the full range of people's needs, including food, shelter and services. This includes outreach, drop-in services, substance use treatment, health care, skills training, nutrition education, budgeting skills, housekeeping, hygiene, vocational education, family support, socialization, adequate income, employment services and housing.

In response to the need for comprehensive services, several umbrella organizations administer multiple programs in a coordinated and integrated manner. For example, the Larkin Street Youth Services in San Francisco began as a simple drop-in site for homeless youth in 1984. Over time, in recognition of the scope of client need and significant service gaps in the mainstream system, this organization developed a comprehensive array of services internally and worked to establish strong external links with relevant services in the community (e.g., shelters, clinics, welfare agencies, legal aid, hospitals and jails.) (Kraybil et al. 2003).

Central City Concern in Portland, which was created in 1979 to address homelessness and drug and alcohol addictions, has since developed a variety of programs including a range of housing, addiction services and employment initiatives (B.C. Ministry of Social Development and Economic Security and Ministry of Municipal Affairs 2000).

Project HOME in Philadelphia is another program that uses a combination of prevention strategies, including street outreach, three levels of housing, extensive on-site services (education, employment, health care, addictions counseling, and social activities) and links to other services (Coughey et al. 1999).

2. **Access to housing.** Stable housing is nearly always central to attaining treatment goals. Individuals living in appropriate housing are more likely to be successful in treatment. Clients may move initially into some kind of transitional housing and later on seek permanent housing. This would include alcohol- and drug-free housing for people who need safe and sober housing to continue a successful recovery after detox and treatment, as well as other affordable options.
3. **Client-centred approach.** Refers to individual treatment based on the client's needs, wishes, capacities, and timeframe rather than on the program's predetermined benchmark for client outcomes. This approach can also be referred to as "meeting the person where they are at." It involves working collaboratively with clients to set goals and plan treatment program, and can be consistent with a harm reduction approach.
4. **Uniquely qualified staff.** The relationship between staff and client is critical to treatment success. Building a relationship is unanimously considered the first and most important step.
5. **Case management.** A number of initiatives to address homelessness among people with addictions have involved various forms of case management. Case management can include the following services (Morse 1999):

- Client identification and outreach;
- Assessment;
- Planning—to develop a treatment and service plan;
- Linkage to services, treatment and support systems;
- Monitoring; and
- Client advocacy—to help clients access services.

The literature describes several types of case management. Most of these approaches have been used in working with homeless people with serious mental illness. The Assertive Community Treatment (ACT) model differs from other case management approaches because it emphasizes direct treatment and services, shared caseloads and use of an interdisciplinary team that includes specialists such as psychiatrists and nurses. ACT has been adapted in various ways to be relevant for people who have a mental illness and who are homeless. These adaptations include assertive outreach, engagement strategies, and an increased emphasis on clients' resource and housing needs. According to the literature, research on the ACT model has yielded consistent results indicating that it is effective for helping homeless clients with severe mental illness to achieve stable housing (Morse 1999).

Approaches for individuals with a dual diagnosis

A great deal of the literature is focused specifically on strategies to address the needs of homeless individuals with co-occurring mental health and substance use disorders. The literature supports the view that special strategies are needed for this population. Studies of dual diagnosis interventions in the 1980s which examined

the application of traditional substance abuse treatments, such as 12-step programs, to clients with mental disorders within mental health programs had disappointing results. Some of the reasons given for this are that 1) the clinical programs did not take into account the complex needs of this population, and 2) early programs often failed to incorporate outreach and motivational interventions. Demonstration programs in the 1990s that incorporated assertive outreach, long-term rehabilitation and motivational interventions that helped clients who did not perceive or acknowledge their substance use or mental illness problems began to show better outcomes (Drake et al. 2001).

One of the key approaches to providing services for individuals with a dual diagnosis is to provide for the integration of mental health and substance use services.

Integrated services. Historically, substance use treatment services for homeless people have been offered either sequentially or in parallel. Sequentially would mean that services are offered one after another. For example, clients might be told they must receive treatment for their substance use disorder before they could be treated for their mental illness, or vice versa. In a parallel approach, clients receive services from two or more systems simultaneously (Kraybil et al. 2003).

Integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance use interventions in a coordinated fashion. The caregivers take responsibility for combining the interventions into one coherent package. There is no need for the client to negotiate with separate clinical teams or programs (Drake et al. 2001 and Meisler et al. 1997).

Integration also means focusing on skills training that emphasizes the importance of developing relationships and avoiding social situations that could lead to substance use.

A study of the Access to Community Care and Effective Services Supports (ACCESS) program, a five-year, 18-site demonstration program sponsored by the Center for Mental Health Services found that the integration of services was related to improved access to housing services. The purpose of the program was to test strategies that encourage cooperation among agencies. Data from 1,340 clients showed that service system integration was significantly related to improved access to housing three months after program entry, and to the achievement of independent housing 12 months after program entry (Rosenheck 1998).

Integrated programs that incorporate the following components have been found to achieve positive outcomes in domains such as substance use, psychiatric symptoms, housing, hospitalizations, arrests, functional status and quality of life.

1. **Staged interventions.** Effective programs incorporate the concept of stages of treatment:

- Engagement—forming a trusting relationship;
- Persuasion—helping the client develop the motivation to become involved in recovery-oriented interventions;
- Active treatment—helping the motivated client acquire skills and supports for controlling illnesses and pursuing goals; and
- Relapse prevention—helping clients in stable remission develop and use strategies for maintaining recovery.

2. **Assertive outreach.** Many clients with dual diagnosis have difficulty linking with services and participating in treatment. Effective programs engage clients and members of their support system by providing assertive outreach, usually through some combination of intensive case management and meetings in the client's residence. Homeless persons with dual diagnosis have been found to benefit from outreach, help with housing and time to develop a trusting relationship before participating in any formal treatment. It is also believed that if clients can access services and maintain needed relationships with a consistent program over months and years, this will help to support treatment initiatives (Drake et al. 2001).

3. **Motivational interventions.** Most dual-diagnosis clients have little readiness for abstinence-oriented treatment. Many also lack motivation to manage their psychiatric illness and pursue employment or other goals. Effective programs incorporate motivational interventions to help clients become ready for more definitive interventions to manage their illness. Motivational interventions involve helping individuals to identify their own goals and to recognize that not managing one's illness interferes with attaining those goals (Drake et al. 2001).

4. **Counselling.** Once clients are motivated to manage their own illnesses, they need to develop skills and supports to control symptoms and to pursue an abstinent lifestyle. Counselling can take different forms and formats such as group, individual, or family therapy or a combination (Drake et al. 2001).

5. **Social support interventions.** Effective programs focus on strengthening the immediate social environment. These activities recognize the role of social networks and family interventions in recovery from dual disorders (Drake et al. 2001).
6. **Long-term perspective.** Effective programs recognize the recovery tends to occur over months or years in the community. People with severe mental illness and substance abuse do not usually develop stability and functional improvements quickly, even in intensive treatment programs. Instead, they tend to improve over months and years in conjunction with a consistent dual-diagnosis program. Effective programs therefore take a long-term, community-based perspective that includes rehabilitation activities to prevent relapse and to enhance gains (Drake et al. 2001).
7. **Comprehensiveness.** Learning to lead a symptom-free, abstinent lifestyle that is satisfying and sustainable often requires transforming many aspects of one's life—e.g., habits, stress management, friends, activities, and housing. Therefore, in effective programs, attention to substance use as well as mental illness is integrated into all aspects of the existing mental health program and service. Inpatient hospitalization, assessment, crisis intervention, medication management, money management, laboratory screening, housing and vocational rehabilitation incorporate special features that are tailored specifically for dual-diagnosis patients (Drake et al. 2001).
8. **Representative payee programs** have been seen as particularly effective for people with dual disorders as a way to stop the cycle of

homelessness and drug use by ensuring the rent is paid. (Dixon and Osher 1995.)

Housing Issues

Housing plays a critical role in addressing substance use issues for people who are homeless. Not only has housing been identified as a cornerstone in providing treatment, affordable housing is also essential following treatment. There is also growing evidence that supported housing is essential *regardless* of treatment. The literature also suggests that there is a need for a full range of housing options to accommodate individuals with different needs. These options include:

Alcohol-and drug-free housing for men and women with a history of addiction who want safe and sober housing to continue with successful recovery after detox and treatment. This form of housing often provides self-help and peer support and can promote and support recovery (McCarty 1991).

Supportive housing involves the provision of subsidized housing with supportive services. According to the National Health Care for the Homeless Council, supportive housing has become “the gold standard for helping individuals with disabilities who are chronically homeless achieve residential and psychiatric stability and sobriety” (National Health Care for the Homeless Council 2003).

The term “supportive housing” refers to a broad range of housing options linked to a variety of support services. It may be scattered-site or congregate; “housing ready” or “housing first;” “wet,” “damp” or “dry;” transitional or permanent (National Health Care for the Homeless Council 2003).

Wet/Damp housing. During the mid 1990s, it was noted that most housing options sponsored by mental health or substance abuse providers were “dry” housing, or housing where alcohol and drug use is prohibited. However, practitioners became concerned about the need to provide housing for people who were not willing or able to maintain sobriety or abstinence. It was noted that if such individuals did not have adequate housing, then there would definitely be no hope of addressing the addiction. Practitioners began to suggest that perhaps a continuum of care should provide for degrees of dryness. It was suggested that “wet” housing, or housing in which the use of drugs and alcohol is tolerated may be the only housing choice acceptable to the patient in the early phases of engagement and treatment. Some called for “damp” housing, where abstinence would be expected on the premises, but clients would not be required to be abstinent off site (Dixon and Osher 1995).

It was suggested that a continuum of housing could be conceptualized in terms of either the level of expectation for program participants or phases of treatment (engagement, persuasion, active treatment and relapse prevention). At one end of the housing continuum could be shelters and other safe havens that are tolerant of use, while towards the other end of the continuum could be stronger expectations and limits.

Although the concept of wet housing may be controversial within traditional chemical dependency settings, proponents argue that all clients have a right to decent, safe housing and that treatment should be a second-order consideration. They believe low-demand settings may at least reduce morbidity and permit the development of trusting relationships (engagement) so that residents can be persuaded to participate in treatment (Drake and Osher 1991).

Harm reduction and housing

This literature review found one author who specifically addressed the application of the harm reduction concept to housing (Denning 2000). Early in 1998, the author was invited to provide training and consultation in harm reduction to a number of agencies in San Francisco that provide housing and services for people with HIV. These programs received funding from the federal Housing and Urban Development Department (HUD) under legislation entitled “Housing Opportunities for People with AIDS” (HOPWA). HOPWA agencies were not treatment facilities, but housing with support services. The Community Substance Abuse Services of the Department of Public Health mandated that these programs include harm reduction strategies. The San Francisco Redevelopment Agency, with funding from the Corporation for Supportive Housing provided leadership for this venture. Over a period of four months, the author worked with 12 different housing agencies, ranging from an eight-bed skilled nursing facility to a 45-bed support services facility in the heart of a drug-ridden inner-city area.

Many of the programs had originally been set up to provide “clean and sober housing,” and people came to live there expecting support for their sobriety. Most resident intake sheets stated clearly that no drug or alcohol use would be permitted under penalty of eviction.

The author helped these organizations redesign their mission statements to be consistent with the harm reduction philosophy. New goals were set to promote healthy activities without punishing people for their drug problems by forcing them out of their homes. This approach reflects the understanding that some people will

at times use drugs or alcohol even when they are attempting to remain abstinent.

One of the key elements in introducing a harm reduction approach was for program members, staff and residents to reorient their thinking to focus on disruptive behaviours rather than drug use itself as the basis for rules and interventions. This approach respects the residents' rights to make choices about their drug use while at the same time minimizing harm to the community. Examples of rules that would focus on behavior include 1) Do not knock on someone else's door after 10 p.m. And 2) Do not offer to sell drugs to another resident.

One of the key aspects of introducing a harm reduction approach was to consult with the residents. Some of their concerns related to drug use included:

- Not wanting other residents to borrow money from them;
- Being angry when someone obviously high on speed could not sit still in the television room or changed the channel without asking; and
- Being disturbed when wakened by someone coming in late at night.

In addition, some residents did not want to be in the same house with drug users, fearing that negative behaviours couldn't be controlled or that their own cravings would be triggered.

As a way to deal with these issues, the author recommended that intervention strategies be developed to address disruptive behaviours associated with drug use. One suggestion was to isolate the resident in his or her room if necessary and to have a "debriefing" session as soon as possible. The purpose of the talk would

be to help the resident articulate why he or she used drugs at that particular time and to supply the user with information about what behaviours were disruptive. The point of developing these strategies was so that even if residents could not control someone else's drug use, they could be reassured that it would not go unnoticed and that staff were actively involved in solving the problem.

The author reported that residents saw some advantages of this approach compared to the abstinence framework. One of the reasons was that although residents understood that their housing agreement required them to be abstinent, the general attitude of many was "live and let live." Many of them had at times been homeless or had lived in substandard, unstable housing and understood implicitly the threat of eviction and its enormous consequences. Residents were generally unwilling to report drug use to staff if this might result in someone being evicted. However, once they understood that under the new harm reduction policy no one would be evicted just for drug use, they began to see possibilities for more active involvement in monitoring other residents' behaviour

The author concludes that there is a clear need for a full range of housing opportunities. While moving in the general direction of harm reduction will help to reduce the incidence of homelessness in some groups of people, there will continue to be residents who use drugs and those who do not, those who are relatively tolerant and those who feel intensely threatened by drug activity near them. Since harm reduction is basically a philosophy of inclusion and choice, it is necessary to offer a full choice of programs, some of which are more abstinence-oriented than others. The key is to communicate the culture of each particular program to prospective

residents prior to their moving in by reviewing typical house policies regarding behaviour.

Another program, provided by Pathways to Housing in New York, also uses a harm reduction approach with regard to housing. Housing can be obtained even if abstinence is an unmet goal, and a relapse does not result in loss of housing (Tsemberis et al. 2003).

Continuum of care model and “housing first”

The predominant and more traditional approach to housing homeless individuals with severe and persistent mental illness in the U.S. has been an approach that follows a continuum of care. Individuals are expected to become more engaged in abstinence as they move along the continuum.

Outreach is typically the first step in an engagement process intended to encourage clients who are homeless and mentally ill to accept a referral for the next step along the continuum. The second step includes a wide range of programs, such as drop-in centres, shelters and safe havens where clients can remain indoors for a specified period of time, obtain meals, a place to sleep, and receive case management services that help with entitlements and access to psychiatric or substance abuse programs. One of the objectives of second step programs is for clients to become “housing ready”—i.e., Able to meet the criteria of housing providers to comply with psychiatric treatment and to maintain sobriety. Enrolment in a residential program is also contingent on abstinence from alcohol and drugs and participation in mental health treatment, which are seen as “housing readiness.”

The third point in the continuum is housing. The expectation is that clients will “advance” to more independent, less supervised and less restrictive settings as they master the appropriate skills required at their current placement. The housing continuum generally starts with a series of congregate living arrangements with varying levels of on-site support before graduating to independent living arrangements. Examples of different levels could include a halfway house, supervised apartments and independent living (Dixon and Osher 1995 and Tsemberis et al. 2003).

Although the continuum of care approach has brought many homeless individuals indoors, others remain on or return to the street. This model has been criticized for several reasons (Tsemberis 2003, Dixon and Osher 1995 and Gulcur 2003):

1. Service providers have pointed to difficulties in engaging individuals with dual diagnoses for services.
2. The requirement that individuals change housing as they “progress” through the continuum may be counterproductive, even causing symptomatic relapse. It is stressful and taxing for consumers to repeatedly develop working relationships with new service providers along each step of the continuum. Stress can also result from congregate living.
3. Many consumers prefer to live in independent housing and have complained about the institutional qualities of many treatment-oriented housing settings and the fact that consumer choice or preference may be ignored (Dixon and Osher 1995). Some researchers have suggested that choice in housing and treatment, which has been associated with greater housing satisfaction and improved housing stability, may be critical to engagement and retention (Gulcur 2003).

4. Skills learned for successful functioning at one type of residential setting are not necessarily transferable to other living situations. More recent research suggests that the most effective way to teach a person the skills required for a particular environment is in that environment.
5. It takes a substantial amount of time for clients to reach the final step on the continuum.
6. Individuals who are homeless are denied housing because placement is contingent on accepting treatment first (Tsemberis and Eisenberg 2000).
7. There is no data on how rapidly a given individual should progress through the phases, so time limits may seem arbitrary and a step-wise progression may not mirror the client's clinical course.

The “housing first” model is an alternative to the continuum of care. In this model, housing is viewed primarily as a place to live, not to receive treatment. Central to this idea is that consumers will receive whatever individual services and assistance they need to maintain their housing choice. Proponents of this model emphasize that it facilitates normal community roles, social integration, and increased independence and control for the client (Dixon and Osher 1995, Tsemberis and Asmussen 1999 and Tsemberis et al. 2003).

According to Pathways to Housing in New York, as of 1999, it was the only organization in the U.S. to offer “homeless street dwelling individuals with dual diagnosis immediate

access to independent apartments” (Tsemberis and Asmussen 1999). Pathways provides housing to individuals rejected by other housing programs due to the refusal to participate in psychiatric treatment, active substance use, histories of violence or incarceration and other behavioural or personality disorders. All clients are offered immediate access to permanent independent apartments of their own. Housing is not connected to treatment. Consumers who are active substance users are not excluded from housing and consumers who relapse while housed are considered in need of treatment, not eviction to a more supervised setting. Housing can be maintained as long as consumers meet the terms and conditions of their leases. This model is called “housing first” because the program provides clients with housing first—before other services are offered.

Clients enter the Pathways program directly through outreach staff or referrals from the city's outreach teams, drop-in centres or shelters. When clients are admitted, staff help them obtain an apartment, execute a lease, obtain furnishings and move in. Most of the apartments are owned and leased by private landlords.

Support services are provided through a multi-disciplinary Assertive Community Treatment (ACT) team. These services address housing issues, money management, vocational rehabilitation, mental health and substance abuse treatment, and other issues. The goals are to meet basic needs, enhance quality of life, and increase social skills and employment opportunities. The majority of services are provided to tenants in their homes and communities. Staff are available 24 hours a day, seven days a week. Unlike traditional ACT models, clients are able to determine the type and intensity of services they receive.

Pathways follows a harm reduction philosophy to address the complex needs of individuals with dual diagnosis. This includes helping individuals move from high to low drug use and from high risk to low risk behaviours. A harm reduction approach also means that housing can be obtained even if abstinence is an unmet goal, and that relapse does not result in loss of housing (Tsemberis et al. 2003). The program has two requirements for their clients: they must contribute 30 per cent of their monthly income towards rent by participating in a money management plan and they must meet with a staff member at least twice a month. These criteria are applied flexibly so that clients are not denied housing on the basis of their refusal to comply.

Studies have been done to evaluate the effectiveness of the Pathways program. In one study, the housing retention rate of the Pathways supported housing program was compared with rates of other New York City agencies operating residential treatment programs according to the continuum mode. The Pathways sample consisted of 241 clients who were housed at some point between January, 1993 and Sept. 30, 1997. The study found that 88 per cent of the Pathways tenants remained housed, whereas only 47 per cent of the residents in the city's residential treatment system remained housed. The study also found that after clients are housed, they are much more likely to seek treatment for mental health problems and substance use voluntarily. More than 65 per cent of the Pathways tenants in the sample were receiving treatment from the program's psychiatrist. Twenty-seven per cent of the tenants were employed at least part-time during 1997.

Another recent study compared the Pathways program with a control group that used the continuum of care model. A total of 225 participants recruited from the streets and hospitals were randomized into two groups. A total of 126 participants were assigned to the control group that used the continuum of care model and 99 participants were assigned to the experimental group who then entered the Pathways Housing First model. The results showed considerable success for the Housing First program in reducing both homelessness and psychiatric hospitalization for homeless individuals with mental illness. Participants who were randomly assigned to the Pathways Housing program were housed earlier and spent more time stably housed than those in continuum of care programs. The Housing First group also spent fewer days hospitalized as compared to individuals assigned to programs in the continuum of care over the 24 months of the study.

The sustained success of the Housing First program over the full two years of the study is considered to have significant implications for interventions designed to reduce homelessness among individuals with psychiatric disabilities and substance use issues. The individuals were not required to abstain from substance use or to participate in psychiatric treatment, although such treatments were made readily available to all interested participants. Supporters of the continuum of care model have been concerned that giving homeless individuals apartments directly from the street before they were "housing ready" was essentially setting them up for failure. The present study provided no evidence of that. It was also noted that ironically, individuals who use substances or engage in disruptive behaviour may be more easily housed in private apartments than in congregate settings where their behaviour directly impinges on others (Gulcur 2003).

The evaluations of the Pathways program suggest that interventions that offer housing first and focus on client choice, by eliminating treatment requirements, remove barriers to program entry and thereby successfully engage the chronically homeless population. Furthermore, the findings demonstrate that literally homeless individuals who use substances and have histories of psychiatric hospitalization can remain stably housed in independent apartments with support services (Gulcur 2003).

The Housing First approach appears to be gaining momentum in the U.S. The National Alliance to End Homelessness has created a Housing First Network to provide information and support among those interested in implementing this approach in their communities (National Alliance to End Homelessness). This approach was originally used for families who faced significant barriers to accessing housing, however, the idea is now being applied to individuals with a wide range of issues and disabilities. Pathways to Housing in New York was the first organization to use this approach for individuals with psychiatric disabilities and addictions.

Literature from Europe

Connection between substance use and homelessness

There is general consensus among European studies that a strong link exists between homelessness and substance abuse. The relationship between the two is acknowledged, however, “cause and effect have proved difficult to disentangle” (Fountain, Howes, and Strong 2003). Homelessness can be seen as a consequence of drug use, for example, “a stage in the life of a user that is associated with the loss of control of one’s use” (Coumans and Spreen 2003) but while “intensive drug use is a posited, potential risk factor for becoming homeless...once homeless they use more drugs” (Lempens, van de Mheen, and Barendregt 2003). Drug use has also been found to be a method of coping with homelessness, “dampening pain, lifting mood, inducing sleep and offering a protective anaesthesia” (Neale 2001).

Coumans and Spreen (2003) propose that the method of intake can be considered indicative of the control over use—cocaine and injection is more prevalent among homeless persons while those on methadone are considered more stable. Once the person is homeless, other problems will accumulate: social relationships will be increasingly based on other drug users, economic circumstances will decline as control of drug use weakens, the drug habit may be supported by criminal activity and physical and mental health deteriorate. These are all considered elements in the process of marginalization. According to this perception of the process, “homelessness is not only...an outcome but also ...a catalyst ... that accelerates the process of marginalization” (Coumans and Spreen 2003).

Drug use has been identified as one of the triggers to youth homelessness. For example, a study of youth homelessness in England and Wales found that after conflict and abuse, substance abuse was the most frequent reason given for homelessness. However, the study found that the substance abuse itself “was not so problematic but rather that the relationships were so fragile it took little to tip them over the edge” (Wincup, Buckland, and Bayliss 2003). The study also found high drug use with almost 95 per cent of homeless youth having used drugs and three-quarters continuing to do so. Furthermore, almost a fifth were considered “problem” drug users (i.e., using heroin, crack or cocaine five or more days in the previous week) and many of these youth also had mental health problems. However, service providers interviewed were not surprised that young homeless persons took drugs. “They said it was a means of escape, or numbing the pain ...” (Wincup, Buckland, and Bayliss 2003). A follow-up study of homeless youth in London found that 42 per cent of 107 youth had a satisfactory accommodation outcome a year after a stay in specialized shelters but that persistent substance abuse was associated with a poor housing outcome and that it is a factor in chronic homelessness (Fichter and Quadflieg 2003).

Reports of growing demands for shelter and assistance among adolescents and young adults in several European countries in the mid-1990s prompted FEANSTA to investigate youth homelessness. The report found, among other things, that youth homelessness is associated with drug use, particularly new designer drugs, and that the street scene was becoming more violent in recent years (Avramov 1997). According to the Council of Europe report, there were one million homeless persons under 21 in the European Community. Often they are youth who have been “rejected” by traditional

institutions such as schools; many are part of a sub-culture that has developed around drug consumption (Conseil de l'Europe 1993). Data from European countries suffers from similar difficulties as elsewhere with defining and counting homelessness. Some research underlines the paucity of studies on various aspects of the issue. For example, a review of single homelessness in Britain found that "There is surprisingly little material on drugs in the health and homelessness literature, with several major studies discussing alcohol problems but not other substance dependencies." (Fitzpatrick, Kemp and Klinker 2000).

However, data available does support a link between substance abuse and homelessness.

- The homeless population in the Netherlands is estimated to be between 20,000 and 30,000, considered a relatively low number for Europe or when compared to the US. The proportion of drug users varies from 30 to 53 per cent according to the city under study (Coumans and Spreen 2003).
- In Rotterdam, it is estimated that the number of drug users has doubled in the city, that about 25 per cent are homeless, and that the housing problem for them has worsened. Further study of the population, however, revealed that 53 per cent were or had been homeless (Lempens, van de Mheen, and Barendregt 2003).
- A study of about 1,000 homeless persons using shelters in Denmark found that about one-third used illegal drugs (Stax 2003).
- In the U.K. about 50 per cent of people sleeping rough have a serious alcohol problem and about 20 per cent misuse drugs, although the drug problem is more serious with young homeless persons. Furthermore in 1997, it was estimated that about one-third of those sleeping rough in London had multiple problems, primarily substance use and mental illness (Verster and Solberg 2003).
- A study of 389 homeless persons in London found that 83 per cent had used drugs and/or alcohol in the previous month and that polydrug use was common (Fountain, Howes, and Strong 2003).
- Deaths directly attributable to alcohol have increased in England and Wales from 2,500 in 1979 to 6,000 in 2001. While no official figures exist, there are an estimated 5,000 to 20,000 street drinkers and many have chronic alcohol, physical and mental health problems. Most are homeless or have housing problems. They have been found to drink on the street for company, because prices in pubs are too high, or the hostels in which they live ban alcohol. Furthermore, they are at risk of assault and arrest for drunkenness (Crane and Warnes 2003).
- A study in Edinburgh in 2001 found that not only was there a decrease in hostel beds for homeless persons, but that those with drug or mental health problems were the most likely to be left on the street because of their drug taking (Verster and Solberg 2003).
- A study of homeless persons in Paris revealed that 16 per cent had used drugs or had experienced dependence in their lives, while another study of persons using shelters found that over a fifth had taken an illicit drug. A study of users of drug addiction centres found that 23 per cent were in precarious accommodation and 7.5 per cent were homeless. The focus in France in the last 15 years has moved from an individual approach to users and risks, to one that views the problem as related to social exclusion. This shift is based in part on studies of drug users that have observed intensification of situations of precariousness and homelessness,

begging activities and a growth in the sex trade (Observatoire Français des Drogues et des Toxicomanies 2002).

- A project in Lille, France for young homeless persons found that 30 per cent state they are addicted to drugs and that 90 per cent are occasional users (De Gouy 1996).
- In Munich, a study of homeless men found that those who were alcoholic were more likely to be homeless in a three-year follow-up compared to those who were not (Fichter and Quadflieg 2003).
- A study of substance abuse in Finland found that there has been a considerable increase of women seeking services and that while alcohol is still the dominant intoxicant (nine out of 10 persons seeking services), many use other substances and those who do not use alcohol is growing. Users of drugs are younger and different kinds of intoxicants are often used (Kärkkäinen 2000).

Illicit drug policy

Successful approaches

The European literature identified two significant approaches used in different countries. Two of these were deemed to have resulted in positive outcomes in terms of control of problems linked to drugs—approaches such as decriminalization in the Netherlands, and harm reduction in Great Britain (Bellot 1997). It is acknowledged that the situation of drug users has improved, public opinion is in support of government policies, and while the problems of consumption have not been eliminated, they seem to be contained.

Since the 1980s the Dutch policy towards drugs, especially “soft” drugs has been characterized as “liberal” with the decriminalisation of consumption of cannabis (i.e., for users or sellers of small amounts—although the legal interdiction has not been removed from the penal code) and its sale in “coffee-shops,” as well as a harm reduction approach to hard drugs. (The approach to soft drugs falls into a harm reduction policy—the objective in instituting the approach was in part to reduce the likelihood of youth turning to hard drugs.) The result has been no real increase in use of hard drugs (Bellot 1997).

The British harm reduction policy, considered a regional rather than national approach, stems from an approach developed in Merseyside in the 1980s. Based on collaboration with police, the harm reduction approach not only includes the provision that police will not arrest persons participating in harm reduction programs, but those that might still be arrested will be referred to harm reduction programs. Furthermore, the approach rests on integration with a range of services from needle exchange to housing and social reintegration support (Bellot 1997).

Switzerland also is considered to have developed a successful approach (Van Caloen and Gervasoni 2000). Harm reduction is based on a vision of drug addiction as a temporary phase in a user’s life; other phases will follow, the person will eventually have a productive role in society and the drug use will be ended or controlled. Important components of the approach include improvement of health, integration into work and re-establishing ties with family, friends, and others outside of the drug network and stabilizing the housing situation. The latter

includes a range of options, from shelters, to supervised and supported apartments (Van Caloen and Gervasoni 2000).

Drug consumption rooms

Drug consumption rooms are one element of a harm reduction approach. A recent analysis (Hedrich 2004) identified both public order (i.e., stopping injection on the street) and public health (i.e., safer injection practices) as rationales for establishing these. Their need sometimes is underlined by experiences that demonstrated that provision of clean injecting equipment and education about safe practices were not enough to guarantee hygienic injection in open drug scenes. Also, it was found that drug users could die from overdoses because they were in locations where no one was present to help them or those who were present did not call emergency services in fear of prosecution. Although semi-official initiatives had been set up for a short period in the late 1960s and 1970s (without supervision of consumption or hygienic equipment as the primary goals) the first supervised facility was opened in Berne, Switzerland in 1986, and in 1991 harm reduction was formally adopted as one of the pillars of the Swiss drug policy. A total of 62 consumption rooms in 36 cities in Germany, the Netherlands, Switzerland, and Spain are identified in the Hedrich study, some allowing not only injection but smoking and snorting (or chasing) of drugs⁵. Other countries are considering these (e.g., Norway) or have made legislative provision (e.g., Portugal).

Three types of consumption rooms are identified: integrated or part of a series of wider services that can include housing; specialized or offering only the consumption rooms; and informal,

tolerated by police but without “official status.”

It is important to note that many of the users targeted by consumption rooms are persons who are homeless with no place other than the street to inject drugs. The data vary from five per cent of consumption room clients in German cities who live on the street to eight–11 per cent in Swiss cities. Proportions are much higher in Spain and the Netherlands, varying from 42 to 60 per cent users who are homeless in Spanish cities and from 30 to 67 per cent in Dutch cities.

Failed approaches

Bellot (1997) identifies a number of failures of drug policy. Notable are post-Franco Spain, which legalized consumption of all drugs, resulting in high consumption levels, rivalling those of Denmark, with very repressive policies. Reasons for the failure in Spain include a lack of traditions to support the liberalization and the geographical location, which put it at the centre of a number of illegal drug routes. Furthermore, a network of community, social and health services had not been put into place to deal with the consequences of the policy. This experience is compared to that of the British with the historical roots of the *British system*, in place since 1926, which had allowed doctors to prescribe illicit drugs to persons already addicted for an indefinite period⁶ or the context of broader liberalization of policies towards “deviance” in the Netherlands (Brisson 1997). In response to concerns, Spain in 1987 reinstated repressive policies towards drug dealing while maintaining some harm reduction programs such as those for methadone.

5 The study also includes some discussion of Canadian and Australian experiences.

6 The *British System* was tightened up between 1960–1980 when youth consumption of drugs increased but with the advent of AIDS was incorporated into the Merseyside approach.

Italian policies are also considered to be a failure but primarily because they wavered, moving from decriminalization of consumption and possession, to imprisonment (albeit with methadone treatment) in the 1970s, followed by recriminalization of possession in the 1990s then a swing back to decriminalization in 1993. While Bellot (1997) is not able to assess the impact of Italian policies, the experience is seen as illustrating the need for not only a coherent policy but one that is constant to allow supports to be put into place and public opinion to evolve rather than oscillating with changes. Finally, according to Bellot, the last example of a failed policy, although not European, is that of the U.S. war on drugs. In spite of continuing pressure for international prohibitions, the internal demand for drugs in the U.S. is the largest in the world and the repressive policies have had a considerable impact on crime levels.

Social reintegration policies

An analysis of social reintegration of drug users reveals that while a variety of approaches are current in Europe, “the actual availability of social reintegration services is limited” (Verster and Solberg 2003). Social reintegration (which can include services such as supported living, help in finding employment, support in education and training, etc.) is not seen as necessarily a post-treatment service and can include current and former drug users. Some housing projects that deal with drug users include:

- The Hestia project in Brussels comprising six apartments that not only helps the drug user with gaining greater autonomy but also helps them sever ties with the drug-using environment.
- In Germany, the emphasis is on helping persons avoid relapses and housing projects seem to be directed at those who are on substitution treatment or abstinent but still in need of support.
- Spain, basing its interventions on a harm reduction model, would appear to have a fairly elaborate supported housing services run by NGOs: 111 centres, capable of receiving over 3,000 users, are identified.
- In France, housing is one of the four groups of interventions used (along with educational, employment, and legal aid). A range of housing services is offered from “therapeutic” apartments, transitional and emergency housing, and host families, depending on the level of addiction, health and social difficulties.
- Two Dutch projects are identified. The first, offers transitional housing in Amsterdam (Jellinek Centre). The second is permanent housing for seven older (over 55) methadone- and cocaine-users in Rotterdam. However, the general welfare system is expected to take care of everyone, so that for example, the Housing Department is responsible for housing, and drug services liaise with the various components needed.
- Finland has a similar approach whereby general social services provide supported housing options for drug and alcohol users. Furthermore, there are specific housing services for alcohol and drug abusers who need daily support.
- In the U.K., one of the policy areas is the difficulty for drug users to have tenancy agreements with local authorities, although initiatives are underway to address this problem.

Intervention strategies for people who are homeless and substance users

In addressing homelessness and substance use issues, there appear to be different approaches to dealing with alcohol and drug use. The latter is a more complex and recent issue and legal impediments, as demonstrated by the Wintercomfort case, described below, make this a more difficult problem to deal with. However it should be noted that as in U.S. studies, (e.g., Shinn and Baumohl 1999), European studies have found that “the follow-up studies which focused on rehousing programmes and projects have proved that the great majority of homeless people who received the necessary support were able to sustain their tenancies, and only a minority of those rehoused returned to homelessness” (Busch-Geertsema 2002). For example, the German EXWOST⁷ experience and subsequent evaluation strongly demonstrates that even chronically and long-term homeless persons can be moved directly into “normal” housing. These projects provided homeless persons “with normal and cheap housing at normal building standards, with usual tenancy agreements, situated in non-stigmatized surroundings.” In one project, the target group was “long-term homeless men with serious personal and social difficulties” whereas another consisted of both men and women, most who had spent over a year in institutions. The results have been positive. Almost all were able to maintain their tenancies and a trend of decreasing intensity of care after a year was noted (Busch-Geertsema 2000). Similarly, in the U.K., it has been found that lacking domestic skills, being alcohol

7 The “Permanent housing provision of homeless people “is part of the larger Experimental Housing Construction and Urban Development” (*Experimenteller Wohnungs- und Staedtebau, ExWoSt*)

dependent, or having mental health problems are issues that don't need to be addressed before resettlement—if a person feels ready to move on, and make changes to one's life, then he or she “can manage bills and cook meals” (Aldridge 1997).

Alcohol

Approaches to street drinking in England and Wales have been of concern to governments and, along with begging and sleeping rough, it is seen as anti-social behaviour and “damaging to the quality of public spaces and residential areas” (Crane and Warnes 2003). Local measures have been instituted in some areas to curb this activity. For example, by 2001, 100 local authorities had bylaws making it an offence to drink in designated areas. The implications of these bans are not known but while it is thought they may benefit local people and businesses, “their impact on street drinkers and the wider community is less clear. Where local authorities have introduced a drinking bylaw, the result has sometimes been a displacement of street drinkers from town centres to residential areas...” (Crane and Warnes 2003).

The Swedish “staircase of transition” approach to homelessness has been criticized for being punitive with referral to lower steps as a sanction for misbehaviour. A series of predetermined stages (although they may vary in number by locality) are defined and individuals must follow each consecutive stage to reach the next. The progression includes lessening supports and greater stability of tenure, as well as increasing privacy, control and independence. Persons can fall off if they don't comply with all the rules that include not only abstinence but also can ban pets and control guests. Housing opportunities are

seen as a potential “motivating and disciplining force” and rehousing homeless persons was a means to “motivate clients to change their lifestyles, e.g., stop drinking or use drugs, start working, paying debts, etc.” (Sahlin 1997). A case study of the selection process in one town revealed that, “Some of the most needy and vulnerable clients had turned out to be difficult as tenants, and the social housing workers responded with gradually increased demands on the applicants. After four years, none of them accepted drug users or alcohol addicts who kept drinking. They also rejected clients who had previously “failed,” that is, had been evicted.... A change in the meaning of “need” was noticeable: clients with severe troubles were regarded as not in need of housing—since they needed treatment or changes of life-styles more than—or instead of—housing, or before they would really benefit from housing.” (Sahlin 1997).

The roots of the Swedish model can be found in a broader approach towards alcohol and drug abuse. Since the beginning of the 1900s “alcoholics have been occasionally subject to compulsory incarceration for treatment. From 1982 on, this has also applied to drug abusers.” (Sahlin 1998). While in the past persons could receive medical treatment if they wished to sober up, this is no longer the case. “Before they will be allowed any treatment resources, addicts generally must stop abusing substances, and then prove their sobriety as an expression of their genuine ambition to be rehabilitated.” (Sahlin 1998)

Finland tends to have a restrictive approach as well. Although alcohol regulations can vary, “inebriation and possession of alcohol is usually forbidden” and persons can be ejected immediately for use, pushing people to drink outdoors or at friends' homes. While supportive housing

is “always rehabilitative in nature mainly

aiming at temperance...in some cases the aim is simply to provide humane living conditions...” (Kärkkäinen 1999). An example are two projects in Helsinki that have evolved to be supportive housing for elderly persons who are difficult to place because of substance use, while a third is for women suffering from mental health and substance use problems. (Kärkkäinen 1996) An interesting initiative in Finland is the therapeutic community that offers “the opportunity for excluded people to regain control over their lives” (Verster and Solberg 2003). One example is the Sirkkulanpuisto Community founded in 1983 and made up of persons who were homeless, unemployed and with drinking problems. Because housing persons with substance use problems can prove difficult with neighbours, the community was built on the outskirts of the city of Kuopio with a range of housing types and services, from a “drying out” centre to an eco-village. While abstinence is not demanded, they are asked to try to be sober, be capable of living alone and manage everyday chores (Kärkkäinen 1996).

A more supportive approach is that of the “wet” (allow drinking on the premises) and “damp” (target heavy drinkers but disallow alcohol consumption on site) projects for homeless persons who are heavy drinkers in the U.K. While little rigorous research into effective methods to deal with long-standing alcohol problems have been carried out, some research suggests that the detoxification approach may not be appropriate since, “multiple episodes of alcohol withdrawal may increase the incidence and severity of seizures during detoxification, render a person more vulnerable to brain damage, and contribute to alcohol-related neuropathology and increased cognitive dysfunction” (Crane and Warnes 2003). Neville House in London is a temporary winter shelter for a range of homeless persons including

heavy drinkers, drug users, “poly users, couples and people with pets. Wernham House, in Aberdeen opened in 1986, provides accommodation for 18 men and women with severe alcohol and/or mental health problems. There is no limit to the length of time that people can stay and the atmosphere is non judgemental and non punitive: “The project tries to create opportunities for residents to change their behaviour when they are ready to do so” (Aldridge 1997). It is situated in an industrial area, isolated from neighbours, while “is not ideal for reintegration” but the location “was partly due to problems in gaining planning permission from the local authority, but has meant that there is no local opposition to the house” (Aldridge 1997). A study of wet day centres found that they played an important role in helping users secure appropriate accommodation, retain tenancies, gain access to health care and stabilize their lives (Crane and Warnes 2003). It is proposed that while Wernham House might not reach targets of numbers of persons resettled into permanent tenancies, a “more appropriate measure of success is how far residents have begun to take control of their lives, or how many have reduce or stopped drinking during their stay, or how many feel more secure. In those terms Wernham House is a success” (Aldridge 1997).

A review of wet hostels in London found that most residents of wet hostels had long histories of alcohol dependency and associated health and behavioural problems. The objectives of the approach were to deal with the consequences of long-term heavy drinking and “improve the quality and purpose of individuals’ lives, and in turn reduce drinking” (Providence Row Charity and Providence Row Housing Association 2003). Another study of wet day centres found a range of services, from work with drug users as well as those with alcohol problems, that the

rules about drinking on the premises varied from one centre to the other: some restricted the amount of alcohol brought in, while others did not and in some, drinking was permitted only in certain areas.

A recent analysis of rehousing homeless persons focuses on “the importance of ordinary, permanent, self-contained housing for the social reintegration of homeless people” with a special emphasis on projects for single persons who were marginalized and had additional problems to homelessness (Busch-Geertsema 2002). Projects in Dublin, Hanover, and Milan were examined. While in Italy, abstinence was a requirement; this was not the case in Germany and Ireland. The results confirm that abstinence is not essential to successful maintenance of housing. “Failure to keep their consumption under control and relapses into excessive drinking was a decisive factor for those service users who did not succeed in maintaining a tenancy, and was a risk factor for the reintegration of some others. But for many successfully rehoused people it was easier to control their consumption of alcohol and other substances when living in their own flat.” (Busch-Geertsema 2002)

Drugs

Approaches towards drug abuse appear to be as variable as those towards alcohol. A study of illegal drug use in Danish shelters concluded that there was limited room for users in the shelters and that “these people were ejected and quarantined from the shelters where they were living. The use of drugs was reported to have most often been the cause for such ejection and quarantining.” (Stax 2003). While some shelters have become more tolerant of drug use, such as not sanctioning use if within the tenant’s room and not in other parts of the shelter, it was

found that this did not represent new beds to meet the need. Instead, this occurred in shelters that already received drug users—often the largest shelters with the lowest ratio of staff to inhabitant. The author concludes that the “current organization of social policy directed towards homeless in Denmark is...based upon certain understandings, beliefs, and attitudes... these understandings and beliefs are not only enabling Denmark’s homeless who use illegal drugs, but are also leading to further exclusion” (Stax 2003).

Similar finding are reported for homeless youth in England and Wales. They were found to have difficulty gaining access to temporary and permanent accommodation because of substance abuse, although most said their most pressing need was accommodation. An important barrier was having to be drug- or alcohol-free prior to admission. However, policies appeared to be flexible and action was taken more often because of behaviours rather than the substance use itself (Wincup, Buckland, and Bayliss 2003). It is recommended that while it may be unrealistic to expect youth to give up drugs, “appropriately delivered harm reduction messages could highlight the possible dangers of poly-drug use; raise awareness of health risks... highlight the danger of injecting in the presence of others; and promote knowledge about and skills to deal with overdose” (Wincup, Buckland, and Bayliss 2003).

Similarly many hostels were found to exclude drug users “thereby making successful engagement with treatment very difficult for homeless people” (Randall and DrugScope 2002). A study of 389 rough sleepers in London found that 39 per cent had been excluded from one or more services for homeless persons in the previous year. Reasons for this were physical violence towards other clients and drug use. “Those dependent on drugs or alcohol were

more likely to have been excluded than those not dependent.” (Fountain and Howes 2001).

Knowledge of procedures is an important aspect to getting care and may prove to be a major obstacle for homeless substance abusers. For example, a study of homeless youth and substance abuse in England and Wales found that there was a general lack of awareness of what was available (Wincup, Buckland and Bayliss 2003). While Germany has facilities to treat alcoholism and health insurance or social welfare will cover all the costs, one must see a social worker or doctor before admission. Homeless men have been found to not use the facilities because they are “either not motivated to go to such facilities or may not be persistent and knowledgeable enough to get through these procedures of admission” (Fichter and Quadflieg 2003). In Italy treatment can differ depending on the potential for social reintegration, although shelters do refuse drug users because they are not equipped for them and because of health and discipline risks (Tosi, Kazepov, and Ranci 1998).

Legal issues can add to the complexity of helping drug users. In the U.K. the Wintercomfort case underlined the fragility of the harm reduction approach. The case consisted of a police surveillance operation at a shelter in Cambridge. Two undercover officers who began to use the services managed to buy heroin on the premises. Following the operation the director of the Wintercomfort charity was jailed for five years and the manager of the day centre for four years. They were convicted for allowing the trading of heroin on their day centre premises contrary to Section 8 of the *Misuse of Drugs Act 1971* (The Guardian July 10, 2000). The Home Office followed with a proposed law targeted toward “crack houses” or other “closed” drug markets that could have meant that service providers working with drug users could be prosecuted

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for allowing substance misuse on the premises. Following strong reaction the government proposal was shelved (The Guardian March 19, 2003).

A number of recommendations about ideal projects to deal with homelessness and drug abuse are proposed, including:

- Residential rehabilitation located outside of urban centres to give clients a break from usual surroundings (DrugScope 2001);
- A range of models of supportive housing, including long-term support for those with dual diagnosis of mental health problems and drug use (Randall and DrugScope 2002);
- It is proposed that housing options should include “variants of community living designed to prevent habituation problems, social isolation, and a relapse to street life” (Lempens, van de Mheen, and Barendregt 2003); and
- There is a need for aftercare. A study of homeless persons in London found that “due to the chaos of the lives of some people sleeping rough, detoxification in the community (for example, with methadone for those addicted to heroin) is unlikely to be successful. Furthermore, even if an in-patient detoxification place is obtained for a person who was previously sleeping rough, unless the appropriate aftercare—including measures to prevent a return to homelessness—is also provided, a return to a chaotic environment where drug use is common means a relapse is highly likely.” (Fountain, Howes, and Strong 2003).

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Appendix D

Methodology

Literature review

The methods used to gather the information for this research project involved:

- Reviewing the relevant literature;
- Preparing case studies to document 13 programs and services that incorporate or are planning to incorporate a harm reduction approach; and
- Conducting interviews with people living in housing or using services provided by the agencies participating in the case studies.

The researchers undertook a review of the literature from Canada, the U.S., U.K. and Europe. The purpose was to:

- Provide an overview of options for interventions that promote access to and maintenance of stable housing for people who are homeless and who have addictions or “concurrent disorders;”
- Provide an overview of evaluations of such interventions with special attention to the differences that exist between conventional and alternative (e.g. harm reduction) approaches; and
- Summarize the state of research regarding housing stability for the identified population and identify areas of consensus, differences of opinion, and areas where further investigation is required.

The researchers focused on materials published in Canada and the U.S. since 1990. This included materials written in English and French. The researchers searched major medical, health and social science indexes and databases.

The researchers also reviewed several Canadian, U.S., U.K. and European web sites available online. The search for materials from Europe included reports available from the European Federation of National Organizations Working with the Homeless (FEANTSA), European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the Qualitative European Drug Research Network, and the International Harm Reduction Association (IHRA).

Case studies

The researchers documented 12 programs that are providing housing and services to people who are homeless or at risk of homelessness, and who use substances, and that incorporate a harm reduction approach. A 13th program was in the planning stages.

All of the information for the case studies was obtained through interviews with service provider personnel most knowledgeable about the program. In addition, the researchers sought to obtain written documentation about the initiative, such as annual reports, policies, and evaluations, if available. Interview guides were used for all interviews. These guides were modified depending on whether the project had operated for a period of time or were in the planning stages. The interview guides for the on site visits and for the program users are attached at the end of the discussion on the methodology.

Three different types of case studies were documented:

- Programs/facilities in operation for at least one year;
- Projects/facilities in Europe; and
- Programs/facilities in the planning stages.

- Programs/facilities in operation for at least one year
- Ten case studies describe programs/facilities that have been in operation for at least one year.

All the interviews for these projects were conducted in person, and were quite extensive. The researchers had planned for the interviews to take about 2½ to three hours, but in fact, most interviews lasted between three and five hours. In some cases, it was necessary to interview more than one individual to document a case study. Sometimes, the researchers interviewed more than one individual from the same agency. Other times, where several partners are involved, the researchers interviewed personnel from more than one agency. The researchers sought to obtain written information prior to the interview. This happened most often when reports were accessible online. Most agencies provided written materials after the interviews.

It is important to note that because of the time required to complete the interviews, in some cases, the researchers were unable to obtain answers to some questions. Therefore, the level of detail provided in each of the case studies may vary somewhat.

Another aspect of this research involved conducting interviews with individuals living in housing or using services provided by the

agencies participating in these case studies (see interviews with residents/ people using services). Therefore, in addition to participating in an interview, the case study agencies were asked to recruit three residents/ individuals using services who the researchers could interview, and to assist with organizing and scheduling the interviews. Agency participants received an honorarium of \$250 and residents/people using the services received a \$25 honorarium.

Projects/facilities in Europe

Two case studies feature programs/facilities in England. Interviews were conducted over the telephone and were supplemented with written documentation. The telephone interviews took up to two hours to complete.

Programs/facilities in the planning stages

One case study documents an initiative in Canada that was in the planning stages. This interview was conducted over the telephone and lasted about two hours. Additional written information was also provided.

The table below shows the different types of case studies documented in this report.

Type of Case Study	Number of programs	Type of interview	Interviewed residents/ participants	Country
In operation for at least one year	10	Face-to-face	Yes	7 Canada 4 U.S.
Europe	2	Telephone	No	2 England
Planned	1	Telephone	No	1 Canada
Total	13			13

Criteria for the selection of case study sites

The researchers identified a list of potential case studies through the literature review, an internet search, and interviews with a number of community groups and government officials across the country.

The following criteria were used as a basis for selecting which initiatives would be documented as case studies.

Harm reduction. One of the requirements for this research was to document initiatives that make use of a harm reduction philosophy or approach. At the outset of the project, it became clear that the term “harm reduction” can encompass a wide range of initiatives and interventions. In developing the criteria for project selection, the researchers considered harm reduction to mean an approach aimed at reducing the risks and harmful effects associated with substance use without requiring abstinence. In terms of housing, the researchers considered initiatives where an individual could obtain housing regardless of whether or not they were abstinent, or where relapse would not result in a loss of housing. These criteria were based on the review of the literature. The provision of services was also seen as an essential element in a harm reduction approach. Therefore, in selecting case studies, the researchers selected programs that had a significant service component.

Client group. Another requirement of the research was to document initiatives that serve people who were homeless or at risk of homelessness. Within this target population, the researchers sought to document projects that serve a range of clients, including youth, single women, single men, families with children, Aboriginal people, and persons with concurrent disorders (mental illness and substance use issues).

Type of housing offered. Another goal was to include a range of housing options with different levels of permanence, including emergency shelters, transitional housing, and permanent housing. As well, the researchers aimed to document initiatives that provided different types of accommodation, including self-contained units, private bedrooms and shared bathroom and/or cooking facilities, units in dedicated non-profit buildings, and units integrated within non-profit or private rental buildings that serve a mix of tenants/residents (e.g. scattered sites).

Innovation. A fifth criterion was for initiatives to contain elements of uniqueness—i.e. that they are doing something differently in terms of the types of housing or services provided.

The researchers gave Canadian initiatives priority over those from the U.S., and sought to be as representative of regions across Canada as possible.

Interviews with residents/people using services

One of the key principles of the harm reduction philosophy is ensuring that clients have an effective voice in the policies and programs designed to address their needs. Therefore, conducting interviews with residents/people using the services described in the case studies was seen as a critical and integral part of this study.

The researchers conducted face-to-face interviews with three individuals from each of the 10 projects where on-site interviews took place. Additional interviews were conducted

with three residents of another initiative that the researchers had planned to document as a case study¹. The purpose of the interviews was to hear from the residents and individuals using the services about what they like most and least about their housing, the kind of services and activities they are involved in, what their life was like before they became involved in the program, how their life changed since becoming involved in the program, and suggestions for other organizations interested in undertaking a similar project.

The case study agencies were asked to recruit three individuals who were most representative of their clients and who:

- Were at different stages in addressing their substance use;
- Have been involved with the program for different periods of time (but have been there long enough to be able to comment on the existing program); and
- Would be able and willing to participate in an interview of some length.

The researchers provided a copy of the interview guide to each recruiting agency. Participants were informed that their participation was completely voluntary. They were also assured that the information they provided would be kept confidential, and would be reported on in such a way to protect their identity and privacy. Participants received an honorarium of \$25 to complete the interview.

The initial interview guide for the residents/people using services was designed for an interview that would last approximately 1 to 1.5 hours. However,

after the first series of three interviews, the researchers found that the interview was too long for the client group. The interview guide was revised and, as a result, interviews ranged in length from 30 minutes to two hours

All the information from the 33 residents/people using services is reported on as a group. The information from these participants was not included as part of the case study of the program they were involved with in order to maintain confidentiality. An overview of the findings from these interviews is included in the report. More detailed findings are in Appendix B.

It should be noted that the information provided by the residents/people using the services is qualitative in nature. Therefore, when considering the information provided by the residents, it would not be appropriate to make generalizations that the findings would apply to the homeless population as a whole. A different study might have recruited individuals with different experiences who might have provided different points of view.²

Ethics review

An oath of confidentiality and a consent form was drawn up for the interviews with participants. The researchers signed the oath of confidentiality with each person interviewed and a consent form was signed by the interviewees. In one case, the Services à la Communauté of the Centre Dollard-Cormier (CDC), the study needed further approval by the ethics committee of the Centre Dollard-Cormier.

1 The researchers had originally intended to document the O'Neil Crack Cocaine Project, a former initiative of Seaton House in Toronto. Interviews were conducted, but it was subsequently decided that the researchers would not prepare a case study for this project because sufficient information about the project or rationale for its ending were not available. Nevertheless, it was decided that the input from the interviews with former residents should be retained.

2 Qualitative research is intended to provide in-depth knowledge about a specific topic based on the view of the participants. This is different from quantitative studies which involve the collection of statistical data from large, random samples for the purpose of generalizing findings to the larger population. (Sheila Martineau, PhD, Qualitative Research Consultant, as contained in the GVRD Research Project on Homelessness in Greater Vancouver, and the report Family Homelessness, Causes and Solutions.)

Stable Housing for People Who Use Substances

Interview Guide for **ON-SITE** interviews - Agency Key Informants

For Initial Telephone Contact

Hello. My name is _____. I am calling from Vancouver/Montreal/ Toronto [in Canada], and am part of a research team that has been funded by the federal government to:

- Investigate innovative approaches to providing stable housing for people who are homeless or at risk and who use substances (e.g. drugs, alcohol or other substances); and
- Prepare case studies to document 14 programs and services that incorporate (or are seriously considering incorporating) a harm reduction approach.

We understand that your program uses a harm reduction approach. Is that right?

☐ Yes ☐ No If no, thank the person very much. End call.

If yes, could you please tell me in what way (it uses a harm reduction approach)? _____

If yes, we are very interested in documenting your program _____

Name of Initiative

Note to interviewer: In case you are asked - by harm reduction we mean:

- An approach aimed at reducing the risks and harmful effects associated with substance use without requiring abstinence;
- In terms of housing, we are interested in a harm reduction approach that means an individual can obtain housing even if abstinence is an unmet goal, and that relapse does not result in a loss of housing.

We would like to arrange an on-site interview with you. We would like to interview you - or someone else that you recommend, interview a few individuals who are representative of the participants in your program, and tour your project. It may also be a good idea to meet others who are involved in this initiative (e.g. service agencies, property managers....)

We recognize that this will take a substantial amount of your time, and would like to offer your organization a small honorarium, [\$250 Canadian/\$200 U.S.] to show our appreciation. We will also offer each program user [\$25 Canadian/\$20 U.S.] for their time and expertise. The interview with the program users should be about 1 to 1.5 hours.

1. Do you think your organization would be willing to participate?

☐ Yes ☐ No

2. Would you be able to approach 3 program users that we could interview when we are at your project?

☐ Yes ☐ No (if outright no, arrange to call back)

3. Who would you suggest we speak with about your program - would it be you or would you recommend someone else?

☐ Person on phone ☐ Someone else

If someone else, who should we contact? _____

4. We will be conducting interviews between July and the end of September. Is there any time period that is best for you? Any time away on holidays?

Weeks that are good _____

Weeks on holiday _____

5. [Note that we may want to meet with people from other organizations. We need to decide who, and if the interviews should be together or separate. Need to ask if we should meet with other staff from the SAME organization, and we may want to ask if there are people from other organizations we should meet with.]

6. We will send you a copy of the questions in advance. And we will also send the questions we plan to ask to the participants in your program. Would you prefer receiving the questions by fax or email?

Email address: _____ Fax: _____

7. I would like to be as prepared as possible before we meet and would like to be able to read:

- a) Any write-ups that have already been done of your project
- b) Your annual report and financial statements (that show the particular program we are documenting)
- c) Any evaluations that have been prepared
- d) Any tenant satisfaction surveys
- e) Policies and house rules
- f) Your lease (if different from standard lease agreements)
- g) Anything else you think is important

8. Are any of these available on the internet? If yes, which ones. If not, would you be able to send me this information?

Documents of interest	On internet	Will send
Any write-ups of the program		
Annual report with financial statements		
Evaluations		
Tenant satisfaction surveys		
Policies and house rules		
Lease (if different from standard agreements)		
Other		

Thank you very much. I will get back to you to arrange a specific date and time.

Stable Housing for Substance Users

Interview Guide for **ON-SITE** interviews - Agency Key Informants

Information for Covering Letter

Thank you for agreeing to an interview for the research project on stable housing for people who use substances. I would like to confirm that our interview will take place as follows:

Date:

Time:

Place:

Others who will attend:

Date and time for interviews with program participants/residents:

Attached are the following:

- Background information about our research as well as our interview guide;
- The interview guide for our interview with you; and
- Information and questions for the interviews with program participants/residents.

If you have any questions or if you need to change the interview times, you can reach me at.....

Stable Housing for Substance Users

Interview Guide for **ON-SITE** interviews - Agency Key Informants

Background

The purpose of this project is to:

- Investigate innovative approaches to providing stable housing for people who are homeless or at risk and who use substances (e.g. drugs, alcohol or other substances); and
- Prepare case studies to document 14 programs and services that incorporate (or are seriously considering incorporating) a harm reduction approach.

This research is being funded by the federal government of Canada, Canada Mortgage and Housing Corporation, with some funding from the National Secretariat on Homelessness.

Our method includes:

- A literature review (which we have completed);
- On-site, face-to-face interviews to prepare case studies of 10 programs/facilities. This will include interviews with service providers who are most knowledgeable about the initiative and with people who have participated in using the services;
- Telephone interviews to prepare case studies of two programs/facilities that are planning to modify a conventional approach or create a new program that incorporates a harm reduction approach; and
- Telephone interviews to prepare case studies of two programs/facilities operating in Europe.

We expect the interview to last approximately two and a half hours. Attached is a list of our questions. We may be able to save a bit of interview time if you could prepare comments to the questions prior to our meeting face-to-face. If you have any questions or concerns, please do not hesitate to contact:

Michael Goldberg, Research Director, Social Planning and Research Council of BC at 604-718-7738 or mgoldberg@sparc.bc.ca

Thank you for agreeing to participate in this research project on stable housing for people who use substances.

Contact Information

1. Name of Project _____

2. Person completing the interview

Name of person	Position	Organization	
Street address	City	Province	Postal Code
Phone	Fax	E-mail	

Background Information

Background on organization

1. In what year was your organization established?
2. What is your organization's mission/mandate?

Background on the program

3. If different from Q1, When was your program [name of initiative] first implemented?

Before going ahead, confirm understanding of the initiative so far (e.g. what you know re harm reduction, housing first, target population, and if there is a network etc. Base this on existing write-up and info sent to you).

4. Researcher to confirm preliminary understanding of the program and target population.

Operational Questions

Reason for this program

5. Why did your organization decide to go ahead with this program? (I.e. what factors prompted this initiative? - What was going on?)

6. What are the goals and objectives of your program - i.e. what does your organization hope to achieve?
7. a. Could you please tell me in what way your program uses a harm reduction approach?
- b. Why did your organization decide to use this approach?

Pathways to housing

8. Could you please tell me the different ways in which people come to your program? *Prompts: (E.g. What kinds of agencies refer people to you? Drop-in centres? Outreach workers? Shelters? Do potential residents require a referral or can they just walk in?)*
9. Are there any eligibility criteria for people to obtain housing/shelter with your program? If so, what are the criteria? Under what conditions would potential residents be denied access to your housing/shelter?
10. What is the application or selection process? *Prompts: (E.g. what steps does one have to go through to get housing in your program? Do applicants need to meet with a committee? Do existing tenants have a role in selection?)*
11. a. What expectations does your organization have about the **degree** of “housing readiness” for households to be housed through your program? What happens to people who are not deemed to be sufficiently housing ready? *Probe: Do you consider this a Housing First Approach?*
- b. Why did you decide to take this approach?
12. What is expected/required of residents? *Prompts: E.g.: Are residents expected/required to:*
 - Participate in any programs to be eligible for housing/shelter? (If yes, describe)
 - Meet with a case worker a certain number of times per month?
 - Have a plan re use of substances?
 - Take medication?
 - Other?
13. Do you maintain a waiting list for your program? If yes, how many people are on it? How long is the average wait?

Type of housing

14. How many units/beds are currently used to provide housing for residents/participants in your program?
15. What type of housing is provided to the people currently housed through your program?
(Format in landscape)

Type of housing	Max length of stay permitted	Total # Beds/ Units	Tenants sign a lease with a landlord Yes/No	Indicate if: Self contained unit, Private bedroom or Shared bedroom (# people/bedroom)	Indicate if: Purpose built dedicated building operated by non-profit Scattered sites operated by non-profit Scattered sites operated by private sector Other (please describe)
Emergency shelter					
Transitional housing ³					
Supportive housing ⁴	N/A??				
Permanent housing (no support)	N/A				
Other (please specify)					
Total units (should be the same as Q 14)					

16. Could you please tell me about the quality of the housing? For example, is it the kind of place people might like to stay on a permanent basis?

Harm reduction and substance use issues

17. What are the most common substances used by the people currently housed through your program (e.g. Alcohol, marijuana, crack cocaine, heroin, prescription drugs etc.)

Has the type of substances used by people seeking housing changed over the last 3 to 5 years? If yes, what do you think the cause of this change has been?

³ The intent is for residents to stay 30 days to 2-3 years. Support services are generally provided.

⁴ Affordable permanent housing with no limit on length of stay. Provides residents with the rights of tenancy under landlord/tenant legislation and is linked to voluntary and flexible support services designed to meet resident's needs and preferences. This definition is based on one provided in the National Health Care for the Homeless Council Newsletter. Healing Hands. December 2003, 7(6).

- a. Are there particular problems that stem from specific substances (i.e. drugs vs alcohol or different types of drugs)? How do you cope with these problems (e.g. extra staff, different programs)?*
 - b. Do persons with concurrent disorders pose different kinds of challenges? Do they require different kinds of supports/services? How are these provided?*
 - c. Are there other groups that are especially challenging?*
- 18. We were wondering if there have been any legal issues arising from the use of illegal substances. How do the police treat your residents? Can you tell me about the relationship between your building (project/initiative?) and the police? [Note: this latter question is more applicable to dedicated buildings].
- 19. To what extent, if any, are participants in the program encouraged to reduce their use of substances, move to less harmful substances, or enter into treatment?
- 20. Ask about policies/rules (that you received or did not receive) and how they are enforced regarding:
 - a. The use of alcohol and drugs in private living space, common areas inside the building, and common areas outside the building?
 - b. The selling of drugs on the property?
 - c. Behaviour that might disturb other residents?
 - d. Special security measures to promote the safety and security of residents?
 - e. Policies about visitors and guests?
 - f. Policies/procedures to address conflicts among residents?
- 21. Is prostitution an issue on the premises? If so, how is that handled?
- 22. If a resident is temporarily absent from his/her unit (e.g. enters a residential treatment program or is hospitalized), is there a time limit after which the resident will lose the unit? Does the resident need to pay rent while away? Is there financial assistance for this?
- 23. What happens if someone becomes abstinent? Do they continue to live here? Do they move elsewhere? Do you provide support/help in moving them?
- 24. Can you tell me a bit about the relationship between the staff and residents? What kind of contact would staff have with residents on any given day or week? Are there ways in which staff are able to watch out for residents? Make sure they are doing OK? Do staff have a role in encouraging residents to participate in services? What strategies, if any, do staff use to engage residents in services? What have they found to be most/least effective?

Ending a tenancy

25. What kind of circumstances would be reasons for a resident to be evicted or asked to leave or move out?
26. What steps would be taken to try and avert an eviction?
27. In supported housing, is there a maximum length of stay - or some kind of program related reason why they would be required to leave (other than a behavioural issue)?
28. For residents leaving a shelter or transition house, where do they generally go after they have stayed the maximum length of time?
29. What are the most common reasons given by tenants who move out of the housing made available through your program?
30. Where do people generally go if they decide to leave the housing made available through your program?

Types of services

31. What kind of services do you make available to your residents? Please see below. (To be formatted in landscape mode).

Examples of Type of Services	Describe the service - How often are these services available?	Who Provides the Service (name and type of service provider)	Are these available on-site (Yes/No)	Source of funding: Public (which level of government) Private sector Charitable foundation.
Medical care				
Mental health				
Substance use				
Employment assistance (training/finding work)				
Money management				
Assistance with life skills, food, transportation, clothing etc.				
Other (please specify)				

32. Have there been any changes in the types of services provided over the last 3-5 years?
33. Which services do you think are most effective in promoting stability among the residents?
34. How stable has the funding been for these services over the last 3-5 years. Is funding provided on an annual basis or over a certain number of years? Has the level of funding changed over the last 3-5 years?

35. Could you please describe the approach that is used to deliver and coordinate services?

Note: If the approach is

- Case management
- Assertive Community Treatment
- Community development

Ask specifically about what they mean - as noted below.

If these approaches are not mentioned, ask specifically if the organization uses case management or assertive community treatment approaches. If they do, ask for details - as noted below.

<u>Service delivery model</u>	Please describe: What services, who delivers them, how often, how are they coordinated, and where
Case management	
Assertive Community Treatment	
Other approach	

36. Could you please describe the nature of the relationships between the client/resident, housing provider and agencies that provide services to the people currently housed through your program? For example:

- a) Is there a written service contract?
- b) Other arrangement?

[Probe: for particular challenges in the housing relationships if case study is a network]

37. Does your program have connections (e.g. formal or informal arrangements) to other programs that are available in the community, e.g. needle exchange, emergency accommodation, hospital or other health care provision, etc? Please describe.

Outcomes

38. If not covered in an evaluation or already addressed - Can you tell me what changes have occurred with residents in terms of the following:

<u>Outcomes</u>	Examples of Changes
Residential stability (e.g. length of time housed)	
Substance use (e.g. decreased use/participation in treatment programs?)	
Mental health (e.g. maintaining medication, reduced hospitalizations)	
Physical health (e.g. less use of emergency services)	
Employment (e.g. part time work)	
Income (e.g. increase)	
Education /Training	
Improved self care	
Personal networks (e.g. more contact with family, new friends)	
Other	

39. What do you think are the top 2-3 features of your program that make it possible for the residents/people who are housed through your program to keep their housing or achieve the degree of housing stability that they do?

Staffing and personnel issues

40. What are some of the critical staffing needs/requirements to run your program?

41. Have any issues been identified re staff burnout? What kinds of support are available to support staff in this challenging work?

42. Do you have any policies about hiring formerly homeless individuals or hiring persons with a history of substance use? If you do hire these individuals, for what positions?

Funding

43. Review/clarify any questions arising from the annual report regarding the various sources of revenue for this program. Determine the amount of funding from various levels of government, the private sector and private foundations/charitable organizations.
44. How much rent do the residents pay - is it a fixed amount or a percentage of income? For the emergency shelter, are residents expected to pay anything? If so, how much?
45. How stable is the funding for this program - is funding provided on an annual basis or over a certain number of years? Has the level of funding changed over the last 3-5 years?

Factors and conditions for success

46. How do you define success for your program?
47. Using that definition, how successful do you think your program has been?
48. In your opinion, has the initiative achieved the goals originally intended?
☐ Yes ☐ No

If yes, what are the top 2-3 reasons for success of the initiative?

If no, please explain_____

Challenges and community issues

49. a. What would you say were the top 2-3 obstacles or challenges to implementing this initiative?
 b. How were these challenges addressed?
50. a. For dedicated buildings - In providing housing for the particular client group you work with, what issues - if any - have arisen with the neighbours or others in the community? How have these issues been addressed? *Probe: NIMBY, negative publicity, complaints stigma re substance use/mental health.*
 b. For units in scattered buildings. Have there been complaints by others living in the building? How are issues addressed?

Lessons learned

51. Do you have any other words of wisdom or advice for other organizations interested in doing a similar project? (E.g. conditions necessary for others to replicate this model successfully?)

Evaluations

52. Review/clarify any questions arising from any evaluations that you received. Are there any [other] reviews or evaluations of your program? ☐ Yes ☐ No. If yes, can we have a copy?

53. Review/clarify any questions arising from resident satisfaction surveys already provided. If none provided, have any resident satisfaction surveys been undertaken? If yes, can we have a copy of this report? If not, do you have any indication of the satisfaction levels?

Other questions if residents/clients are families or Aboriginal - Minnesota Only

54. Families - How is it that the children are able to remain with parents if the parents are using substances? Are there reasons why the child protection authorities have let the families stay together?

55. Aboriginal - Are there any Canadian Aboriginal people who have come to the program?

56. Aboriginal - What are some of the aspects of the program or services that are specifically designed for Aboriginal people? [Take Photos if possible - no people]

V. Basic Information

Number of people served

57. How many people (families and individuals) did you work with last year to help them access housing?

Types of people housed

58. What kinds of households are currently housed through your program?

<u>Type of Household</u>	Number or Proportion of Households
Single men	
Single women	
Single people who are transgendered	
Couples	
Families with children	
Other - please comment	
Total Households	

59. Is this typical of the people you have housed or helped find housing for over the last 3-5 years?

☐ Yes ☐ No

If no, how has the population you house or help find housing for changed over the past 3-5 years?
[Note: we are asking about changes in the new/intake population looking for housing].

60. What is that age range of the people currently housed through your program?

☐ Children under 16 with parents ☐ 16-22 ☐ 23-50 ☐ 51 and older

61. What is the ethnic background of the people currently housed through your program?

<u>Ethnic Background</u>	<u>Number or Proportion of Residents</u>
Caucasian	
Aboriginal	
Visible minority (please specify)	
Other - please comment	

62. Is this typical of the people you have housed or helped find housing for over the last 3-5 years?

☐ Yes ☐ No

If no, how has the population you house or help find housing for changed over the past 3-5 years?
[Note: we are asking about changes in the new/intake population looking for housing].

63. What types of challenges do the people who are housed through your program have?

Types of Issues	Number or Proportion of Residents
Substance use	
Concurrent disorder (mental health and substance use)	
Mental illness. Formal diagnosis and/or connected to mental health team/services	
Mental health. No formal diagnosis or connection to a mental health team/services	
HIV/AIDS	
Domestic violence	
Involvement in the criminal justice system	
Behavioural issues	
Other (please specify)	

64. Is this typical of the people you have housed or helped find housing for over the last 3-5 years?

☐ Yes ☐ No

If no, how has the population you house or help find housing for changed over the past 3-5 years?
[Note: we are asking about changes in the new/intake population looking for housing].

Income of residents

65. What is the main source of income for the people who are currently housed through your program?

Primary source of income	Number or Proportion of Residents
No income	
Income assistance (welfare) only	
Both welfare and employment	
Employment only	
Other (please specify)	

66. Has the source of income for the people currently housed through your program changed over the last 3-5 years?

☐ Yes ☐ No

If yes, how has the source of income for the people you have housed or helped find housing for changed over the past 3-5 years? [Note: we are asking about changes in the new/intake population looking for housing].

Contact Information

67. Do we have your permission to include your contact information in our report? OR is there another person in your organization who should be designated as the contact person?

☐ **It is OK to include my contact information in the report.**

☐ **You should include someone else as the contact person in the report.**

Designated contact person to be published in the report (if different from the person interviewed)

Name of person	Position	Organization	
Street address	City	Province	Postal Code
Phone	Fax	E-mail	

Conclusion

- Thank you for participating in this project. Is there anything you would like to add?
- We will send you a draft of what we write up about your project for your review and approval - so that you can review and correct it before it is submitted. Would you be willing to do this? And we will send you a cheque for your honorarium. (Note: we will send the cheque with a thank you letter).
- We will provide your mailing address to CMHC so that you can be sent a copy of the final report.

Supporting information

Check if there is any additional information to be provided:

Information	Date received
Evaluations	
Resident satisfaction surveys	
Annual report/financial statements	
Policies/Rules	
Lease	
Other	

Stable Housing for People Who Use Substances

Approach and Interview Guide for Interviews with **Program Users** and

Approach to the Interviews with People Using Services

The method and approach for conducting interviews with people participating in your program is outlined below.⁵

Number of interviews

The consultants plan to obtain qualitative information from three individuals for each of the 10 case studies where information gathering will take place on-site, for a maximum of 30 interviews.

Program users to be interviewed

The consultants will rely on each participating agency to recruit individuals who are involved/housed in the program. We recommend interviewing individuals who are currently involved in the program because once a person has left the program it is often difficult for agencies to track them down.

We will ask the agencies to recruit individuals who are most representative of their clients and:

- Who may be at different stages in addressing their substance use; and
- Have been involved with the program for different periods of time (but have been there long enough to be able to comment on the existing program).

Training

All interviewers will participate in a training session (to take place by telephone) to review the purpose of the study, the goals of the interviews, the method and approach, and the interview questions.

Training will also address issues such as the role of the researcher, confidentiality, anonymity, body language, clothing, compensating the interviewee, recording and note-taking.

Ethical Concerns

In approaching program users to participate in an interview, the consultants (and recruiting agencies) will explain the nature of the study. They will also explain to each individual that their participation is completely voluntary and that they may end the interview at any time if they are uncomfortable. Participants will also be assured that the information will be kept confidential and will be reported on in such a way as to protect their identity and privacy. Each interviewer will be required to sign an Oath of Confidentiality (attached Appendix A).

⁵ This method is based on the report prepared by Jim Woodward and Associates Inc., Eberle Planning and Research, Deborah Kraus Consulting, Lisa May Communications, and Judy Graves, for the Greater Vancouver Regional District, entitled: Greater Vancouver Research Project on Homelessness, A Methodology to Obtain First Person Qualitative Information from People who are Homeless and Formerly Homeless, April 2002. It is also consistent with a report prepared for the National Homelessness Secretariat, entitled Ethical Guidelines for Conducting Research Involving Homeless People, 2004.

Interview guide

A copy of the Introduction and Consent Form and Interview Guide are attached. The purpose of the interview guide is to find out *how the program has affected the lives of the participants*.

Interviews with the three users in the first case study completed will serve as a test of the interview guide.

Protection of privacy

It is necessary to respect and protect the privacy of study participants. Participants will be asked to provide their initials, and the report will use made up names if individual situations are described. The interviewer will advise participants how confidentiality will be handled in reporting the research findings.

Location of interviews

Interviews will take place where both the participant and the interviewer will feel most safe and comfortable. One possible location may be in the offices of a recruiting agency. The location should be safe, reasonably quiet, private, and offer few distractions.

Recording of interviews

Each interviewer will record interviews by taking hand-written notes during the interview. If an interviewer wishes to have a second person to assist with note-taking this will need to be accommodated within the allocated budget.

Honorariums

A budget has been set to provide each participant with an honorarium [\$25 Canadian per interview in Canada and \$20 U.S. for interviews in the U.S.] to show respect for the time and information provided by the participant. Additional amounts spent for refreshment or a small snack will be reimbursed. (A maximum amount to be determined).

Oath of Confidentiality

The researchers will sign an Oath of Confidentiality with the Participating Agency.

Oath of Confidentiality

Research Title: Stable Housing for People Who Use Substances

Agency funding the research: Canada Mortgage and Housing Corporation

Principal Researcher: Michael Goldberg, Research Director,
Social Planning and Research Council of BC,
Vancouver, B.C. Canada
Phone: 604-718-7738
Email: mgoldberg@sparc.bc.ca

Researcher conducting the interview:

Confidentiality agreement:

As a member of the research team, I understand that I may have access to confidential information about study participants. By signing this statement, I am indicating my understanding of my responsibilities to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research study that could identify the persons who participated in the study.
- I understand that I am not to read information and records concerning study participants, or any other confidential documents, nor to ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research study.
- I understand that a breach of confidentiality may include termination of the study.
- I agree to notify the principal researcher immediately should I become aware of an actual breach of confidentiality or a situation which could potentially result in a breach, whether this is on my part or on the part of another person.

Signature of Researcher

Date

Printed Name

Request for Assistance from Participating Agency

The Government of Canada, (Canada Mortgage and Housing Corporation) has commissioned our research team to learn more about innovative approaches to providing stable housing for people who are homeless or at risk and who use substances, and to document approaches that incorporate a harm reduction approach. Our team includes:

- Michael Goldberg, Research Director, Social Planning and Research Council of BC, 604-718-7738 or mgoldberg@sparc.bc.ca
- Deborah Kraus, 604-221-7772 or dkraus@shaw.ca or
- Luba Serge, 514-525-0827 or lserge@videotron.ca
- Jim Woodward, 604-883-0794 or jgwoodward@dccnet.com
- Jacques Tremblay, 416-863-0499 #227

As discussed, the research team would like to conduct face-to-face interviews with three participants who are using your service/program.

The purpose is to find out *how the program has affected the lives of the participants*.

We are asking you to recruit individuals who are most representative of your clients and:

- Who may be at different stages in addressing their substance use; and
- Have been involved with the program for different periods of time (but have been there long enough to be able to comment on the existing program).

We expect each interview to last approximately 1 to 1.5 hours.

Each participant will be given an honorarium [\$25 Canadian per interview in Canada and \$20 U.S. for interviews in the U.S.] for agreeing to participate in this research project on stable housing for people who use substances.

Attached is our approach and list of our questions. If you have any questions or concerns, please do not hesitate to contact me or Michael Goldberg.

Thank you for agreeing to participate in this research project on stable housing for people who use substances.

Notes for Participating Agency to Recruit Program Users

The Government of Canada, (Canada Mortgage and Housing Corporation) has commissioned a research project to learn more about approaches to providing stable housing for people who use substances. The purpose is to learn more about good programs that help people have a place to live where they feel safe and can afford the rent.

The researchers want to interview some people from this program to find out how it has affected people's lives.

When speaking to potential interview participants, some important information for them is that:

1. Participation is entirely voluntary.
2. The researchers will not ask for the participant's name, so their identity will be anonymous.
3. Participants can choose not to answer any question or can stop the interview at any time.
4. Participation will not affect their use of services in any way.
5. The interview will be kept anonymous. (All notes will be stored securely in the researcher's office and destroyed when the report is completed.)
6. Participants will be given [\$25 Canadian per interview in Canada and \$20 U.S. for interviews in the U.S.] for their time and expertise to complete an interview.
7. The interview is expected to take about 1 to one and a half hours.

Please ask the person if they would be willing to participate.

Let participants know where and when the interview will be held.

Date:

Time:

Place:

Introduction by Interviewer and Consent Form

Hello, my name is _____ [and this is my associate if applicable]_____.

1. The Government of Canada, (Canada Mortgage and Housing Corporation) has commissioned us to learn about approaches to providing stable housing for people who use drugs or alcohol. The purpose is to learn more about good programs that help people have a place to live where they feel safe and can afford the rent.
2. We are interviewing people who are using different programs and services to find out how it they feel about them and how they have affected their lives.

Offer some sort of refreshment (small snack or coffee)

3. The research will take about 1 hour of your time. I will ask the questions, and [my partner] will write down your responses.
4. We will give you \$25 (Canada) /\$20 (U.S.) for your time and expertise.
5. Your participation is entirely voluntary, and you can stop the interview at any time.
6. We will protect your privacy and not release your identity to anyone. (All notes from your interview will be stored securely in the researcher's office and destroyed when the report is completed.)
7. Do you agree to participate: ☐ Yes " ☐ No "
8. I will sign my name to indicate that that you have agreed to participate as set out above, and would ask that you provide your initials. (We are not asking you to sign your name so your identity can be kept confidential and anonymous.)
9. Would you like to make up a name (Pseudonym) to put on your survey so that we can both identify you?

Date

Researcher

Participant's initials

10. If you have any questions, concerns or complaints about the research or researchers, please contact: Michael Goldberg, Research Director, Social Planning and Research Council of BC at 604-718-7738 or mgoldberg@sparc.bc.ca OR, contact

Name

Recruiting Agency

Phone Number

Give a business card - This will be the card of the person responsible at the local recruiting agency. If problems or concerns arise, the agency will be expected to follow up with the Consulting Team Leader, Michael Goldberg, Social Planning and Research Council of B.C.

Questions

[Ask participant if he/she would like a copy of the questions]

Pseudonym _____

I'm going to start by asking you a few questions about your background. I would just like to remind you that all your answers will be kept strictly confidential. We are not going to ask you your name, so the information will be anonymous.

Background

1. Where were you born (what city/ country)?
2. a) If not born in city where interview taking place - how did you get to....?
b) If same city, did you always live here or have you travelled around?

Current living situation

I am now going to ask you some questions about your current living situation.

3. How long have you been living here? [In housing provided or made available by Sponsor Agency]? A few weeks, months, years?
4. Can you describe the place where you are living/staying? Do you share a bedroom, have your own private bedroom? Your own apartment?
5. Are there any rules or conditions for living here? What do you think of these rules?
6. On a scale of 1 to 5, how satisfied are you with the current place you are living - 1 is the least satisfied and 5 is the most satisfied

Least

Most

1 2 3 4 5

7. What do you like **most** about the place where you are living? [E.g. room/apartment/building.]
8. What do you like **least** about the place where you are living? [E.g. room/apartment/building.]

Current programs/services

9. Describe a typical day for you. What kinds of things do you do? E.g. What kinds of activities/services? Who provides or organizes the activities/services? How do residents get to these activities/services - do residents walk, take public transit, get picked up by an agency?
10. Are you involved in any other activities/programs - e.g. run by [Sponsor Agency]? If yes, please describe them.
11. a) What do you like about these activities/ programs?
b) Is there anything you don't like?

Previous situation

12. What was your life like before you came here? For example, how is your typical day different from a typical day before you became involved with [Sponsor Agency]?
If not already covered, some of the things we would like to know about are:
 - a. *Where did you live/sleep most of the time?*
 - b. *What was your health like?*
 - c. *Did you tend to use more drugs or alcohol than now? Can you tell me about the drugs you were using e.g. Alcohol, crack, heroin, marijuana, pills - some or all of these? How much? How often?*
13. Did you try any treatment programs before coming here? Tell me about them? How did they work or not for you? What was good about them? What was not so good about them?
14. How did you come to be involved with [Sponsor Agency]?

How life has changed

15. Can you tell me about how your life has changed - or if anything has changed for you since and became involved with [Sponsor Agency] and started living here? *Probe: what were things like before and what are they like now?*
 - a. Has your income changed?
 - b. How has coming here affected your physical health?
 - c. How has coming here affected how you feel about life?
 - d. What about friends and family?
 - e. Since you have been involved with [Sponsor Agency], has there been any change in your use of drugs (*e.g. choice of drug, how much, how often?*)

- f. Have you noticed any other changes in your life?
- g. If there have been changes: What would you say are the factors most responsible for these changes?
- h. What kind of changes would you like to see for yourself over the next year, if any?

Recommendations

- 16. What, if any, words of wisdom or advice do you have for any other organization that might be interested in doing a similar project to the one like [Sponsor Agency]? Please comment.
- 17. If there are one or two things you would like to be different [re the Sponsoring Agency], what would they be? E.g. Food? Housing? Staff? Rules? Services?
- 18. If there are one or two things that should definitely not be different [re the Sponsoring Agency] what would they be? Food? Housing? Staff? Rules? Services?

Demographic questions

I have just a few last questions about your age and background. We are asking everyone these questions so we can describe the range of different people we are interviewing in this study. Again, this information will be anonymous.

1. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
2. How old are you?	
3. What would you say is your ethnic/cultural background? [It is up to each individual to self-identify].	

20. Ask if any comments about the interview process/questions

Thank you very much for your time

Put on separate sheet

☐ *Pay honorarium*

Signature of interviewer to confirm payment of honorarium

Initials of participant to confirm receipt of honorarium

Put on separate sheet

H. Interview and Note-Taker Comments

Record observations, thoughts, impressions, or questions arising from the interview.

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