

**Continuum of Services for Single Homeless Men
Final Report**

**Prepared for
The City of Ottawa Community Capacity Building Team for
Homelessness**

**Prepared by
Social Data Research Ltd.**

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1.0 INTRODUCTION

1.1 Scope of this Report

Social Data Research Ltd. is pleased to present this report to Ottawa's Community Capacity Building Team for homelessness. The purpose of this study was to examine the existing framework for the development of a continuum of services model for single, homeless men, including an environmental scan and an evaluation of the adequacy of existing services, research into models and best practices, and descriptions of optional models that might serve the Ottawa community. The research was conducted in August and September 2005.

1.2 Approach

To complete the research for this study in the short timeframe available, a number of activities were undertaken simultaneously. These were:

- An analysis of existing data, specifically:
 - City of Ottawa Inventory, July 2005
 - HIFIS database – a national database that HRSDC maintains, with input from local agencies across the country (from shelters and off-site emergency beds)
 - Domiciliary Hostel Program
 - Alliance to End Homelessness Report Card
- A literature review of Canadian and international publications and unpublished reports focusing on single homeless men, the continuum of services model, and best practices related to coordination and delivery services
- Key informant telephone interviews with experts in homelessness and models of service delivery (see Appendix A for list of experts)
- Telephone interviews (and email follow-up) with agencies serving homeless single men in Ottawa (See Appendix B for list of respondents)
- Face to face interviews with 13 male clients accessing one or more of the following agencies -the Union Mission, Shepherds of Good Hope, Salvation Army, Centre 454, and The Inner City Health Project
- Consultant brainstorming workshops to problem solve, interpret results and arrive at conclusions and recommendations

1.3 Parameters

The short time frame allotted to the research was the main challenge faced in completing this work. To address this challenge, multiple sources of information were analysed simultaneously to address the research objectives. Local statistics on the homeless are limited, however, a composite picture could be produced when different sources of available local data and studies are combined with the current client statistics kept by various agencies. Most agencies contacted were able to respond during the field period allotted to the study. The results reported are based on the opinions of the individuals interviewed from these agencies and may not be representative of agencies

that were not able to respond. Although not in the original work plan, interviews were also conducted with a small number of clients. The results of these interviews are revealing and give some perspective of the quality of services received from the clients' viewpoints.

2.0 THE QUALITY AND AVAILABILITY OF SYSTEM-WIDE DATA

In reviewing the existing data on single homeless men in the City of Ottawa, the following observations were made:

- Discrete information from shelters (HIFIS) – these data may be unreliable as much is garnered on a one-time basis. As well, there is a high incidence of non-response on individual items or questions included in the data. A further issue, according to the data analyst responsible for the processing of the results, is the fact that different forms of software are used by agencies and then converted by central office. As a result, the data may be further compromised during the conversion process.
- The City of Ottawa Inventory is a step in the right direction, particularly if it becomes a regular survey. However, there may be some definitional problems in the way questions are asked (lack of standard definitions) that could result in inaccurate or missing information.
- Overall, there have been great strides made in the collection of information on the homeless in Ottawa, however, some data has only been collected on a one time basis, and it is not clear what key data should be collected for ongoing monitoring of the status of homelessness for single adult men, who should compile this and what indicators would show that there is over or under supply of various parts of the continuum of services.
- There are some privacy concerns to address with respect to sharing of data and protection of client confidentiality.
- The way statistics are collected now can result in duplication of counts since it is not possible to identify those persons with chronic problems, who continually enter and re-enter the system.

3.0 SIZE AND PROFILE TRENDS OF SINGLE HOMELESS MEN ACCESSING SERVICES IN OTTAWA

This section provides a profile of the single homeless men who currently use services available to homeless persons and those at risk for homelessness in Ottawa. The information is drawn from a number of sources including the 18 service providers interviewed for this study, local data collected by the City (HIFIS), and other recently completed local studies.

3.1 The size of the client group

Single men comprise a significant proportion of homeless people in Ottawa. According to HIFIS-Ottawa data on persons who have accessed shelters, the proportion may be

about 80%. In 2005 from January to the end of August, according to the HIFIS data, there were over 3000 distinct male clients on average accessing shelters in Ottawa during that time period. In 2004, HIFIS-Ottawa reports 4,369 distinct clients making on average almost 5 visits each. On a daily basis, some shelters interviewed reported currently serving as many as 300 or more single men. Agencies providing meal services also report seeing several hundred men come through their doors on a daily basis. Agencies such as the Inner City Health Project report that 85% of their caseload is single men with chronic health related problems (The current number stands at 75 men). For the other agencies interviewed serving exclusively homeless people, single men make up the highest percentage of their clients.

In terms of the actual number of homeless men accessing services, there is no available data that can give an exact discreet number. However, it is estimated that about 20% to 30% are chronically homeless. The HIFIS data for distinct clients, which is reported at about 3000 currently, may be inflated since it is not known how many of these clients are accessing more than one shelter.

3.2 Profile of single homeless men

The following is a more detailed profile of the single homeless men served by the 18 agencies interviewed for this study. Where available, HIFIS data and data from other local studies describing this client group are added.

Age range

The age of single homeless men in Ottawa can range from as young as 12¹ to over 90. The average age reported by most agencies is between 40 and 45. These statistics correspond closely with those reported by HIFIS where about 53% of single adult males fall into the age range of 35-45. The ages of the male clients interviewed ranged from 23 to 59, with the majority between the ages of 40 to 49.

Cultural background

Caucasian (English or French speaking) Canadian-born men are the most predominant cultural group among single homeless men, however some agencies report that as many as 25% of their clientele have other cultural backgrounds. Aboriginal clients were the most predominant among the other cultures with one agency reporting that up to 40% of their clients are Aboriginal. Other studies (Aubry et al., 2003) have found that about 17% of the homeless in Ottawa and 10% of homeless men have an Aboriginal background – an over-representation relative to their proportion in the Ottawa population at large (1.1%). Several agencies reported that newcomers to Canada were becoming more predominant among their clients. Some agencies reported that equal access was an issue for some groups, in particular transgendered persons, gay men, persons whose first language was not English or French (Chinese was mentioned) and visible minority clients such as Somali new Canadians.

¹ One agency reported youth as young as 12 accessing their services – persons aged 12-16 would be considered youth and are not included in the statistics reported elsewhere in this report.

Physical and Mental Health

Agencies reported that the majority of the single homeless men they serve have very poor physical health. One agency indicated that 15% of their clients are physically handicapped. Another reported that most of their male clients “suffer from a wide range of untreated illnesses including chronic illnesses such as COPD, diabetes, and various cardiovascular illnesses.” Most agencies report that between 50% and 70% of their single male clients suffer from mental illness. Agencies specializing in mental health indicated that almost all of their clients have symptoms of severe and persistent mental illness.

Of the 13 male clients interviewed for the study, 35% reported their general health to be fair or poor with only 10% reporting excellent or very good health. Almost half reported physical health issues such as AIDS/ HIV, liver damage, asthma and degenerative back problems. A smaller percentage (15%) reported mental health problems including schizophrenia, anxiety and depression.

Substance use

According to the agencies interviewed for this study, the use of alcohol and street drugs is high among single homeless men in Ottawa. Most agencies reported that the majority (as high as 90%) of their single male clients had substance use issues. Over half of the 13 male clients interviewed for this study indicated they had substance use problems including street drugs and alcohol.

Concurrent disorders

About half of the agencies report that the majority of the single homeless men that they serve have concurrent disorders (mental illness plus substance abuse).

Other characteristics

A few agencies mentioned other client characteristics related to their need for services and difficulty of access. These included the issue of aging clients, extreme poverty, being victims of violence, having acquired brain injuries, and dementia combined with substance use problems.

3.3 Have clients’ profiles changed over time?

All of the agencies interviewed reported changes over time in the profile of single male clients they have served – changes that for the most part mean they are serving clients with more severe and complex needs. Respondents indicated that they were seeing more:

- men with complex mental health problems
- younger men, including youth estranged from their families
- men with HIV and Hepatitis C
- high risk sex offenders
- newcomers including refugees
- working poor
- IV drug addicts

- young men with addiction and mental health issues (especially difficult to house)
- men who are “new” to homelessness
- men who have been in and out of jobs due to addictions.

3.4 How have changes in clients’ profile affected service delivery?

The agencies surveyed indicate that serving higher risk clients has had implications for service delivery. The types of changes and needs in service delivery include:

- An increased need for supportive/supported housing
- An increased need for case management
- The need for more assistance from police services
- An increase in staff-client ratio – particularly at night (for those providing 24 hour service)
- The need for more staff
- The need for specialized staff and visible minority staff
- Additional training for staff, particularly cultural sensitivity training
- More collaboration with provincial and national initiatives around prevention, care, support and treatment for persons with HIV
- The need for more security because of an increase in violence among clients

A few agencies indicated that in spite of the increasing challenges they have not made major changes in the way they deliver services. Lack of resources is the main reason given.

4.0 CONTINUUM OF HOUSING AND SUPPORT SERVICES

4.1 An overview

Exhibit 1 shown in Appendix C (attached separately) provides a schematic overview of the City of Ottawa’s Continuum of Housing and Support Services for those that are homeless or who are at imminent risk of becoming homelessness. The housing components depicted above the horizontal rectangle include emergency shelter, supportive/transitional housing, social housing and private market housing. The service components shown below the horizontal rectangle include outreach, shelter services, and housing loss prevention. The schematic also indicates which agencies offer housing and services by component for single, adult homeless men. A brief description of each component of the Continuum follows.

Emergency Shelters

Sleeping arrangements are usually in dormitory facilities and to a lesser extent in shared or single bedrooms. Shower facilities and meals are also available. During the winter months, when demand outstrips the “permanent” supply of beds, shelters can add beds or mats to accommodate the overflow. Emergency shelters serve both the short-term homeless and the chronically homeless who often have complex health needs and are unable to access mainstream services due to behaviour or lifestyle issues. Emergency shelters also accommodate men recently released from prison who have not yet been

able to find housing in the community. A significant proportion of homeless men accessing emergency shelters are Aboriginal, Métis, and Inuit.

Supportive/transitional Housing

Supportive housing usually has on-site services complemented by provision of specialized individualized off-site services to meet the specific needs of residents. Services usually fall into two broad categories – health and personal support. The focus is on rehabilitation, skills training and community integration. While supportive housing may be long term, transitional housing is intended to be a stepping-stone that provides a supportive environment until the individual is ready to move to permanent housing. The length of stay in transitional housing varies from six months to three years depending on the place and needs of the individual. Examples of supportive housing in Ottawa are Salus, Daybreak, Shepherds of Good Hope and Options Bytown. There is far more need than can be met by these providers. Most shelter operators will attest that more supportive housing is one of the top priorities to properly address homelessness. Domiciliary Hostels also provide a form of long term supportive housing. About 25 operators provide 850 subsidized beds in supervised boarding house milieus. Domiciliary Hostels accommodate the frail elderly, persons with mental illness, persons with developmental disabilities, and an assortment of other vulnerable individuals.

Social Housing

Rent-geared-to-income housing is provided by Ottawa Community Housing Corporation (OCHC), and other non-profit, and co-op housing operators. Rent supplements are also provided in private market housing. There is a long waiting list of families and single persons who need affordable housing. It can take years to get an offer of a housing unit. The Housing Registry maintains a centralized waiting list. Single men are eligible for one-bedroom apartments and bachelor apartments. There is sometimes an onsite support worker available in certain social housing buildings to help new high risk tenants to integrate into the community and to link residents with community support services. Specialized service providers may also offer assistance to individuals or groups in social housing. However, services are stretched thinly and single homeless men can be very high-risk tenants who are not able to maintain their housing without considerable support. Their behaviour can be very problematic in age-mixed social housing buildings.

Private Market Housing

Virtually the only affordable private market housing option available for single homeless men is the stock of about 200 rooming houses in Ottawa. This is the only accommodation where rent will be close to the \$335 shelter allowance provided by Ontario Works. Some rooming houses have a supportive superintendent on site. The City of Ottawa's Rooming House Services Team² is available to help resolve crisis situations that inevitably arise. Rooming houses are one of the most feasible housing options for single homeless men to exit the shelter system. However, stock has been lost over the years and neighbourhood ratepayer groups are often vehemently opposed to the opening of new rooming houses, especially those that are likely to house single men from shelters.

² Coordinated and deployed by the Rooming House Coordinator for the City of Ottawa Housing Branch, fire, building, police, By-law representatives can be marshalled as circumstances demand to resolve and defuse the crisis.

Outreach Services

Drop-in centres and some agencies have outreach workers who are assigned to streets in the surrounding neighbourhoods, bringing survival essentials such as food, clothing, blankets, first-aid, information and other services to single homeless men who do not want to use shelters.

Shelter Services

There are services located on-site in the emergency shelters. These can include assessment and referral, housing search and stabilization, and health services. Each shelter has a housing placement worker to help homeless individuals find an appropriate, affordable place to live. Health service providers (physical, mental and addictions) often come to the shelters on a regular, pre-determined schedule, as well as on an emergency basis.³

Housing Loss Prevention

Housing Loss Prevention workers try to prevent eviction among high-risk tenants. It is much more cost-effective to help someone keep their housing than to have them cycle through an emergency shelter and the housing search process. The Housing Loss Prevention Network works through Community Health Centres to identify individuals and families at risk of becoming homeless. Workers intervene with help such as short-term loans (to cover arrears or outstanding utility bills) and mediation to resolve disputes with landlords. Workers can make referrals to appropriate programs and resources. Single homeless men who find housing typically need to receive follow up from a worker to ensure they get connected to services, pay their rent, and begin to transition from street life.

Assumptions

The effective functioning of the Continuum assumes that the following prerequisite are in place:

- system-wide planning
- partnerships and linkages between the components of the continuum
- adoption of a rehabilitation philosophy
- all components are present in the system
- clients enter the system at various points along the Continuum and can move within the continuum to attain the type of housing and support they need. The goal is affordable, appropriate permanent housing (i.e. either independent, or with the appropriate level and types of support).

4.2 Capacity

A significant number of supportive service transactions with homeless men take place every year in Ottawa. The July 2005 City of Ottawa Inventory of Support Services for the Homeless provided data from which service transactions for single homeless men were

³ Partnerships with Inner City Health, Canadian Mental Health Association (CMHA), Public Health Department, and Royal Ottawa Hospital – Outreach Program bring health services to homeless individuals on the street, in the shelters and supportive/transitional housing.

extracted for the past year. Appendix D contains an exhibit that shows the range of services provided by each of the provider agencies serving single homeless men. According to 2005 City of Ottawa Inventory of Support Services for the Homeless:

- There are 587 emergency shelter beds available for single homeless men in three locations - 168 at the Salvation Army, 216 at The Mission and 203 at the Shepherds of Good Hope. These three agencies have a total of 42 FTE support workers for their residents.
- There are 40 transitional beds for single homeless men - 14 at John Howard and 16 at the Salvation Army. These locations have 11 support staff in total.
- There are 152 supplementary beds for single men - 26 at John Howard, 24 at Daybreak and 102 at the YMCA - with a total of 5.5 support staff available.
- A total of 45 staff in seven agencies provided outreach services to 1172 single male clients.
- Fourteen workers at 11 agencies helped 3,096 single men with housing search.
- Thirty-two workers at four agencies had 5,200 service contacts with adult males in day programs.
- Twenty support staff served 380 male mental health clients who were homeless or at risk of homelessness. There are 1,172 outreach clients supported by 75 outreach workers.
- Twenty-five staff at five agencies offered physical health services to 1,057 homeless men.
- Twenty-six staff at four agencies made employment services referrals to 887 homeless male clients.
- Twenty-two staff at eight agencies made 1478 additional service referrals for single homeless men.

It is important to note that the numbers above do not necessarily represent unique individuals. The same workers and the same clients are probably counted in several categories.

5.0 EVALUATION OF CONTINUUM OF HOUSING AND SUPPORT SERVICES

The information presented in this section comes from three sources:

- interviews with 18 agencies positioned along the continuum of services
- interviews with experts in homelessness familiar with the City of Ottawa's current service system, and
- interviews with 13 clients of the current delivery system.

5.1 From the perspective of providers

Capacity

Agencies were asked if they had the capacity to meet the needs of single homeless men in the context of the services they offer. Most agencies reported yes, but also indicated gaps in services. In addition to funding for operations, reported gaps included:

- Long-term affordable and supported housing with a harm reduction philosophy
- Lack of case management
- Lack of mental health services
- Lack of bilingual staff
- Lack of staff trained to deal with an aging population and aboriginal population

When asked if they felt their agency should be trying to fill these gaps, most agencies indicated yes and reported initiatives they had taken to do so. The initiatives included:

- Forming new partnerships to address gaps such as supportive/supported housing and addictions support
- Providing longer term transitional housing (up to five years)
- Increasing staff-client ratio
- Renovating existing space to provide more units
- Re-examining the housing application process
- Taking a more case management approach in the context of system planning

Some agencies felt it was not up to their agency to address gaps but to work together to improve the system with more emphasis on preventing homelessness in the first place.

About client access

Agencies were asked how clients get to know about their services. For most agencies it's a combination of self-referrals through word of mouth and referrals by other agencies in their network. Some agencies have a very wide referral network while others report a smaller number of well-defined referral sources that includes shelters, the court system, ROH outreach, and aboriginal agencies, mainly Wabano. Some agencies report they are well known in the community and their referral relationships are working well, while others admit to being less well known. One respondent spoke of errors made (wrong service hours) about their agency in an information pamphlet distributed by one of their partners. Another spoke of inappropriate referrals made by other agencies to their agency and conceded there should be better communication among the partners in this regard. Client awareness about services may be an issue. A housing registry indicated that clients might not know how to access their service directly. Applicants are typically referred by another agency.

It was clear from the interviews that some agencies are frustrated by the lack of follow-up they are able to do and are concerned about what happens to clients once they leave their care or are no longer eligible. Some of the concerns expressed by respondents have implications for system-wide planning and are best illustrated in their own words:

"Our services in our Hospice and Special Care Unit programs are not intended to be long-term; however, frequently we have clients with us for very long periods as there are no other suitable options for them."

"It is very difficult for our clients. Some end up on the street and the youth tend to couch surf. A portion of our clients does get back into the mainstream. Some get into supportive housing. There is some follow-up for those in rooming houses & we do provide a crisis service. There is lots of room for improvement, especially with the youth. Our main goal is to help the clients get employment. "

"Our clinical goal is to stabilize individuals and then move them to a family physician. This goal is rarely realized due to the shortage of family physicians and the reluctance of fee for service physicians to work with people with

addictions and HIV who need complex care and whose appointment times are longer than those in traditional practices”.

“We feel that to succeed, clients need to have a connection with some kind of worker. This is so helpful to the landlord. Then things can be worked out, rather than resorting to an eviction.”

“For those that are housed in private market housing, we do not have enough support, so they return to a shelter in a short period of time. Not much money and little life skills are barriers.”

Not all agencies expressed frustration with the lack of follow-up. In their own words, workers describe the nature of their follow-up with clients:

“There have been cases whereby a client stabilizes and is well enough to leave and go on to other housing (sometimes rent-geared-to-income) and has re-entered into the workforce. They will be followed up until stabilized and re-established.”

“Our agency has a full time housing support caseworker. Some of the clients do get placed in social housing and tied in with support. They are followed up at 3 months and then at 6 months. I'd say that 20% get housing; 20-30 % rotate through housing and shelters, and 10-15% are transient. There is not enough supportive housing out there.”

“Depending on the individual situation, we help with general community supports, employment, and independent living. We work with people on goals that they establish and provide client directed service.”

Access to services in the system and special needs populations

Respondents were asked if any sub-population of single homeless men had more difficulties than others in accessing the system, and if so, what was needed to improve access. One respondent stood alone in saying that there were no convincing access issues and that frontline staff go out of their way to operate fairly. However, almost all other respondents held the opinion that access was an issue for some sub-populations of men. The answer given most often was that men with mental health problems had more difficulty accessing services. Other sub-populations mentioned included: aboriginal men, elderly men, youth; men with fetal alcohol spectrum disorders, men with personality disorders, refugees, new immigrants, older gay men, transgendered persons, and francophone men.

Agency staff provided some suggestions on how to address the principal barriers:

- More accessible Social Services (Ontario Works and ODSP)
- Bus tickets for clients.
- More food bank services.
- A better understanding of the signs and symptoms of mental illness.
- How to identify and work with individuals who may have a fetal alcohol spectrum disorder.
- Tools (e.g. addictions and employment services) to tackle the immediate underlying issues of homelessness.
- An eviction prevention program like HomeSafe for singles.
- Client services open later, i.e. until 7:30 pm.

Some comments from providers included:

"We need a model where everyone would have a decent place to live with support workers on site 24/7."

"Housing first, but you need the right supports in place. Warehousing is not the way to go. I would like to see smaller facilities and more diversified models. You still need the shelter component."

"I would liaise with city employees with regards to the OW and ODSP programs, analyze results of the different services each partner provides, identify the chronic problems, and try to come up with solutions. In other words, work together."

"There should be more homeless men engaged in planning the system – participating in operations, being asked what they need. "

About working with other agencies

Respondents were asked how effective their partnerships have been in terms of helping them meet their own goals. They were also asked if there was something that could be done to increase the effectiveness of their existing partnerships. Just over half of the 16 agencies interviewed indicated that they felt their partnerships were very effective, however, almost as many said they were somewhat effective and that some aspects could be strengthened. Some of the ways that partnerships could be improved according to these respondents are as follows:

- Working together to acknowledge and identify client needs (particularly related to mental health, HIV)
- More information sharing around who is responsible for what
- Agencies should recognize they are a business and have accountability for their services.
- Having regular monthly meetings
- More opportunity to sit down and problem solve
- Avoid token partnerships designed to secure funding.

Agencies were asked if there were other agencies, groups or sectors that they felt they should be working with more and what was preventing them from forming or strengthening these partnerships. Almost all agencies felt that they should be working with more partners. Several respondents mentioned that they would like to form partnerships or strengthen their partnerships with the Aboriginal agencies serving the homeless. Stronger connections with agencies in the mental health and addictions fields were also mentioned more than once as well as new/stronger partnerships with multi-cultural agencies such as the Catholic Immigration Centre. Other partnership gaps mentioned included the long-term care sector, supportive housing, and some CHC's.

Limited time, staff and resources were factors preventing agencies from addressing gaps in partnerships. However, a difference in values was also mentioned, as was the rapid increase in mental health issues that agencies are faced with.

Best practices

Respondents were asked if they had conducted any formal or informal evaluations (or had been part of a multi-agency evaluation) of the impact their agency has had on its clientele – specifically single homeless men. More than half of the agencies interviewed indicated that they had conducted or been part of a formal evaluation. A number of agencies also do regular informal client satisfaction surveys. Based on these studies,

respondents were asked what aspects of their services were working well. The following excerpts from the interviews illustrate some of the successes:

"We have had good success in helping homeless men whose lives were very disorganized and chaotic to regain a "normal" lifestyle with some structure and routine. We have been able to help them manage complex health and social problems and integrate socially."

"Our findings point us towards a "housing first" approach. We are also quite effective working with landlords. With rentals down in the city, we actually have landlords approaching us looking for tenants. When we are attached to a tenant (i.e., portable supports) the rent gets paid."

"We have found that respecting the dignity of the individual works – for example, engaging clients in the day- to- day operations of the drop in center."

When asked where they would like to improve based on the findings of their evaluations, respondents indicated the following areas:

"We would like to help men who have been homeless for a long time to learn the skills needed for long term housing success."

"The evaluation told us we need more services in French, more knowledge of specialized services (e.g. psychology), training in work with dually diagnosed people, and services in the evening and over the weekend."

"The consistent feedback from service users is that they simply want more of what we offer. The evaluation also recommended that we provide counselling, hire a life skills worker who could help clients in areas such as improved nutrition."

"Clients would like to see the program run seven days per week (no place to have a meal on weekends)."

"Evaluation indicated we need a better framework for training of frontline workers, and better training for managers."

"We would like to involve clients more if we could in the planning of our services"

Agencies were asked to describe where they have been most successful in supporting the needs of single homeless men and what advice they would give to others based on their experience and lessons learned. Here is what responding agencies had to say:

"An approach where goals are established by the client seems to work better than a structured program with pre-established expectations."

"Try not to do it alone. Partnerships are crucial."

"Men are often viewed as active agents in their own homelessness rather than victims of circumstance. You need to assist them to get past their own internalized sense that their homelessness is their own fault."

"We have learned that the homeless do want to work and that they have the necessary skills and are more than willing. "

" Make sure to get good employees. Hire qualified staff and provide them with on-going training."

"We use a strength-based approach. To try to help clients find a job, then everything else seems to fall into place."

"The most successful programs are those where the client has input. Listen and act."

“Help clients develop confidence by being available to those who come on a regular basis.”

“Defend tenant rights for the more vulnerable and abused - in cases of illegal eviction, discrimination, harassment, and invasion of privacy.”

“Moving from the shelter or the street to one’s own private place is a major adjustment. It takes time and cannot be rushed. For some this is difficult. It’s important to be there – not in an intrusive way, just available if needed.”

“When rooming house tenants and community members meet as neighbours instead of antagonists they find they have many common issues. Rooming house landlords need support too. Better to resolve disputes in a small group setting or with shuttle diplomacy instead of through a large group when issues become politicized quickly.”

“We have most successful in building a sense of community with clients, recognizing that we are all the same – clients and agency workers”.

Desired changes to current system

Agencies were asked: “If you were in charge of designing the ideal service model in the City, what changes would you make to the existing model? Or would you take a completely different approach and what would that be?” Here are the suggestions they made:

“I would reward shelters for converting shelter capacity to housing”.

“The Housing Branch is doing an excellent job. The problem is in moving people on from shelters. It is difficult finding locations for supportive housing that meet zoning criteria.”

“From our perspective, which is serving the seriously and persistently mentally ill homeless population, the system works well. “

“I would gather information from the micro to determine the macro.”

“Make sure to have a clear definition of what functions come under a shelter. Set realistic goals and fund the goals and then let the shelters decide how to operate.”

“Be able to offer employment and housing right away.”

“Develop a common vision about services and development of new housing through communication and collaboration between the different levels of governments and agencies.”.

Another question about system changes posed to agencies was, “Other than more money, if you had a magic wand, what three things would you wish for to strengthen your agency’s capacity to serve single homeless men in Ottawa?” Not all respondents gave three responses. There were many similarities in the responses, Wishes included:

- More affordable housing and rent supplements
- More supportive/supported housing
- More support services
- Higher rooming houses standards
- Better access to hospital beds at the ROH
- Bilingual capacity
- Better treatment of our clients at hospital emergency rooms

- More education around homelessness and mental illness
- Addiction counselors and mental health workers
- More case management and ACT Teams
- Stable ongoing agency operating funding
- Job training for the homeless
- HIV infected individuals treated without stigma
- Staff was better trained on mental health and addiction issues
- Laundry and shower facilities on site
- More space
- A better newer facility
- Fewer people coming through the door

How well is current system working now?

Agencies situated along the continuum of services (Shown in Exhibit 1) were asked to refer to the Exhibit during the interview and rate how well the system is functioning now for single homeless men. Most respondents felt the current system needed improvement. Only 3 responding agencies reported that the system was working very well. The following describes why some respondents felt the system was not working well:

“There is a serious shortage of supportive living facilities for mentally ill men and women. As a result, they live in rooming houses and other poor quality housing where their needs are not being met and they are in fact being victimized.”

“The size of the shelters has always been a concern for me. The system needs to be sensitive to special needs populations that cannot safely live in the male shelter system. It would be helpful to “unpack” male homelessness and differentiate interventions based on characteristics of sub populations (addicts, mentally ill, physically ill, newcomers, transient, recurring episodic homelessness, chronic homelessness).”

“The services are fragmented and there is duplication. Agencies tend to work in isolation and are not working collaboratively.”

“One problem is need for a systematic way to assess – it’s by “guess and by golly”. We need a comprehensive team approach.”

“We are so busy attending to the basic needs of feeding our clients that we don’t know what’s going on in the other services in the city.”

“If our overall goal is to end homelessness we are not doing very well as we are not making much progress. We need more permanent housing”.

For those agencies that felt the system was working well in terms of communication and coordination, the following quote explains why they felt this way:

“Community partners (at various levels) along with the City have worked very hard over the past 14-15 years in a deliberate fashion to develop a coordinated and broad-based support system, that is based on best practices. There is always room for improvement, but generally I feel it is progressing well.”

Respondents were asked to identify the gaps in the system for single homeless men – components that they felt were missing. There was some agreement among the agencies in this respect. Gaps that were identified included :

- Affordable, appropriate, supportive/supported, safe permanent housing (mentioned most often)
- Mental health services and addiction services (from engagement to assessment to treatment)
- Employment readiness programs and life skills programs
- Shelter services in French
- More support for male survivors of childhood sexual abuse (by increasing services offered through The Men's Project).

Some respondents offered suggestions on how to address gaps.

"We need to lobby the Province to provide adequate addictions treatment (e.g. 28 day treatment programs have been shown not to work but that's all they fund). We need a concurrent disorders treatment program. There has not been an increase in addictions services resources in nearly 10 years."

"Those who exit the addictions treatment setting or who naturally stop using on their own are set up for failure as we drop them into rooming houses and other places where drug use is commonplace. Portable supports should be available to assist some people to maintain housing. We have these in place for people with severe mental illness but not for people recovering from addictions"

"We need advocacy to improve EI benefits and on increasing social assistance rates. ODSP will give a single individual an appalling \$12 000 per year on which to live."

"We need an increase to the emergency shelter per diem – it's gone up a small bit, but it doesn't cover the costs."

"We need creative approaches to housing development. All new developments should be required to have mixed housing. There shouldn't be any more investment into shelters. The goal needs to be the downsizing of shelters and improving all other areas."

When asked what components or pieces are needed in the system to address gaps, responding agencies had this say:

"An expansion of case management services"

"A lot of advocacy work and public awareness to put pressure on the province to move on resources."

"Consultation and planning for any new social housing that may be developed in the near future."

"A central referral system."

"Not just formal supports. Community development aimed at helping formerly homeless people moving to a new neighbourhood adjust to their new home and make connections in the community."

Agencies were asked to rate how well the existing system was coordinated, how well services were linked, and whether there were any overlaps. Here the answers were split. Those agencies that seem to be well connected felt the system was well coordinated while those who were less connected were more critical of the system. The following quotes illustrate the two viewpoints:

"There are not enough linkages. The system is too informal. "

"The system is too fragmented and some duplication occurs."

"Right now it is not a good coordinated system of services."

“There is a good network of programs and services. They communicate really well together for the most part. There is excellent leadership among the Executive Directors. Only the services which are outside the mainstream (e.g. Ottawa Inner City Ministries, Capital Mission) do not seem well linked to the others.”

“From my perspective, the components are linked together by the knowledge, skill and dedication of the front line staff. Where there is significant staff turnover (e.g. in the shelters) the coordination of services suffers accordingly. I am not aware of any overlaps.”

“The Inner City Health Project has led to a greater coordination of services, moving people from managed alcohol program at SOGH to the special care unit at the SA and the Mission Hospice. There are good connections with CMHA for those with severe mental illness and concurrent disorders and links to the walk-in services at Sandy Hill CHC.”

When asked what was needed to improve coordination, most respondents reiterated the same suggestions they gave earlier in the interview when they were discussing the needs of their own agency. Responses that had relevance for the system as a whole could be grouped into a number of categories. Some respondents felt that an articulated written plan was needed – one that all agencies had input into and could buy into. Several respondents mentioned the need for an electronic database where client information could be shared among agencies. Others reiterated the need for a mechanism that would help agencies increase their awareness about the services others were offering.

Some guiding principals

Agencies were asked what guiding principles should be considered in designing the ideal model. Following is a distillation of the suggestions made by agencies:

- System is community directed and managed as a collaborative service model
- Inclusiveness
- Commitment to finding a housing solution for each person
- An assessment and care plan for every shelter resident.
- Keep the homeless man safe from long term harm
- Provide services in a non-judgmental way
- Partnership with other agencies
- Provide client choice
- Easy and equal access
- Client-centred approaches that give homeless men dignity and self-respect.
- Clients would become empowered by having a voice.
- Link housing providers in much more cooperative manner
- Evidence-based best practices
- Include homeless in service and housing planning
- Respect individuality and different cultures
- Understanding of cultural diversity

5.2 From the perspective of clients

Interviews were conducted with 13 adult men (age range 23-59) who currently access one or more services for homeless people or those at risk for homelessness in Ottawa. Aboriginal men were over-sampled for comparison reasons. Eight of the 13 respondents were Aboriginal. All but one respondent was Canadian born. One respondent immigrated to Canada with his family from the United States as a child. Only one respondent (23 years old) was born in Ottawa and had lived here his whole life. Most of the remaining respondents have moved to Ottawa from other locations in Ontario, however, others came from communities in Quebec, Alberta, Saskatchewan, Nova Scotia, and Prince Edward Island. About one third of the respondents indicated that they moved around a lot.

In terms of education, most respondents have not completed high school, however, several have some post secondary education including one respondent who has a telecommunications engineering degree and lost his job five years ago during the telecommunications downturn in Ottawa. Most respondents were receiving some form of regular income (welfare/disability) but most earned their money by either panhandling, part-time cash jobs, street performing (including an artist) or borrowing money from family and friends.

Respondents were interviewed on location (at the agency that provided the client referral to the consultants) and were remunerated for their time and opinions. Prior to the interview, respondents were assured of the confidential nature of the interview and were encouraged to speak freely. Potential respondents were recruited through The Inner City Health Project and Centre 454. Interviews were conducted at the Centre as well as the Mission, the Salvation Army (Special Care Unit), and the Shepherds of Good Hope.

Length of time using service

The length of time respondents had used the services offered by the agency where their interview took place ranged from one month to 14 years. Most, however, had used the service for more than one year but less than five years. Several respondents reported that they had been “couch surfing” and one respondent spoke of the difficulty finding an affordable apartment while on welfare.

Why using service

Respondents were asked what brought them to the location where they were interviewed. Most respondents had heard about the service (drop-in meal service, shelter) through a friend or acquaintance. However, several had been referred by another agency such as The Inner City Health Project, Wabano, or CMHA. For those using shelter services, most had lost their previous housing for different reasons (roommate moved out and couldn't afford rent, or couldn't afford to pay friends for food). A number of clients reported serious health related problems including HIV, substance use issues, infections led them to be referred to services offered by The Inner City Health Project or the Salvation Army Special Care Unit. Several respondents reported that they had been "kicked out by family" at an early age and were surviving on the streets or couch surfing most of their lives.

How service is helping now

When asked how they were being helped now most clients referred to the basics of receiving food and shelter as well as a place to shower and clean up. However, it was also clear from the respondents that they were receiving other benefits. The following quotes illustrate the range of assistance being given to clients:

"I'm able to be clean, have somewhere to go. Good moral support. More guidance. Waiting for SIN & birth certificate. Then I'll go to Windsor for brothers wedding." (Union Mission)

"They see to my dental & medical needs, take us to the hospital for check-ups. They roll my cigarettes because I can't use my left hand (stroke). They give referrals for housing, employment, counselling." (Shepherds of Good Hope)

"They helped me quite a bit, a lot healthier, eating steadily, a stable place, not getting drunk, not falling down drunk and getting hurt." (Shepherds of Good Hope)

"They give me medical attention for my health and addiction. Medical attention is the best here. They give me alcohol daily to prevent me from going into withdrawal & from drinking Listerine and or alcohol or whatever I can get my hands on." (Shepherds of Good Hope Harm Reduction Program)

"They monitor my health, see that I get my meds, am now diabetic so they check my sugar levels. If I need anything they help me out with clothing, getting me to the hospital." (Salvation Army)

"I use the free phones, get messages here, use it as a mailing address. There are people to talk to, socially and can talk to counsellors if something is bothering me" (Centre 454).

When asked if they feel safe coming here, almost all respondents indicated yes. Respondents spoke of the feeling of comfort, how it's safer than living on the street, how the staff is supportive of their needs and how the environment is well controlled and secure with the presence of on-site staff that appear to be trained to handle problem clients (including violent clients). Two Aboriginal clients indicated that they would feel more comfortable if there were more native people using the service. As one client put

it..."I get paranoid when I'm in a place where I don't know anybody". This same client felt there should be more "native" programs available.

Services/agencies used most often

When asked which services they had used most often, 11 of the 13 men interviewed mentioned The Mission. A number of respondents mentioned the good food at The Mission as one of the main reasons why they go there. Other reasons included the central location close to parks, the staff, friendships they have developed, and the feeling of safety (controlled environment). The Shepherds of Good Hope and the Salvation Army were also mentioned by almost half of the respondents. In addition to meals and friendships, one respondent mentioned having access to harm reduction services for alcohol addiction as to why he accessed Shepherds of Good Hope. Some chose the Salvation Army because they perceived it to be cleaner, brighter, and safer for sleeping than some other locations. One Aboriginal respondent mentioned Wabano.

Use of aboriginal agencies

At a later point in the interview, aboriginal respondents were asked if they had used any of the aboriginal agencies in Ottawa (provided a list). All 8 aboriginal respondents reported that they had accessed the services of one or more of these services. Half of the respondents had accessed the services of two agencies, and one respondent had used the services of three different agencies. The agency reported most often in terms of service use was the Wabano Centre. Five of the 8 aboriginal clients had used the services at Wabano – all reported being satisfied with the help they received. The types of services respondents received from Wabano included: anger management class, the food van and use of the telephone, obtaining bus tickets, counselling, referrals for housing, and the medical services (doctor). Two respondents also reported accessing Wabano's lunch program (Biindohgen).

Four respondents reported that they had used the services at Odawa. All but one respondent reported satisfaction with the help they received. The types of help respondents reported receiving from Odawa include: help finding employment, referrals to housing, help with transportation (bus tickets), obtaining food and clothing, help going back to school, and use of computer and telephone.

One respondent reported using the services of the Assembly of First Nations. The types of services used included the resource library and the employment listings.

Two respondents indicated that they were not aware of some of the aboriginal agencies. Another respondent reported that although he was aware of all the aboriginal agencies, he didn't use them because they were not able to find him a place to live.

Agencies that are not used

Respondents were asked if there were any agencies or services that they did not use for any particular reason, and if so, why not. 8 of the 13 men interviewed had a response to this question. Three respondents mentioned the Salvation Army. Two of these three respondents said the reason they did not go there was because of the strict rules against the use of alcohol. The third respondent, who was Aboriginal indicated that he was not comfortable going to the Salvation Army because the other clients are mostly non-natives.

Other agencies mentioned were Odawa (too far), Pink Triangle (an Aboriginal respondent who felt the services were mainly for non-native people), YMCA (a 43 year-old man felt there were too many gay men cruising, and the dress code was too stringent –not for street people), The Mission (one respondent indicated he was barred from the Mission and accused of stealing from other clients; another client who was Aboriginal felt the Mission was non-native oriented and catered more to street people, drug addicts and alcoholics), Shepherds of Good Hope (a 38 year old male reported not feeling safe there).

Unmet needs

Respondents were asked if there were any help they needed right now that they were not getting. Nine of the 13 men interviewed responded positively to this question. The types of unmet needs could be grouped into the following categories:

- Housing – 3 respondents reported a need for affordable housing and a desire for an apartment of their own – two of these respondents, both Aboriginals, felt that landlords discriminated against them because they were Aboriginal and homeless – one indicated that he was receiving enough money each month to pay rent. A third respondent was saving to be able to eventually afford a private market rental apartment.
- Employment – 3 respondents reported that they would like work – one (a 37 year old man) was too sick right now to work but wanted help getting employment in the future, another respondent was an unemployed carpenter (a 37 year old man), and another was a telecommunications engineer (a 59 year man)
- Health – 1 respondent reported a need for treatment for his back and nerves, and another respondent reported a need for counselling to help with a marital break-up
- Transportation – 1 respondent reported a need for more help with transportation

Health and support

Respondents were asked if their overall health had changed at all since coming to the agency where they were interviewed. Ten of the 13 respondents said yes – 8 for the better and 2 for the worse. For those whose health improved, the reasons given included:

- Better nutrition (gained weight)

- Better hygiene
- Getting counselling, have someone to talk to
- Access to good medical care and medication – one respondent said he wouldn't be alive today without this help
- Reduction in substance use

For the two people who said their health had worsened, one indicated his mental health was worse because living with a lot of people was stressing him out. The other person didn't know why his health was worse – it just was.

Most respondents had health related problems including physical health issues such as liver damage, HIV/Aids, pancreatitis, degenerate arthritis, and asthma as well as mental health issues such as anxiety, depression and one case, schizophrenia. In addition a number of respondents were battling substance use issues including alcoholism and the use of street drugs. When respondents were asked if they were getting the help they needed for these issues, 9 out of 12 respondents reported yes. However, in spite of responding positively to this question, several respondents with substance use issues said that although the help was offered, they were not ready to accept it. Others appreciated the support they were receiving from staff as well as the roof over their head.

For the three respondents who indicated they were not getting the support they needed, one said it was because the agencies were not sensitive to the aboriginal culture. The other two respondents admitted they were not receptive to the help. In one case, the respondent was not ready to give up cigarettes, and in the other case, the respondent said he had trust problems and problems with paranoia and anxiety which made it difficult for him to wait in lines with other people.

Additional comments made by clients

At the end of the interview clients were asked if there were anything else they would like to say about their situation or about the services in Ottawa for people who are experiencing homelessness. Everyone added some comments, often about their own personal hopes and dreams. Here is a sample of what respondents had to say:

“I became an alcoholic after I split up with my wife and lost my kids. Mentally and emotionally I couldn't deal with it. Now that my children are grown up I can see them. I had to let everything go because of my illness. If I were healthy I would get back to work and get back on my feet. If I really wanted help I could get it here.” (A 42-year-old aboriginal man)

“I wouldn't be alive if I wasn't living here. One time when my body temperature went really high if I hadn't been taken to the hospital by staff I would be dead”. (A 47-year-old aboriginal man)

“Housing is the main issue. There are a lot of places to go and eat; clothing is available here and at Shepherds. You can be well dressed. Lack of affordable housing is the issue. I'm looking for my own place. I can't find a place for less than \$500. There's nothing

wrong with The Mission except for the lack of privacy. I don't think there is a solution to housing". (A 59-year-old man)

"Ottawa is the best city for homeless people. The Salvation Army van picks people up and takes them to the shelters. If you go hungry or freeze it's your own fault. They're here to help." (A 52-year-old man)

"Before I was a labourer. After I got injured in 2001 I had no income. Being homeless was new to me. I found that there were many places to eat. I used to sleep outside because I didn't like the shelters. I didn't like the other clients but there was always a bed. I'm really grateful that the programs are in place". (A 35-year-old man)

"I am quite happy where I am. I'm ready to move on. I couldn't take care of myself one year ago but now I can. Homeless people are pretty well taken care of in Ottawa." (35-year-old man)

"If they had a native shelter I would like it more than here – more comfortable but it's not a racial issue here – it's nice." (A 23-year-old aboriginal man)

5.3 From the perspective of key informants

Key Informants familiar with the Ottawa Continuum of housing and service supports were asked for a critique as it pertains to homeless single men. Their views are summarized and presented below.

- Demand for low-income housing highly exceeds current supply. No new low-income housing development by the City of Ottawa since 1995, despite marked population growth.
- Not enough new affordable housing that meets the needs of adult single homeless men (best design is bachelor or one bedroom apartments/independent living.)
- Shelters are filling the void for a lack of permanent supportive/supported housing. Lack of programs and funding has resulted in long-term use of shelters by single homeless men.
- Critical shortage of short and long term supportive/supported housing.
- Need to develop an effective program with the primary aim of finding stable housing for the homeless and to identify those at risk. Some see the Housing First model as a promising approach.
- Real shortage of services in particular portable long-term services (outreach and caseworkers for all clients).
- Research and evaluation literature indicates the practice of system planning in Ottawa is conventional and is consistent with a community development approach.
- Cut-backs to the Housing Branch at City have led to a perception that "we are moving backwards".
- Little room in the current system to shift resources from one component of the system to another – a minority opinion.

- Target all investments to permanent solutions that end homelessness – a majority opinion.
- Rooming houses have a significant role to play as a stable housing alternative for single adult men providing they are of appropriate quality, size (small) and location (mixed residential neighbourhoods); and residents have access to portable services.
- Not enough information on Aboriginal homeless populations (generally or locally). Aboriginal homeless need solutions that are specific to their unique needs and developed from within the community.
- Need to work with Aboriginal groups and non-profit organizations to ensure that services are culturally appropriate.
- Aboriginal communities may be reluctant to embrace harm reduction approaches, especially amongst community of elders. Youth have been more receptive and interested.

5.4. Dominant Themes

The following are dominant themes were heard from different sources:

- City of Ottawa is currently providing high quality services meeting the immediate and intermediate needs of homeless men.
- We have not done as well as we could in involving individuals who are homeless in the process of addressing homelessness
- On the whole, clients appear to be satisfied with services and appreciative
- Agencies have dedicated staff, long successful track records in the business, and strong leadership
- Some agencies are recognized leaders in the field
- There are major gaps related to lack of affordable permanent housing choices and supportive/supported housing options
- Having the ability to more fully address the needs of chronically homeless men would ease pressure on the system immensely
- Currently the system does not allow for longer-term follow-up of clients from one agency to another
- More coordination between aboriginal and mainstream agencies is needed and desired by all parties
- Increased multicultural client base including high proportions of aboriginal clients requires greater sensitivity to multicultural and diversity issues and culturally specific approaches
- There is a lack of harm reduction services and housing options

6.0 WHAT THE LITERATURE SAYS ABOUT BEST PRACTICES

This section presents a summary of the main issues and best practices found in the literature on how best to work effectively with homeless people, and reduce and prevent homelessness. The references are contained in Appendix E. A more extensive body of material informed the overall study.

6.1 Prevention

Prevention is the key to addressing homelessness. Poverty is the one single common denominator of homelessness. Long-term efforts to address homelessness need to include:

- Building more housing and subsidizing the costs to make it affordable to people with incomes below the poverty level;
- Helping more people afford housing, by providing them with better education, better training, and better jobs; and
- Preventing the next generation of children from experiencing homelessness.

Shorter-term programs found to be effective include:

- Programs that negotiate with landlords and help with bad credit histories
- Access to funds that can solve a household's short-term problems, such as rental arrears, security deposits, and moving expenses
- Programs that encourage development of affordable, accessible properties, and help managers ensure good maintenance and repair; and
- Programs that help people develop personal and family financial management skills, establish or re-establish good credit and rental histories, and;
- Programs that help high-risk tenants retain their housing.

6.2 Stable housing

Stable housing is necessary to break the cycle of homelessness. Research has shown that two forms of public support - entitlement income and subsidized housing - were the most important variables associated with exits from homelessness into stable housing.

Most people who become homeless enter and exit homelessness relatively quickly. There is a much smaller group of people that spends more time in the system, the majority of whom are chronically homeless and chronically ill, living in the shelter system, hospitals and jails.

6.3 Supports

People should be helped to exit homelessness as quickly as possible through a housing first approach. For the chronically homeless, this means permanent supportive housing (housing with services) - a solution that will save money as it reduces the use of other public systems. For families and less disabled single adults it means getting people very quickly into permanent housing and linking them with services. People should not spend years in homeless systems, either in shelters or in transitional housing.

The importance of stable housing is repeatedly emphasized in the literature. There is evidence that housing can stabilize even the most chronic and most severely mentally ill people if they are supported with the appropriate help. People with extensive histories of substance abuse have left the streets and obtained stable housing. Furthermore, the evidence shows not only that making these services available works to end homelessness, but also that, for long-term homeless people with substance abuse and mental health histories, these service provisions are virtually cost-neutral.

Recent years have seen fundamental shifts in the objectives and delivery of assistance to the homeless. An early emphasis on emergency shelter and monetary housing assistance has been replaced by a focus on programs designed to blend shelter with an array of social services.

An example of a successful support program combined with a housing first strategy is the Pathways to Housing Program. Unlike the traditional Assertive Community Treatment model, the Pathways to Housing Program:

- allows clients to determine the type and intensity of services they receive - or refuse them entirely
- includes the practice of radical acceptance of the consumer's point of view
- uses a harm-reduction approach to drug use
- includes a staffing model of full-time employees, about half of whom are consumers.

The Pathways to Housing program represents a significant paradigm shift from the linear residential treatment model. It challenges popular clinical assumptions about the limitations of people with severe mental illness and the type of housing and support that is best suited to meet their needs.

Policy design should differentiate crisis situations from chronic homelessness. Sometimes a "quick fix," such as emergency financial assistance, really is the answer for a particular individual or family. This approach is more rational than providing services only after the individual or family becomes homeless.

6.4 Root causes of homelessness

The literature is consistent in indicating the following straightforward factors about the availability of housing and support services as the root cause of homelessness:

- the demand for social housing outstripping supply
- low vacancy rates and high rents
- the lack of funding for community supports for people with mental illness
- the inadequacy of the addiction treatment system
- the inadequacy of social and income supports in preventing family breakdown

6.5 Planning process

Much more intensive planning for addressing homelessness has been recommended in many reports and should include:

- a community-based planning process

- stakeholder planning workshops
- a wide distribution of information bulletins at critical phases in the plan's development
- small group sessions with homeless individuals in shelters and drop-in centres.
- continual outreach and consultation efforts with organizations serving homeless people, including those serving urban Aboriginals and youth
- collaboration among all levels of government

6.6 Guiding principles

Guiding principles are common to a number of city / regional plans. As an example, the Vancouver Regional plan included:

- a coordinated and inclusive community response.
- address the needs of people who are without shelter, staying in shelters/safe houses, or who are at risk of homelessness (living in shelter that is not safe, healthy, secure or affordable).
- flexible and coordinated responses that recognize the diversity of homeless people and their needs
- a continuum of housing and supports
- access to and distribution of all components of the continuum according to community need
- a plan that is a living document, to be updated as circumstances require

6.7 Common barriers

The literature identifies common barriers to ending homelessness as follows:

- jurisdictional gridlock and political impasse
- lack of coordination
- increasing poverty
- inadequate supply of low-cost rental housing
- emergency bias
- inadequate community supports for people with serious mental illness and addiction problems

6.8 Directions

To overcome the barriers to the reduction and prevention of homelessness, changes may be necessary on several fronts:

- a facilitator to focus action on homelessness
- shelter allowances for the working poor
- more supportive/supported housing
- new affordable housing
- preservation of existing affordable housing

- incentive funding to encourage the shift from emergency response to prevention
- service planning organized around different sub-groups - youth, families, and
- a Homeless Services Information System
- a harm reduction approach
- eviction prevention strategies
- better discharge policies and practices
- community economic development
- self-help

6.9 Economic argument

Recent studies examining the cost of homelessness to society in Canada and elsewhere have found that

- businesses need to adopt the cause of homelessness
- not doing so results in significant losses to business community. For example, “the average Canadian mid-sized community, such as London, will lose \$24 million and 219 jobs in retail income, \$24 million and 442 jobs in leisure income and up to \$20 million in losses through theft in the retail sector – a total \$68 million”⁴.
- cost of supportive housing or permanent housing with minimal supports is roughly 30% to 73% that of the cost of operating emergency shelters.
- supportive housing with a high level of support, including 24 hours/7 days per week staffing involves just over two-thirds (70 %) of the cost of tertiary care (e.g., psychiatric hospital or treatment centre, detention centre/lock-up)
- directing new investment to the lower cost (and arguably more effective) supportive option is likely to be more cost efficient than investing in new prisons, psychiatric hospitals and emergency shelters.

6.10 Reasons to act

- compassion, moral obligation
- economic argument

7.0 BEST PRACTICES AND ALTERNATE MODELS

Interview with key informants generated the following examples of best practice approaches, programs and organizations locally and elsewhere. The examples presented here are not intended to be exhaustive. They reflect the knowledge and breadth of experience of the key informants interviewed.

⁴ Source: Ivey School of Business, University of Western Ontario, press release, May 17, 2003, page 3.

7.1. Local examples

- Salus Corporation offers housing for residents with mental illness. Offers a mix of on-site and off-site supports, intensive case management, and independent living units (apartments) within managed housing developments. Millennium House project supported in Phase 1 of Promising Approaches through NHS.
- Options Bytown offers rent geared to income apartments and support services, but currently has a waiting list for housing. A variation on Housing First, but doesn't seek housing options outside of their own developments.
- Daybreak offers several houses with rooms to rent, with supports.
- Housing Help has service workers who help find housing and negotiate with Ontario Works for increased supports.
- The Inter City Health Project, The Alliance to End Homelessness and The Mission's hospice.
- Managed alcohol programs – Shepherds of Good Hope offers “wet-house” shelter and controlled alcohol programs.

7.2. Examples elsewhere

- Tent City Initiative (Housing First) had good results from combining portable (mobile) supports, Rent Geared to Income Housing (RGI) and portable rent supplements (but these can allow individuals to move without resolving issues with landlords and can increase administration time).
- Streets to Homes in Toronto, City of Toronto (Housing First, using same premise without portable rent supplements). Initiated February 2005, focussing on long-term solutions. Offers unsheltered homeless permanent housing solutions. Pro-active client solicitation by portable and virtual service support team. 9 staff working in conjunction with 12 non-profit agencies to locate, house and resource clients. Clients housed using Shelter component of Ontario Works (\$325 monthly). Three biggest city landlords (among others) have entered into agreements with individual homeless clients for reduced rents. Landlords have access to on-call support for tenants through the program. The program also works with stakeholders through all Ontario Works programs in the City and other enforcement officials (police, parks, by-law) to increase access to the program and rates of success. Streets to Homes have housed 277 individuals (1.2 daily) since February. Streets to Homes funded through SCPI.
- Canada Centre for Quality Rights in Accommodation (Toronto, funded through the City). Eviction prevention.
- Overnight Respite Centre, Toronto. Offers services between 8pm and 8am for clients who want to access resources to improve their own situations. Not a drop-in, clients must be active participants in seeking supports and resources and caseworkers offer assistance.
- Street Cleaning, Toronto. Identifies low-income individuals with mental and physical health issues that are at risk of eviction. Pro-active approach that provides supports and services to address needs before individuals become homeless.
- Beat the Streets, a youth program in Toronto, exemplifies innovative fundraising by securing corporate sponsorship for teaching resources like computers.

- Housing First models in US jurisdictions like New York City, Philadelphia (Housing Support Centre), Chicago and Community Care in Washington. All share a well-developed ten-year plan with strong strategy components.
- For related services, harm reduction approaches developed in Vancouver (pioneer in Canada) and Frankfurt (Monday's Round). These models bring all levels of support together to share resources, funding and knowledge.
- The Annex harm reduction program, Toronto. Servicing Adult Male Homeless with Alcohol related issues).

7.3. Best practise approaches for clients with addictions and mental health problems

- Address housing issues. People can't address other issues until they have a place to live. These populations can be housed immediately.
- The literature indicates that this housing first approach has been effective for clients with mental illness and substance abuse issues. Albeit, it is difficult as Streets to Homes (based on the housing first model) reports that the hardest population for them to serve are those people with chronic mental illness.
- Collaborate with other experts serving this population to develop customized strategies for specific populations.
- Models emerging involve intensive case management (to address mental health issues) combined with access to support groups to deal with addictions, harm reduction and stages of the approach.
- Offer mixed service delivery models, where non-profit groups and governments are both involved and both providing direct services.
- Have government agents deliver services to the most difficult to reach clients. They have the leverage necessary to coordinate efforts with other governmental partners and stakeholders.

7.4. Promising Alternative Options

Two promising, complementary best practice approaches emerged from the literature, from providers and from key informants.

Housing First/Pathways Approach

The focus of this approach is housing clients first before addressing other issues. This model bypasses transitional housing and shelter supports. Once homeless persons are housed, other issues and services (alcohol and drug rehabilitation, mental health services, community services) are offered and explored as they are needed and wanted by individual clients. Services are developed to support permanent housing arrangement and are client-driven (not attached as a condition of housing), individualized and flexible. This approach shifts the orientation from "Can I help you" to "Can I house you" and is geared to empower individual self-determination.

Harm Reduction Approaches

This approach offers an alternative service delivery model to zero tolerance and abstinence models. It focuses on delivering reality-based messages and setting client-

driven goals that reduce risk, prevent disease and lessen harm. This approach requires service delivery systems to be non-judgmental, flexible and individualized. Examples include Toronto's Drug Strategy using the four pillars approach (harm reduction, treatment, enforcement and prevention). Many large urban centres have programs that use this approach and target homeless populations. Examples include safe injection sites and managed alcohol programs.

8. CONCLUSIONS /OBSERVATIONS

8.1. Quality of data

Statistics and current program data are inadequate for program planning. For example, agencies could not differentiate client use by sex or differentiate between chronic homeless adult males and new adult homeless males. As well, there are no discrete counts on the number of homeless and no system for client follow-up from service to service.

8.2. Clients and program use

- The needs of homeless men appear to be becoming more complex – poor health, higher prevalence of concurrent disorders, an expanded age range, and cultural diversity.
- The high prevalence of mental illness and substance abuse problems among homeless men cannot be ignored. This is consistent with previous research⁵ – 60% identified with a diagnosable mental health problem {based on a self-report screening tool} and 65% reported drug use)
- Aboriginals are disproportionately represented among homeless single men
- Some agencies have a broader, more dominant mandate than others and offer a wide array of services to a large number of homeless men daily – e.g., Inner-City Health, Mission, Shepherds of Good Hope, CMHA and OASIS, St Luke's Lunch Club.
- There is inadequate follow-up of homeless men who exit shelters into housing. Many fail in housing and cycle back to the shelter system.
- There are access issues for sub-populations of the homeless single male population, in particular, GBLT and new Canadians

8.3. Strengths of the current Continuum Model

- willingness of agencies to work together in a coordinated way
- dedicated, stable management – most have been in the homelessness field for a long time
- most of the components are in place

⁵ *Harm Reduction for Homeless Persons with Addictions in Ottawa* by Beth Allan and Judith Nolté, for the Working Group On Addictions in the Homeless Population, October 2001, fact page for Homeless men in Ottawa-Carleton.

- some recognized stars in the field, e.g. Inner City Health and Alliance to End Homelessness
- services are mostly geographically grouped in two neighbourhoods in the City - Centretown and Lowertown – which makes access easier for the homeless downtown but decreases access for those in the suburbs and draws the homeless to the centre core of the City
- mainstream resources have adapted to the homeless e.g. the Royal Ottawa's Outreach Team and CMHA ACT teams

8.4. Weaknesses of the current Continuum Model

- The system is fragmented from the perspective of the homeless person – a homeless person may approach any agency and may (or may not) gain entry, and may or may not get connected to other programs and services.
- There is little to no follow-up by individual agencies once the homeless person leaves their agency.
- There is a serious shortage of permanent affordable housing, including supportive/supported housing
- Partnerships are few among agencies serving the homeless
- Agencies do not know much about each others' roles and mandates
- The plight of the homeless is exacerbated by the failure of other systems such as the lack of addiction services.
- There is a lack of qualified staff to adequately respond to the complex needs of single homeless adult men in the following areas – mental health, addictions and multi-cultural sensitivity, in particular Aboriginals
- There are insufficient case management resources
- Few staff could make the leap from concerns of the agency to the system as a whole
- Agencies are not always aware of best practices in the sector
- Staff may respond to clients based on their agency's mandate rather than the client's individual need
- Agencies appear to be responding to clients as a homogenous group – there is no planning data about chronic versus relatively recent clientele.,
- There is little reference to helping homeless single males obtain employment.
- There is a shortage of portable supports for single, homeless men (e.g. Aggressive Community Treatment program (ACT)).
- There appears to be a need for crisis intervention teams - e.g., on-call emergency response team, support by telephone, crisis beds.
- There is a shortage of safe places to sleep off a drunken stupor or drug high employing a harm reduction approach especially for Aboriginal men
- Community leaders have not championed addressing homelessness– no mayor, chief of police, or business leaders have taken up the cause. Advocacy depends mostly on front-line agencies and staff

9.0 RECOMMENDATIONS

1. Strengthen and invest more in data collection systems to facilitate short term response and long term planning for more effective services for single, homeless men. This could include:
 - Assigning someone/an organization to oversee data gathering.
 - Allocate sufficient human and financial resources for this activity
 - Address concerns about confidentiality
 - Provide training to boards, management and staff on the benefits of good data

2. Introduce a Housing First Approach for single homeless men. This would require minimal shift in the thinking of current service and housing providers as many have already adopted this philosophy and approach. Changes necessary to facilitate the transition would include:
 - System-wide acknowledgement and acceptance by agencies serving homeless single men that this is the desired direction.
 - A more flexible mix of on-site and portable services. The way services are delivered would need to be reinvented and increased.
 - Workshops including Boards, management and staff to design strategies directed at realigning the present system towards a housing first approach
 - Acceptance of research that challenges popular clinical assumptions about the limitations of people with severe mental illness and the type of housing and support that is best suited to meet their needs.

3. Increase the understanding and implementation of a harm reduction approach for all residential and support services for single homeless men, both in the shelters and in the community. There will always be a portion of those with concurrent disorders who resist or are not ready to accept help. Needle exchanges and safe injection sites with an opportunity for engaging clients is one example. The high use of substance abuse among the homeless and high incidence and prevalence of HIV/AIDS speaks to the need for this approach. Research and experience elsewhere suggests that this leads to safer communities and a subsequently lower prevalence of substance abuse.

4. Encourage primary service providers for homelessness men to sit down with community mental health agencies to develop a plan for better services organization and delivery to single homeless men.

5. Convert a portion of the emergency shelter stock to supportive permanent housing for the chronically homeless, in particular, for those chronically homeless men unlikely ever to have the resources to live independently. This would relieve considerable pressure on the system as a whole as it should

reduce the “revolving door” syndrome and substantially reduce the homeless population. Pre-requisite work would be required prior to implementation:

- a bed study to ascertain how many single men presently occupy emergency shelter beds on a long-term basis and would be more appropriately housed in permanent supportive/supported housing
 - An assessment of the support needs of the homeless single male population that frequents emergency shelters
6. Efforts are required to support and encourage the expansion of the rooming house sector for single homeless men. Rooming houses are one of the least costly forms of transitional and permanent accommodation available to low-income Canadians, mostly the working poor, students and those on social assistance.
7. Invest in staff education to help staff respond more relevantly to:
- diverse cultures – including Aboriginal-specific training
 - single, homeless men suffering from concurrent conditions – mental illness and addictions.

The following recommendations are system-wide cutting across all sectors. However, given that homeless men comprise a substantial proportion of the homeless population in Ottawa, they are the subject of this sector report.

8. Strengthen partnerships and linkages
- between agencies in the sector
 - with mainstream organizations
 - government programs
 - business such as high tech sector
9. Identify what organization should be responsible for overall planning. The City presently administers funding. The Alliance to End Homelessness presently does information-sharing and advocacy. Will the CCBT take the lead in planning?
10. Work towards establishing a local blue ribbon panel, which would champion the cause of preventing and reducing homelessness in Ottawa. Membership would include highly influential leaders with representation from politics, business, government, health, poverty groups, Aboriginal community and media. An excellent model is the Success By Six Council of Partners.
11. The City of Ottawa should champion the development of more affordable permanent housing.

12. Lobby the Province for higher shelter allowances. Shelter subsidies are inadequate in today's housing market. Shelter subsidies have not changed since the mid-nineties while housing costs have risen considerably for landlords. This mismatch makes it extremely difficult for the single homeless man to connect to the housing market.
13. Lobby HRSDC to roll out SCPI as long term funding for services. Once funding is long term/sustainable, it becomes more feasible to make happen whatever is needed toward ending homelessness.

Appendix A

List of Expert Key Informants

Appendix A: List of Key Informants

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Appendix B

List of Agency Representatives

Appendix B: List of Agency Representatives Interviewed

Wendy Muckle, Executive Director, Ottawa Inner City Health Project, Ottawa Hospital

Paul Wallace, Manager, Psychiatric Outreach Team, Royal Ottawa Hospital

Sheila Burnett, Acting Executive Director, compiled by Joanne Hansen, Senior Manager – Shelter Services

Elsbeth McKay, Co-Executive Director, Causeway

Marnie Smith, Program Manager, CMHA

Maxine Stata, Program Coordinator, St. Luke's Lunch Club

Rosine Kaley, Executive Director, Action-Logement

Craig Defries, Co-ordinator, Project Upstream

Hilary Jocelyn, Manager, Community Development, Salus

Don Wadel, Executive Director, John Howard Society

Rob Boyd, Oasis Program Director, Sandy Hill Community Health Centre

Dom Hostels, Alexander House, Kimberlane Residence (Dom Hostel for men with schizophrenia) Staff completed questionnaire

Diane Morrison, Executive Director, The Mission

Jay Koornstra, Executive Director, Bruce House

Perry Rowe, Acting Executive Director, Salvation Army-Booth Street

Debbie Barton, Chair, Ottawa Social Housing Network, and, Centretown Community Housing Corp.

Mary Martha Hale, Executive Director, Centre 454

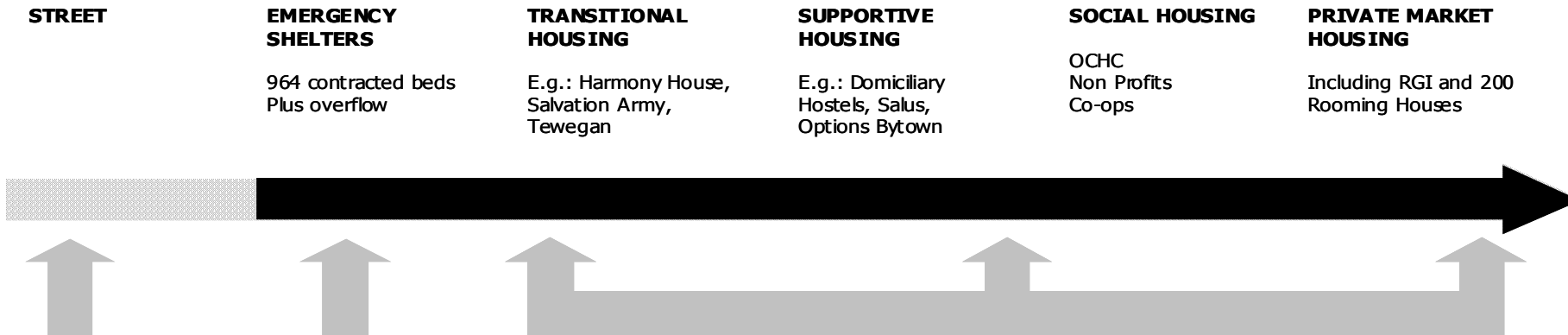
Lorraine Bentley, Executive Director, Options Bytown Non profit Housing Corp.

Appendix C

City of Ottawa Proposed Framework for a Continuum of Housing and Support Services

Continuum of Housing and Support Services

Housing



STREET	EMERGENCY SHELTERS	TRANSITIONAL HOUSING	SUPPORTIVE HOUSING	SOCIAL HOUSING	PRIVATE MARKET HOUSING
	964 contracted beds Plus overflow	E.g.: Harmony House, Salvation Army, Tewegan	E.g.: Domiciliary Hostels, Salus, Options Bytown	OCHC Non Profits Co-ops	Including RGI and 200 Rooming Houses

Support Services

STREET	EMERGENCY SHELTERS	TRANSITIONAL HOUSING	SUPPORTIVE HOUSING	SOCIAL HOUSING	PRIVATE MARKET HOUSING
<p>OUTREACH</p> <ul style="list-style-type: none"> - health - housing - counselling <p><u>Street</u> Salvation Army Van Centre 507 Operation Go Home Odawa Friendship Centre Wabano Health Centre* Jewish Family Services Ottawa Inncrity Ministries</p> <p><u>Drop-in</u> Centre 454 The Well Centre 507 St. Joe's Centre Espoir Sophie St. Luke's Shepherds of Good Hope Odawa Drop-in*</p>	<p>HOUSING SEARCH AND STABILIZATION</p> <ul style="list-style-type: none"> - housing assistance - referrals to community resources - health services: physical, mental, addictions <p><u>Onsite in shelter</u> The Shepherds of Good Hope The Mission, The Salvation Army Cornerstone, Oshki Kizis, Reception House, PQ CRS and SWCHC in Family Shelters, Youth Services Bureau Ottawa Inner City Health, Royal Ottawa Hospital, Public Health Department, CMHA E. Fry*, Harmony House*, Tungasavvingat Inuit*</p> <p><u>Community-based</u> Housing Help Action Logement CMHA The Well Minwaashin Lodge* The Mission* Rideau Street Youth Enterprise* Catholic Immigration Centre*</p>		<p>HOUSING LOSS PREVENTION</p> <ul style="list-style-type: none"> - life management / social supports - financial assistance - health: physical, mental, addictions - employment / training - legal / advocacy <p><u>On-site</u> Bruce House, Salus, Options Bytown, Daybreak, Cornerstone Shepherds of Good Hope, OCHC (through Options), Evelyn Horne, Tewegan*, CMHA (youth)*</p> <p><u>Community-based</u> Pincrest-Queensway CRS and 6 other agencies (Housing Loss Prevention Network), The Salvation Army, Catholic Immigration Services, Housing Help (rooming houses), Centre 507*, Catholic Immigration Centre*, City of Ottawa Rooming House Services</p>		

* SCPI service funding to March 2006

Appendix D

Types of Services Offered by Agencies

AGENCY	SHELTER HOUSING	EMERGENCY HOUSING	TRANSITIONAL HOUSING	SUPPLEMENTARY HOUSING	HOUSING SEARCH	OUTREACH	HOUSING LOSS PREVENTION	DAY PROGRAMS	MENTAL HEALTH HELP	PHYSICAL HEALTH	EMPLOYMENT HELP	ADDITION HELP
Ottawa Withdrawal Management												YES
Ottawa Inner City Health, Inc												YES

Data Source: Katherine Hale, re City of Ottawa, Inventory of Homelessness, July 2005

Appendix E

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Appendix E: References

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A Plan, Not A Dream: How to End Homelessness in Ten Years

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