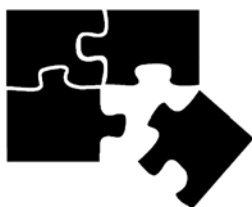


MODELS OF HOUSING WITH SUPPORTS

1. **FINAL REPORT – 14 pages**
2. **A LITERATURE REVIEW – 38 pages**
3. **HOUSING WITH SUPPORTS INFORMATION GRID – 2 pages**

Prepared For
The City of Ottawa, Housing Branch

By



L. Bonnie Dinning
Health and Social Services Consulting
Organizational Development

February 29, 2008

**Funded by the Homelessness Partnership Strategy
(Government of Canada)**

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City of Ottawa Affordable Housing with Supports Framework
Final Report

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1. Introduction

Christine Davis, President of Social Data Research Ltd. and L. Bonnie Dinning, Health and Social Service Consulting, are pleased to submit this report to the City of Ottawa Housing Branch. The report presents a framework for the provision of affordable housing with supports in Ottawa.

The purpose for the development of the framework was to:

1. Identify population sectors that need housing with supports;
2. Identify optional models for the provision of housing with supports;
4. Identify best practice examples; and
5. Identify urgent local projects.

The framework builds partly on previous work completed by the consultants. Additional activities to gather and present the most current information included:

- Discussions with the City of Ottawa Housing Branch to set the context for the work and gather relevant background material;
- An internet scan for recent reports completed in other jurisdictions;
- A survey of selected key informants in Ottawa (described below);
- An updated literature review based on the above activities (Attached under separate cover in Attachment A); and
- The development of an Information Grid to succinctly describe the range of different models of affordable housing with supports, recommended client groups, pros and cons for each model and best practices; (attached under separate cover as Attachment B)

2. Survey of selected key informants in Ottawa

To obtain a reading on the most current local issues related to the provision of affordable housing with supports, a survey was conducted with fifteen experts in the field of housing and homelessness in Ottawa. All but one of the key informants responded within the time frame allotted for the survey. (List of respondents attached in Appendix A) Participants for the survey were identified by the consultants and the City of Ottawa Housing Branch and drawn mainly from:

- Members of the Supportive Housing Network;
- The Women's Roundtable;
- Alliance to End Homelessness Steering Committee; and
- Developmental services agencies.

The survey was conducted by Email and telephone using an unstructured interview guide. The questionnaire was designed to collect the following information:

- A description of the respondent's model of housing with supports (where applicable);
- Examples of best practices based on evaluations and lessons learned from their own practice or from others;
- Identification of projects most needed in the community (i.e., gaps in the system); and
- References to reports related to best practices and costing of different models.

3. Results of the Survey

Of the fourteen key informants who responded to the survey all but one were in the business of providing housing with supports. The number of people served by these agencies ranged from a half dozen residents to several hundred. Collectively, these respondents serve well over 1300 people in a variety of housing settings and service arrangements. The different segments of society included in this number are:

- Single people and families affected by HIV/Aids
- Persons who are developmentally disabled
- People living with severe and persistent mental illness
- Low income, homeless adult males who have been living in shelters and ready for a change
- Young Aboriginal women who are homeless or at risk for homelessness
- Homeless youth and adult ex-offenders
- Women of all ages and cultural backgrounds who are homeless or at risk for homelessness
- Newcomers to Ottawa
- Women fleeing domestic abuse
- Young single mothers on low income
- Single adults with a history of homelessness, addictions, mental illness and poverty
- Adult men who have completed an addiction treatment program, who have tried harm reduction, have concurrent disorders with a severe addiction and mild to moderate mental health issues
- Adults or youth with a serious mental illness

3.1 Models of Housing with Supports

In terms of the different types of models of housing with supports delivered by the respondents, the survey made it clear that "one size does not fit all" and that a whole range of different models are available in Ottawa. This includes

transitional housing, and supportive housing, as well as more “independent or semi-independent” supported living arrangements where residents have their own self contained apartments with access to other supports.

Some providers offer a mix of different types of housing settings (including unit sizes) located in different sites across Ottawa. In a few cases, agencies are able to offer “a continuum” or flexible range of housing with support services to residents depending on their particular situation such as transitional housing with 24/7 on-site supports for several months to one year followed by more permanent housing with minimal supervision but some supports.

There are times according to a number of respondents that people fall between the cracks. For example, a client might be ready to move from transitional housing with on-site supports to more permanent housing without on-site supports. However, in some instances, these residents lose their housing because they need more support and often end up on the street.

3.2 Types of On-Site supports

All respondents offered some on-site support. Agencies that provide transitional or supportive housing in a group living setting typically offer 24/7 on-site support. These organizations reported different scenarios of full and part-time staff including personal support workers, community development workers and trained one - to - one case workers. The type of on-site support provided includes assistance with meals, help with day to day activities - including personal care, crisis intervention, and life skills training. One organization with scattered units in different locations operates a resource centre at each location that is staffed during week days and one evening per week to assist clients housed in these buildings on a “walk-in basis”. Others provide 24/7 on-call assistance. In most cases, on-site supports are provided by the housing agency.

3.3 Other Support Arrangements

Many agencies reported other types of supports provided (on-site and off-site) made possible mainly through community partnerships. These supports included:

- Case management
- Outreach to help clients find appropriate housing
- Referrals for addictions and mental health issues
- Pre-employment/employment assistance
- Anger management counseling
- Access to appropriate medical specialists
- Educational and vocational supports
- Recreational therapists/support

- Clinics for special behaviours/diagnoses

4. Lessons Learned and Recognized Best Practices in Ottawa

Respondents were asked if their model had been evaluated and if so what lessons were learned or interesting outcomes had they realized. They were also asked if they were using or were familiar with any “recognized best practices” in their field based on their own evaluations or evaluations completed elsewhere.

4.1 Lessons Learned

In terms of lessons learned from their own practice, the following reflects the responses received from survey respondents:

- Being able to provide a range of different housing with support options offers flexibility and choice, ability to meet individual needs and a “continuum of services”. (Organization that offers residential group home, transitional housing and scattered semi-independent self-contained housing)
- Scattered units (using a “Housing First approach”) in different locations are a good option; however, some residents feel isolated and sometimes lose their housing before needed supports are put in place. It is more difficult to stay connected to these residents and provide support when needed, particularly when the housing and support services providers are not part of the same organization. The “Block Lease” approach works well as housing and supports are provided by same agency.
- Evaluations have identified the importance of having well trained and supervised staff to ensure effective treatment and monitoring (for agencies dealing with addictions and mental health issues). Importance of stable funding has also been identified. (Organization that offers transitional housing)
- One agency targeting persons with addictions has found that if a person stays abstinent (from substance use) for at least one year, there is a better outcome for permanent health which is why this agency offers transitional housing to its residents for at least one year and longer if needed.
- Those lacking social supports for abstinence or reduced substance use generally do less well than others. (Organization that offers transitional housing)
- Treatment outcomes are improved when appropriate supports are provided for significant life problems (communication problems, lack of assertiveness, unemployment.). (Organization that offers transitional housing)

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- The community reinforcement approach has consistently been shown to be effective, particularly with clients having fewer social supports and more severe drinking problems. (Organization that offers transitional housing)
- Appropriate therapy by competent counselors with strong intellectual skills, such as empathy and the ability to forge a therapeutic alliance with the client, is associated with an increase in positive treatment outcomes. (Organization that offers transitional housing)

One agency that uses a “Housing First” approach listed the following outcomes based on evaluations of this model and lessons learned:

- Housing is key to recovery. More so even than supports, the availability of housing for previously homeless individuals is linked clearly with positive outcomes in recovery life domains.
- Though not predictors of success or failure, two factors that are statistically associated with those who lost housing in this housing model are substance abuse and non-compliance with medications.
- Housing Outreach services targeted at housing homeless individuals with serious mental illness are effective means of housing people and over 80% remain housed after 3 months

From other studies of the “Housing First” model, in support of the agency’s own anecdotal or experiential learnings, the following lessons have been learned:

- Success or failure of tenancy cannot be predicted by severity of illness or by any other single factor or aggregation of factors (even substance abuse or non-compliance with medications).
- The presence of Concurrent Disorders needs to be an expectation of any services and housing targeting those with mental illness or those with addictions or those who are homeless, given how high the prevalence and correlates are among these three categories.
- Increased choice in housing setting is related to positive housing outcomes.
- Housing First approach works (e.g. no special substance abuse or medication compliance rules).
- One of the challenges for this housing model is the degree of integration into the community and its correlate, loneliness.

4.2 Recognized Best Practices

The following “best practices” are adhered to by survey respondents and recommended to others providing affordable housing with supports:

- It is important to have a strong staff presence (on-site or on-call) and to ensure that all clients are aware that 24 hour crisis intervention assistance

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- is available. This results in fewer significant crisis situations, very little property damage and a positive relationship with the surrounding community, most specifically immediate neighbours. (Organization that offers transitional housing)
- With a high risk/need population, there are significant benefits to having self-contained units to minimize criminal associations and allow clients to focus on their own case plan. It is also important that the level of need be matched with sufficient staff supports and monitoring. (Organization that offers transitional housing)
 - The Ottawa Supportive Housing Network is working with The University of Ottawa to establish benchmarks for best practices in the housing with supports sector. This study (called Housing Plus) is in its early stage and will invite input from all stakeholders including agency directors, front line staff and residents. The study in itself is a “best practice” as it is the first of its kind in Ottawa.
 - One agency that offers permanent supportive housing with full-time on-site supports has developed best practices over 20 years of operation. Some key components of their approach include:
 - Having a two stage intake process involving an initial screening application followed by a face-to-face interview to determine the applicant’s suitability for supportive housing;
 - Assisting residents with life skills and goal setting by assigning a personal housing support worker to each new resident who is available seven days a week and meets with the resident on a regular basis;
 - Networking and collaborating with other resource agencies to meet the individual needs of residents, to maintain their housing and attain their personal goals; and
 - Integration of the resident into the planning and management of their residence through the provision of formal (sitting on Board of Directors, Tenants’ Associations etc.) and informal opportunities. This involvement helps to empower residents, increase self-esteem, and promote the belief that all residents can be a positive role model in the community.
 - Housing with supports is the proven best solution for overcoming homelessness for people with chronic and persistent conditions such as mental illness, addiction to substances, and more. But housing is only the first step for many residents. Employment supports have long been a key element of success for formerly homeless residents. (Published 2007, Enterprise Community Partners)
 - A related theme is the high need for support and continuity of care to deal with the wide range of health and psychosocial difficulties, including for example, the need for housing, prenatal or child care, income, employment, and money for transportation. The support of family, friends, employer and the agency support worker were seen as critical. (Best

Practices - Concurrent Mental Health and Substance Use Disorders
(Health Canada) Consumer Focus Group)

- One organization that offers supported housing is currently embedding the Integrated Treatment Model approach into their agency – a model recognized by Health Canada as a Best Practice. The model has at its core “one person, one team; one plan” meaning that all service providers involved in supporting a client with severe mental illness communicate and collaborate together around the creation of a recovery plan with the client. A plan that includes the roles and responsibilities of everyone involved in providing service.

5. Most Urgent Needs

Respondents were asked where they would allocate resources in Ottawa to help meet the most urgent needs related to the provision of housing with supports for different target populations. In some cases, responses were quite broad and in others very specific. In the respondents’ own words the following represent the many answers given to this question:

- More resources should go towards finding housing with support solutions for persons who are mentally ill, homeless or developmentally disabled.
- Based on experience, more money should be allocated for transitional housing for young Aboriginal men and women. Currently, there is only one transitional housing option for Aboriginal people in Ottawa. There should also be more money allocated towards housing support workers to assist clients who are already housed but may have difficulty with paying rent due to financial difficulties, addictions, mental health etc.
- There is a need for more second stage housing for persons with mental health problems, addictions, and HIV/AIDS. Currently it is a vicious circle – clients get well enough to leave a group home with 24/7 support, go into independent living but then lose their housing because it’s not enough support. There is no continuum of care right now. A lot of people are being “recycled” through the system.
- There is a need for more affordable transitional housing for the homeless and those at risk of homelessness. More supports are needed for this target population.
- There is a need for more subsidized housing units (individual apartments). Many people are living in shelters who might better be housed in longer term arrangements.
- There is a need for more options for people living with concurrent disorders (severe mental illness and substance use problems).
- There is a need to create, stabilize and maintain long-term supported housing and create additional capacity for individuals leaving treatment. There also needs to be a way to divert individuals leaving custody from shelter accommodation. They are much less successful when they have to rely on shelters as there is insufficient monitoring and support and increased association with criminal associates.

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- There is still a need for supportive housing for older homeless women. Cornerstone/LePilier is moving forward with a multi- service complex that will incorporate shelter beds, 30 transitional beds and 15-20 permanent supportive housing units (self-contained). Partners include the Royal Ottawa, Centretown Housing and Ottawa Inner City. However this will take time and right now there's no place to go for women on the streets with severe mental health and/or addiction problems. Cornerstone/LePilier sees many of the same women coming back because they can't make it on their own.
- There is a need for affordable housing for the approximately 10,000 households on the Social Housing Registry waiting list. There is an equally urgent need for supportive housing for the approximately 2000 people who are waiting for housing with supports.
- There is a need for all housing to be self-contained and affordable. Those in need of housing with supports need either on-site supports or outreach/case management (depending on their individual needs.) This population needs adequate drug treatment both residential and out-patient as well as effective methods for dealing with concurrent disorders.
- If the City really wants to make a dent in homelessness it should focus especially on single men who represent over 60% of the homeless population and who experience the most difficulty in achieving housing stability after being homeless.
- There is a need for more effective housing with support options for homeless single adults (men and women). It is recommended that a supported housing approach be promoted – one that includes rent supplements or Rent Geared to Income (RGIs), flexible and portable support in the form of an outreach worker focusing on housing issues and assisting a person to access needed health and social services, and financial management help as needed (including setting up trusteeships if indicated). This has essentially all of the elements of the “Housing First” approach which has been shown to be effective even with individuals who have complex health and psychosocial needs. It would be more effective to put resources on these types of “supported housing” programs rather than supportive housing (congregate living) or transitional housing.
- Advocate for a policy intervention to increase social assistance rates to lift individuals out of a “core need” situation where they are spending in excess of 50% of their income on housing. This would make a huge dent in the level of homelessness.
- There is a need for more permanent housing with supports available 24/7 for people with severe mental illness (with or without an addiction).
- For individuals with serious mental illness who are homeless, studies of consumer preference have consistently shown that the housing of choice is regular apartments or houses and that integrated housing (into the community at large) is a preference as opposed to dedicated or segregated housing and definitely as opposed to congregate living

models. Models that promote integrated, self-contained, regular housing situations should figure large in any targeting of resources. Substance abuse and mental illness go hand in hand to such an extent that it is clear that all support services and housing for this population and for those who are homeless must be fully capable of providing integrated concurrent disorders treatment and/or support through in-house capacity and partnerships.

6. Results of the Literature Review

An updated literature review that examines different models of housing with supports from an international perspective is provided under separate cover in Attachment A. This literature review presents an overview of the current “state of knowledge” related to the provision of housing with supports. It also provides descriptions of several models common to the needs of a wide variety of individuals and families with special needs. There is some congruence between the results of the literature review and the key informant survey. The Information Grid, provided in Attachment B integrates the results of both of these study components and summarizes the key learnings.

Studies that assess the advantages and disadvantages of different approaches and “real life” experiences by front line organizations providing housing with supports demonstrate that “one size does not fit all”. The needs and preferences of potential residents must be considered a priority when developing a housing with supports program. What also seems clear is that communities must work together to coordinate existing programs and services to ensure that individuals do not fall between the cracks and to maximize resources in the “system” as well as in the organization.

7. Conclusions

The following themes resonate in the literature and are reinforced by the key informants for this study. These points provide some “food for thought” for possible next steps in the creation of a caring and responsive “affordable housing with supports system” in Ottawa:

- There still appear to be systemic gaps in the community and a lack of ability to offer a “continuum of care” or flexible and responsive approach to meet clients needs.
- Adding more transitional housing does not make sense unless ready made links are available to next step housing – the needed variety of housing with supports options is not apparent in Ottawa.
- The community would benefit from a mechanism that links transitional housing providers to other types of housing providers to ensure individuals don’t fall through the cracks.

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- The “Housing First” model may work for many types of special needs target populations and should be promoted, however, more research is needed to assess the effectiveness of this model for all target populations – this model may not work for all.
- Combining the best aspects of the “Continuum of Care” approach and “Housing First” model may be optimal and allow communities to offer a wide range of inter-related housing with supports options.
- “Self-contained” units (versus rooms) are preferable by most residents and according to the latest research may be better for those in treatment and those who are tempted by criminal behaviour, particularly if the units are scattered.
- The community would benefit from increased partnerships between social housing providers and agencies providing support - for example, offering drop in locations near social housing sites for one on one support to social housing residents is a good idea that should be expanded.
- Links should be forged with developmental services housing providers. DS clients are found in shelters and housing with supports for those leaving homelessness or at risk of homelessness. (The current list of those waiting for housing with supports also does not include those on waiting lists for DS housing.)
- Using the Information Grid in Attachment A as a starting point, the City of Ottawa’s Housing Department should consider developing a reference tool and or provide a short workshop on the pros and cons of different housing with support models.
- Continued advocacy and action is needed for more rent supplements, as well as more affordable housing. The use of rent supplements provides a relatively quick housing solution compared to the lengthy timelines associated with new construction. It also allows individuals to blend in with the broader community. However, it requires that units be available in the private market. Dedicated or mixed buildings allow for increased support to individuals and offer individuals a much needed sense of community. This is an especially important component for individuals wishing to be in an alcohol and drug free housing option through their recovery. (City of Vancouver 2007)
- Priority groups requiring housing and supports in Ottawa are difficult to identify. The greater reality documented in the literature is that waiting lists abound and that all special needs populations represented in this community lack sufficient housing and supports.

Appendix A – Key Informants

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MODELS OF HOUSING WITH SUPPORTS: A LITERATURE REVIEW

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1. INTRODUCTION

Christine Davis, President of Social Data Research Ltd; and L. Bonnie Dinning, Health and Social Service Consulting, are pleased to submit this literature review about models of housing with supports to the Housing Branch of the City of Ottawa.

The combined results of this review and a key informant survey will be examined to:

- Identify population sectors in Ottawa that need housing with support
- Identify optional models of housing with supports
- Identify existing information about the cost of housing with supports
- Identify best practice examples
- Identify urgent local projects

1.2 Source of Information and Parameters of the Review

Previous research and literature searches undertaken by the consultants form the basis for this report (CMHC 2005, Dinning 2005, Ginger Group Collaborative 2005 & 2006, SDR 2005, SDR 2005, SDR 2005, SDR 2007). An electronic search was conducted for relevant information generated since 2005. Key informants for this project were also asked to identify relevant documents.

1.3 What is Housing with Supports?

Housing with supports, in its broadest definition, is public, private or non-profit housing linked with health and social services. The majority of housing with supports options is tailored to the needs of a designated target population.

The term “Supportive Housing” is frequently used in the literature as an umbrella term to cover a variety of housing with supports combinations. (City of Vancouver 2007, Glauber 1996, HRDC 2003, Corporation for Supportive Housing Website).

In Ontario, the term “supportive housing” is used to connote housing with “on site support”. To avoid confusion, the term “housing with supports” has replaced “supportive housing” where references imply the more encompassing definition.

1.4 The Need for Housing with Supports Options

Social housing developers and service providers have long recognized the importance of comprehensively addressing the needs of residents and clients who cannot live independently in the community. Housing and support services are interdependent; both are less effective in the absence of the other. Without such a combined focus, many studies document housing instability, poor quality of life and eventual homelessness as outcomes for persons with special needs. (Glauber, 1996)

Like most forms of social housing, housing with supports is in short supply. Unfortunately, though, there are not comprehensive measures of need for housing with supports in the same way as there are for other types of social housing. For social housing generally, CMHC regularly produces "core housing need" statistics (CMHC, 2004) that identify who is unable to afford suitable and adequate accommodation in their locale without paying more than 30% of their income. This is the number that gives us 1.7 million households in Canada with a need for social housing. As well, in Ontario, municipalities have been obliged to develop coordinated waiting lists for social housing. These lists are often used as another indicator of the need for social housing in a particular community.

For the most part, housing with supports options are a subset of core housing need, but are overlaid with the specific needs for health and/or social supports that are characteristic of this form of housing. Many individual special needs groups have their own estimates of the housing needs for their populations as evidenced in a variety of reports about specific client groups (Alliance to End Homelessness, Service Coordination websites), but no comparative estimates currently exist across special needs populations in Ottawa to help identify priority populations or urgent need.

The 2006 combined waiting lists for housing and supports in Ottawa included 2,630 applicants. Despite a recent small increase in the number of housing and supports units, the waiting list for this type of housing grew that year (Alliance Report Card, 2006). This is not a comprehensive number as it focuses on the need of those using emergency shelters for the homeless or most imminently at risk of homelessness. It also does not include individuals with developmental disabilities, seniors and a variety of other special needs groups in need of housing and supports.

2. WHO CAN BENEFIT FROM HOUSING WITH SUPPORTS?

According to the literature, individuals who can benefit from the combination of housing with supports include:

- Those requiring continuous medical care for debilitating medical disabilities, conditions and illnesses;
- The developmentally/intellectually disabled. Impairment may be mild to severe, requiring a broad range of housing and supports options;
- The psychiatrically disabled. Disabilities in this group vary greatly and may involve periods of extended hospitalization. Although disabilities may diminish, long term support is generally the norm;
- Those fleeing abuse;
- Sex trade workers;

- Those who are frail and elderly and facing long waits for access to care facilities;
- Youth who are pregnant or parenting;
- Low income families;
- Members of Ethno - Cultural groups;
- Aboriginals;
- Those who are Gay, Bisexual, Lesbian or Transgendered (GBLT);
- Those involved with the Criminal Justice System;
- The physically disabled, including those with mobility and sensory impairments; and,
- The hard to house, including the chronically homeless and those with complex issues and co-occurring disorders such as addictions and substance use.

(Dinning 2005, Pleace 1995, Regional/Municipal Working Group on Long Term Supportive Housing 1996, HUD 1995, Ministry of Municipal Affairs and Housing, Corporation of Supportive Housing , ONPHA, U.K. Shelter websites)

2.1 Priority Groups Requiring Housing with Supports in Ottawa

A review of the literature relevant to Ottawa does not clearly describe any analytical processes to judge the relative importance, or need of one client group over another, in regards to housing with supports. The majority of reviewed reports merely identify the need for more housing options for the client group studied.

The following information, however, does suggest that some form of comparison was undertaken to identify priority client groups requiring additional housing with supports:

- On April 29/05, the Government of Canada and the Government of Ontario signed a Canada/Ontario Affordable Housing Agreement (AHP) committing funding, in part, to increasing the supply of housing with supports for persons with mental illness and housing for victims of domestic violence in Ontario (City of Ottawa Report 2006).
- A lack of housing with supports for homeless individuals and families was identified as the highest need in community interviews undertaken in developing Ottawa's current Community Action Plan to address Homelessness.

Most respondents interviewed during the development of that plan expressed the need for more transitional housing, to assist people in transitioning from abusive situations, incarceration, drug treatment facilities and other temporary situations.

Of all potential housing and supports options for the homeless, key informants identified the need for increased mental health services as the number two priority for Ottawa's Community Action Plan

(Potter et al, 2005).

- Studies about single women, single men, adults with developmental disabilities, newcomers, aboriginals, rural homeless and French language requirements, commissioned by Ottawa's Community Capacity Building Team (CCBT) in 2005 (Potter et al, 2005), could be considered an indication of greatest need. Findings within these reports indicate the need for more housing support workers for women, aboriginals and newcomers; and the need for more housing with supports and a harm reduction approach for men with addictions or concurrent disorders.
- Key informants in a study undertaken for the National Capital Region YMCA-YWCA (Social Data Research et al, 2007) collectively cited the following populations as priorities for housing with supports in Ottawa, :
 - Single adult men and women with mental health illness and/or active substance abuse issues
 - Persons leaving addictions treatment programs
 - Adult men and women who are developmentally disabled and/or dually diagnosed
 - Homeless older women with complex needs
 - Persons requiring access to social or affordable housing but no other supports
 - Youth leaving shelters and requiring transitional and longer term housing
 - Young single parents/mothers, poor families
 - Single men & women and families new to Canada
 - Aboriginal men, women and families
 - Adults with physical disabilities

The following sections provide information found in the literature about the housing with support needs of many of the special needs populations identified in section 2.1.

2.1.1 Victims of Violence

Women with custody of their children have difficulty leaving violent situations because of the struggle to find adequate housing. Although shelters for abused women and their children exist in limited quantities, the biggest need is for housing and security after the initial crisis. If there is no where to go, victims may return to the abusive situation. For those receiving social assistance, accessing the waiting lists for social housing with priority status is one avenue. However, priority status is conditional upon the ability of the applying woman to produce proof of previous co-habitation with the abusing partner. When unable to do so, some women have no alternative but to return to their abuser.

First stage housing or shelters provide an immediate crisis housing, support and intake process important to assisting women in accessing second stage and or permanent housing.

(SDR, 2005)

To date, few studies have examined the links between domestic violence and the unique situation faced by immigrant and refugee women. This gap in knowledge consequently affects our knowledge of – or lack of knowledge – regarding effective and culturally appropriate housing and supports options for these women. (CCSD website)

2.1.2 Immigrants & Refugees

The Ottawa action plan to address homelessness recommends the creation of 50 units of transitional housing annually, including temporary accommodation for newcomers (Potter et al, 2005)

No references to the housing and supports needs of immigrants and refugees with special needs were found. However, the immense barriers they face in accessing rental accommodation due to landlord requirements, discrimination, affordability problems, and a lack of rental accommodation for large families, often combined with trauma incurred before arriving in Canada, have been noted to result in mental health issues (Murdie, 2002)..

One research study, in following Polish and Somali immigrant newcomers in Toronto, documented significant housing discrimination for Somali immigrants. While Polish immigrants experienced an improvement in their housing situation, the Somalis moved into cheaper and smaller units making them more vulnerable to homelessness. (Murdie, 2002). This downward trend is confirmed by recent CMHC information. The percentage of immigrant urban tenant households in core housing need increased from 34.4 percent in 2002 to 36.3 percent in 2004, compared to about 28 percent for non-immigrant urban tenant households (CMHC 2007)

An additional issue for those new to Canada is federal policies that limit or deny access to settlement services and work permits, especially in the case of refugees - leaving people with no choice but to resort to shelter services. Cities then end up responsible for housing many immigrant families including bearing a significant portion of the direct costs of sheltering immigrant and refugee families that cannot find housing. When housing is lost, primary problems are similar to the difficulties encountered by others who are homeless; however, they are intensified by a lack of understanding of customs and language in their new country.

Studies indicate that a relatively small number of immigrants and refugees know how to or feel comfortable in accessing formal housing help, indicating a need to strengthen informal networks. One report noted concern about the lack of “culturally competent practices” in housing and supports options – staff are not culturally sensitive (i.e. to the Muslim requirement for a place in their home, and a time in schedules for daily prayers)

(Mattu, 2002).

A Toronto working group called Supportive Housing and Diversity (SHAD) is working to improve housing stability and reduce homelessness among members of racialized communities who have mental health and addiction issues. SHAD is currently identifying evidence-based best practices in developing culturally competent housing with supports models with funding from the Canada Mortgage and Housing Corporation (CMHC). This will provide the missing body of information linking culturally competent mental health services and housing with supports best practices. (CAMH, 2006)

One website identifies the types of support newcomers need.

- Translation services and a wide range of other culturally appropriate services are incorporated into the continuum of care process. At the very least have translation services at the disposal of all service providers.
- Health services and mental health services available in culturally appropriate settings.
- Preventive health, health case management and affordable health care.
- Referral and collaborative approach between the different service providers, in order for newcomers to know where services are available and easy access. The creation of a referral system that is easily accessible by newcomer families and service providers.
- Provide adequate information to newcomers about the limit of services available to avoid confusion and to address their high expectations.
- Provide extensive life skills and education.
- Adequate English as Second Language services
- Career development and job creation and placement.
- Information about laws and regulations
- Adequate orientation and cross-cultural training for families and case workers, social workers, and other service providers, etc
- Affordable legal advice, family reunification, immigration and citizenship services.

(Kurdish Human Rights Watch Website, Forum Summary 2003)

2.1.3 Mentally Ill

Research on housing for people with mental illness is abundant in the literature¹. Collectively, studies call for a range of housing with supports options that use a recovery approach. When summarized the qualities and features of housing settings and supports that produce positive outcomes² for people with serious mental illness point to:

¹ Attachment 1 contains a list of housing related articles specific to mental illness that was provided by a key informant for this study

² Such as good quality of life and adaptation to community living

- Use of good quality generic housing dispersed widely in the community (scattered) and in favourable locations close to amenities and services
- Provision of flexible individualized supports, which vary in type and intensity, including assertive community treatment and intensive case management. Ensure support levels match consumer needs and are integrated with other mental health and community services
- Consumer choice - people with psychiatric disabilities are documented as being capable of reporting their housing with supports needs accurately; but since these can change over time, ongoing assessment is needed
- Assistance in locating and maintaining housing
- No restrictions on the length of time a client can remain in the residence
- Case management services that are not tied to particular residential settings but are available regardless of whether the client moves or is hospitalized
- Sufficient privacy involving a small number of residents, and resident control and choice over who they live with, if not living alone
- A need to review the usefulness of custodial stock with a view to transforming it into rehabilitative focused housing
- Secure adequate levels of funding

(Parkinson et al 1999, Trainor & Ilves 1999, CAMH website, IBI Group 2003, Sylvestre et al 2007)

Research (Geller & Kowalchuk, 2000) on the housing with support needs of women with mental health related issues was carried out with the Regina YWCA in 2000. Collected data showed a need for both short and long term housing in a wide variety of contexts, including residential housing, supportive living units and independent housing units. Women who need such housing included those who are leaving a psychiatric facility, have left abusive relationships, are in unsuitable approved homes, require greater support (including more physical care), and can no longer be cared for by a family member.

A summary of the literature undertaken by CARMHA in 2007 indicates that housing with supports for homeless people with substance use and mental disorders results in superior retention in housing compared to case management or usual care in the community; and achieves these benefits with only modest increases in public costs (CARMHA, 2007).

In a similar study (Nelson et al, 2007), the conclusions of a review of 16 studies indicate that housing with support interventions (involving ACT-Assertive Community Treatment and ICM-Intensive Case Management) were able to reduce homelessness and hospitalization of people with mental illness, relative to standard services that are typically available to this population. That review also shows that the provision of permanent housing to homeless mentally ill people produces relatively large positive effects on their housing status at follow-up intervals. In contrast, residential treatment in which housing is provided only during the treatment process (transitional housing) does not have a positive

effect on participants' housing status. In terms of the most effective approach in reducing homelessness, it appears that providing permanent housing with supports is the most successful approach. In particular, permanent housing with supports involving ACT appears to be the most effective combination in improving housing outcomes for those with mental illness.

Researchers for the Nelson et al, 2007 study caution that meeting basic needs through housing with support is only the starting point, rather than the end-point in the process of recovery. There is a need to focus on the larger themes of empowerment and community integration of people who have experienced mental illness.

The Nelson et al, 2007, review also documents the effectiveness of rent supplements in reducing the financial barriers to affordable and decent housing. They enable people with severe mental illness to have greater choice in the location and type of housing that they access.

2.1.4 Homeless and At Risk of Homelessness Individuals

One-person households accounted for almost half (46.7 per cent) of Canadian urban households in core housing need in 2004, up from 43.7 per cent in 2002. (CMHC 2007)

Challenges in providing housing with supports options are related to the complex health and social issues homeless individuals face. Concurrent disorders, dual diagnosis, substance use, etc are often compounded by other co-occurring issues/disorders/disabilities. While men still form the greatest component of the homeless population, the number of women is increasing in Ottawa according to this City's newest Action Plan (Potter et al, 2005).

According to the United Way of Greater Toronto, almost ½ of the homeless population has a disability. The significant incidence of individuals with mental illness within the homeless population is well documented. Concerns over individuals diagnosed with FASD and those who are developmentally disabled are emerging. Such concerns are documented in Ottawa community planning efforts to prevent and end homelessness. (National Public Radio website, United Way of Greater Toronto 2002, Potter et al 2005).

The predominant approach to housing homeless individuals with psychiatric disabilities in the US is a collection of programs that form a Continuum of Care. Clients begin with outreach programs and drop-in centres that place few demands on them, and then progress through a series of congregate living arrangements with varying levels of on-site support before graduating to independent living arrangements. Enrolment in residential programs is contingent upon abstinence from alcohol and drugs and participation in mental health treatment, which are seen as critical to 'housing readiness'. Clients' improvements in clinical status, as determined by health professionals, lead to advances along the continuum toward less restrictive housing and service arrangements (Gulcur, 2003).

The Ottawa Women's Roundtable (WRT) is a network of agencies providing services and housing for women who are homeless or at risk of homelessness. Collectively they are working on a plan to address the housing and supports needs of homeless women. The following priority sub groups have been identified (Women's Roundtable, 2005).

Who is a priority?	How do we know?
Aging women with physical limitations and complex needs i.e. behaviour	"We see them every day"
Those using substances	"We see them every day"
Women of all ages with complex needs	"There are currently few services for this group. They are underserved"
Women of all ages with multiple risk factors	Same as above
Newcomers	"Based on what we see & because of great need for integration into services & supports"
Aboriginal women of all ages	"Because of integration barriers in addition to housing needs"
Sex trade workers (Note: Although a group identified by the Women's roundtable, not all sex trade workers are women)	All of above <i>In addition to WRT discussion:</i> <i>A study undertaken in Victoria B.B. notes the need for a continuum of harm reduction supports and services that include health services, needle exchanges, street nurses, street outreach programs, 24 hour crisis lines and intervention services, food banks/vans, information brochures, soup kitchens, mentorship, advocacy, training/education and drug/alcohol treatment. These services should be encouraged to work in coordinated ways and to be sensitive to the special needs and issues of sex trade workers of all ages. The need for transitional and second stage housing is also noted in which youth are not separated from adults (as is the case with most housing services). It is recognized that these youth have been adults in terms of responsibilities for some time (Carter, 2000).</i>

2.1.5 Substance Users and Recovering Addicts

For recovering drug addicts and substance users, it's not just what's in a home that matters, but what isn't. Housing with supports options need to follow 2 streams – one where any alcohol or substances are strictly forbidden; and - the other where a harm reduction approach is evident. Successful discharge planning from treatment and detoxification (detox.) facilities requires access to “clean” housing with supports models. Likewise, ongoing assessment of those involved with substances by service personnel using a harm reduction approach requires immediate referral abilities to detox. and treatment when this stage of change is appropriate for a client. "The key to getting somebody to stop using drugs and alcohol is enough time in the right setting (Bessant et al 2003, npr website).

A positive relationship has been reported between housing with supports and various measures of social and occupational functioning for persons with substance use and concurrent disorders. As well, people with substance use or concurrent disorders tend to remain in housing with supports once it has been provided. People with substance use or concurrent disorders report that stable housing is one of the most important factors contributing to periods of successful abstinence from drug use (CARMHA, 2007).

Despite the diversity across studies, there is consistent support for the positive impact of housing with supports on health and social outcomes for people with substance use and/or mental disorders. Moreover, evidence suggests that this type of housing can have a minimal (or even positive) impact on the neighbourhoods in which they are sited. There is not sufficient evidence to differentiate the effectiveness of any single model of housing. Rather, the available research suggests that housing should be made as accessible as possible, with the flexibility to add additional supports in response to the expressed needs and wishes of each individual. (CARMHA, 2007)

2.1.6 Low Income Pregnant and Parenting Singles and Families

The Young Parent Support Network is working to address a multitude of needs, including housing, for young single parenting and pregnant youth who are homeless or at risk of homelessness. Members of the network that provide housing are: St. Mary's Home, Youville and Emily Murphy Non Profit Housing.

Findings from a recent review (Nolte & Allan, 2006) of St. Mary's Home suggest that trends reflect a change in societal attitudes over the past few decades, to include a greater acceptance of teen pregnancy and parenting. As a result, many young women do not need residential services because they and their infants are able to obtain needed support from their families or from community-based outreach programs, including services at the St. Mary's Home's Teen Parent/Child Outreach Centre. However, while many youth find adequate support in the community, the review also identified a group of very high risk pregnant and parenting youth who have multidimensional needs because of their complex life circumstances and a lack of resources to support them. These young women

have a profile that includes addictions, homelessness, family dysfunction, mental health issues, and street involvement. They are often invisible to (or hiding from) existing social and health services. A great majority have child welfare involvement. Many of these pregnant youth have very little (if any) prenatal care and, in some cases, their first contact with the health system during pregnancy is when they arrive in labour at the hospital. The review recommends the continued need for a residential program of this nature for this high risk group.

In December 2005, the Ottawa Social Housing Registry documented four hundred and fifty-three requests from single parents for housing at Emily Murphy Non Profit Housing. Sixty of those requests were from young single parents under the age of 25. Potential tenants may wait up to 2 years for housing. In the past 5 years, there has been an increase in the number of immigrant single parents on the waiting list and living at Emily Murphy (Emily Murphy, 2005).

2.1.7 Developmentally/Intellectually Disabled

The Ministry of Community and Social Services has taken the initiative to transform developmental services with a focus on moving to a completely community-based approach. (MCSS, 2006). The government, in its last budget, invested 200 million dollars over 4 years in the transformation process. This is assisting the sector to address its significant staffing issues.

Ontario's developmental services sector still faces significant pressures. The need for accommodation and services for aging residents, combined with increasing demands from aging parents to house and care for their disabled family members continues to push the sector beyond its limits. (Eakin 2005, CMHC 2006, OASIS 2008).

Approximately 80% of Canadians with a developmental disability receive care solely from family members (CMHC, 2006). Disabled individuals on waiting lists for services and housing only receive assistance when a crisis precipitates immediate need. In comparison to the local waiting list for social housing, where length of waiting time is in the 5-7 year range, those on the Ottawa waiting list for developmental services housing may wait 3 times that, or longer, depending on individual circumstances. For those that are housed, many live in group homes and share a bedroom, even though they may be capable of more independent living. Too often, individuals are housed where space is available, rather than in housing suited to their specific needs (CMHC 2006, Ginger Collaborative 2005).

The 2006 CMHC study identified flexibility and choice, the separation of housing from support services (portable) and a person centred approach (the individual or advocate is directly involved in planning and choosing housing with supports) as best practices in housing individuals with a developmental disability. Favoured housing models amongst informants were:

- Independent living (supported housing often referred to as SIL – semi-independent living in Ottawa) -The person with an intellectual disability lives independently, often sharing a house or apartment with other consumers and/or with service providers. Service providers may also be

close by (for example in a neighbouring apartment) instead of sharing living quarters.

- Co-ops and co-op-like arrangements - In co-op housing, a group gets together, builds their own multi-unit building, and gives up some private space for community space. Residents are people who want not just housing, but also community support.
- Home ownership/adaptation of family homes: This option, while cited by many study participants as a best practice, is one that is rarely available to most people with intellectual disabilities.
- L'Arche model - L'Arche was the only group home that was identified as a best practice. L'Arche homes exist in a number of provinces. All are faith-based, geared to aging-in-place, and feature employees who function more like family members than staff.
- As part of a seniors' complex - A number of study participants felt that adults with intellectual disabilities need the same types of supports typically provided in seniors' residences, and saw merit in combining facilities for seniors and adults with intellectual disabilities.

In 2005, a study was undertaken for Ottawa's Community Capacity Building Team in response to the growing concern of service providers about individuals with developmental disabilities using services and shelters for the homeless. Information gathered for that project confirmed the existence of individuals who are developmentally disabled and homeless. The magnitude of the situation and a complete understanding of their pathways into and possible pathways out of homelessness remain outstanding items of investigation. (Ginger Collaborative 2005)

2.1.8 Individuals Leaving and Entering Incarceration

A study (author unknown) undertaken between 2001 and 2004 about Adult Correctional Facilities in the Toronto area disclosed a steady increase in the number of admissions of individuals with no fixed address. Recommendations in that report included a call for the Government of Ontario, the City of Toronto and community agencies to work together to build supportive and transitional housing for homeless persons leaving the criminal justice system: such housing to include specialized rent subsidies and 24 hour, on-site support.

A 2005 CMHC study about women offenders identifies safe, private, secure and stable transitional housing as critical for women who are leaving prison and re-entering the community. These women typically lack money, family support, life skills, and identification papers; and suffer acute and chronic general and mental health problems as well as addiction when leaving prison. Most have childcare responsibilities. Program supported housing is a priority if re-offending is to be avoided. The burden of issues and problems experienced by most women offenders suggests that program support and counselling needs to be delivered in conjunction with transitional housing.

Gradual release was identified in a 2007 CMHC study as a very effective way of re-integrating offenders following a period of incarceration. The time spent in a halfway house allows the offender to adjust to living in the community, obtain the services needed, such as mental health counselling or substance abuse treatment, and secure suitable housing and supports to retain housing (for example, employment or social assistance). Supportive housing was also considered effective. Many individuals in prison have special needs that can only be addressed through housing with supports specific to those needs (for example, mental health).

A U. S. study (Common Ground, 2004) documents a significant decrease in the chance of recidivism into New York City jails and prisons for those ex-offenders living in housing with supports. It also reveals a “substantial and statistically significant decline in both the numbers of prison terms and in the number of days served following a housing with support placement.

In addition to a home, the studied housing with supports provided services such as employment counselling/training, substance abuse treatment, mental health counselling, and access to quality health care. The average cost of maintaining a permanent apartment with supportive services in New York City is far less than that of a maintaining an inmate in a New York prison, jail, shelter, hospital or psychiatric institution (Common Ground, 2004)

2.1.9 Aboriginal Persons

A comprehensive study on aboriginal homelessness was undertaken by Social Data Research in 2005. It documented the following:

- A large proportion of Aboriginal homeless people are very ill, suffering from chronic physical health, mental illness and addictions, as well as from the impacts of poverty, sub-standard living conditions, poor education, and few job opportunities. The direct and generational impact of residential schools has had a profound, deleterious effect on many Aboriginals. Not all individuals want, or are ready for, help – especially those suffering from addictions and alcoholism.

- Aboriginal men are typically the most predominant group among the non-Caucasian cultures represented in the general male client population of mainstream agencies serving homeless and those at risk for homelessness. According to mainstream agencies in Ottawa, between 10% and 40% of male clients have an aboriginal background. Other studies (Aubrey et al., 2003) have found that about 20% of the overall homeless population and 10% of homeless men in Ottawa have an Aboriginal background – an over-representation relative to their 1.1% proportion in the Ottawa population at large.

- Aboriginal women also may comprise a larger proportion of the aboriginal homeless than is the case for women in the overall homeless population. Most experts estimate that about 30% of the aboriginal homeless population is comprised of women and 70% men.

There is some indication that the number of Aboriginal women accessing Aboriginal services in Ottawa is on the rise. Statistics provided to the City of Ottawa's Housing Branch by Minwaashin Lodge/AWSC showed an increase of 37% in the number of women accessing housing-related services between October to December 2004 quarter and the January to March 2005 quarter. Most (88%) of these clients are single women and 12 % are lone parents with at least one child. The same trend was borne out at AWSC-Oshki Kizis where the increase in women accessing services over the same time period was 33%. In terms of age grouping, 73% were adult women between the ages of 31 and 64, 12% were between the ages of 15 and 30 and about 10% were children under the age of 15. Most were single adults. It is likely that there is considerable overlap in these statistics and that the same clients are accessing services at both agencies. Nevertheless the increase is notable.

- According to the Youth Services Bureau, about 6-7% of all youth clients in the Young Women's Shelter, waiting for YSB housing or accessing downtown drop-in services are Aboriginal and Native.
- Stable, permanent housing and employment are very high priorities for Aboriginals. Aboriginal clients access both mainstream and culturally specific agencies for help, a necessary practice to obtain a full range of services and housing options. However, there is a high probability that a homeless Aboriginal will experience discrimination and racism and feel vulnerable in mainstream agencies, especially in the larger shelters. This discourages access. Discrimination also limits suitable housing choices. Aboriginal homeless people do better and, for the most part, prefer to be helped by Aboriginal-specific agencies.
- Identified gaps in housing with supports include:
 - a treatment centre for men and women;
 - long-term housing with appropriate on-site and portable support services; and
 - social housing options with flexible portable supports.

3. TYPES OF SERVICES PROVIDED THAT SUPPORT NEEDS

Support services provided regarding housing for special needs populations can range from 24 hour/7 day a week on-site support, to occasional visiting support from off-site service providers. Supports may be provided by the same agency

that does the property management or through partnerships with social and health service agencies. Supports can be tied to the individual, the housing site, or both. The support services required by special needs individuals typically fall into two broad categories- health related and personal support services. (City of Vancouver 2007, Pleace 1995, Fitzpatrick et al 2000)

Health related services include assistance with physical tasks such as toileting and with treatment plans. Personal support services are more varied. They include assistance with:

- Daily living skills such as cooking, cleaning, and housekeeping responsibilities for personal and shared living spaces;
- Financial management skills such as budget planning for shared rent and grocery expenditures as well as personal expenses; and
- Social skills to ameliorate the isolation often experienced by those with special needs. If in a shared living arrangement, additional support is needed to interact socially, form relationships and comply with house rules.

Adequate and dependable long and short term support to those living in the community can help individuals maintain independence. However, it is important to emphasize that housing with supports options are not a substitute for long term care. In recognizing and promoting the valuable role of housing with supports in the community, there is a danger that individuals who need residential care might be kept inappropriately in units that cannot meet their needs or that medical services might be offered in an unlicensed and inadequate environment. This is particularly important in meeting the needs of individuals such as those seeking addictions treatment or seniors with dementia. The need for high quality hospital and residential care will always be required.

4. HOUSING WITH SUPPORTS MODELS

The majority of individuals with special needs require stable, affordable housing plus supports to remain in the community. Their combined provision is a recognized best practice.

The literature provides an overview of housing with supports options for various special needs populations and recognizes that the best combination of support and housing for any individual requires assessing that individual's needs and circumstances. A range of housing variables are linked to better outcomes but research, in general according to Sylvestre et al, fails to provide the broader range of practices required to run successful housing with supports programs.

Research undertaken by John Sylvestre and his associates (2007) in Toronto is currently being replicated in Ottawa as "Housing Plus". The goal of the work is to support community stakeholders in identifying recommended practices and

subsequent benchmarks for promoting housing stability among consumers using housing with supports.

This project will provide:

- A tool for evaluating the implementation of housing with supports³.
- A study of the implementation of housing with supports in Ottawa.
- Strategies for improvements in the delivery of housing with supports in Ottawa.
- A sustainable collaborative community⁴ focusing on housing with supports in Ottawa

(Housing Plus website, Sylvestre et al 2007)

The reviewed international research on models and consumer preference has yielded a range of approaches that are proven to work in specific circumstances. Collectively they call for a variety of flexible models and recognition of the importance of continuous access to housing over the course of an individual's life for optimal health and quality of life. (CAMH 2001, Pleace 1995, Regional/Municipal Working Group on Long Term Supportive Housing 1996, HUD 1995, Ministry of Municipal Affairs and Housing, Corporation of Supportive Housing , ONPHA websites)

Key informants in a study about housing with supports need in Ottawa, undertaken for the National Capital Region YMCA-YWCA (SDR, 2007), voiced a similar need regarding housing with supports to that identified in the literature. "One size does not fit all: a range of housing options are required including short and longer term housing depending on the particular target population". Within this range, however, there was an expressed need for more permanent housing with supported (portable services attached to the individual) as well as supportive (on-site services) options. In addition, informants agreed that there should be an emphasis on apartment or bachelor style units (in other words self-contained units that include at a minimum some cooking facilities and an ensuite bathroom); but with access to some shared areas for socialization, possible delivery of support services, and in some cases opportunities for communal cooking and shared meals⁵.

³ The Toronto tool provided benchmarks within the four service domains (Housing, Person, Support, and Systems), and key practices participants recommended for achieving them.

⁴ Researchers use the term "collaborative communities" to describe groups of professionals and consumers of services who are working together to address a shared challenge. In this project, a collaborative community consists of the staff and tenants of HousingPlus organizations in Ottawa. Together with University of Ottawa researchers, this community is working together to develop tools for evaluating the implementation of supportive housing in Ottawa.

⁵ Recognition of the importance of physical design as a support in the absence of sufficient personnel support

Different communities and countries use similar terms in different ways. The following descriptors of models reflect common usage and respect definitions already in use in Ontario for common housing with supports models found in the literature.

4.1 Transitional Housing

4.1.1 Description

Transitional housing is considered short-term accommodation (6 months to three years) while assistance is obtained to address problems such as unemployment, addictions, mental health issues, educational deficits, physical and cognitive disabilities, and domestic violence. Transitional housing units take many forms, for example, a treatment centre with intensive case management, or second stage housing for individuals leaving either an emergency shelter or a first stage health care centre. It typically provides access to a mix of support services that enable an individual or family to move from emergency shelter towards self-sufficiency and permanent housing.

(CMHC 2004, City of Vancouver 2007, Focus 2007))

4.1.2 Assessment

Transitional housing programs are more effective than services alone. There is evidence of short-term success in improving housing status.

Transitional housing may be an appropriate setting for those whose present circumstance requires structure and targeted support services to regain stability and develop skills. Typical users are victims of domestic violence, recovering substance abusers, immigrants and pregnant and parenting teenagers. However, for some, transitional housing represents one more unnecessary move and adjustment to new rules and regulations.

Where outcome data is available, 66% to 90% of residents from agencies included in a 2004 CMHC study moved to permanent housing or achieved other forms of success. Transitional housing projects that were able to provide subsidized housing or housing subsidies for their graduates had higher rates of success in terms of achieving permanent housing than projects that were not able to provide such assistance. Other improvements were varied and modest.

Potential residents of transitional housing require good assessment to determine if this is an appropriate housing step towards other longer term or permanent housing and supports models. At a minimum, it is hoped that program “graduates” will not use the emergency shelter system or become homeless again. Two Canadian studies evaluating such housing for families found mixed results. Both stressed the need to provide subsidized permanent housing and transitional support services, not transitional housing, so that families could develop stable social connections and neighbourhood supports

(Novac et al, 2004).

4.2 Supportive Housing

4.2.1 Description

Within Ontario, the term “supportive housing” typically connotes a situation where supports are linked to a specific accommodation unit and staff work on site supporting all who live there. The amount of time staff spend on-site depends on the level of assistance needed by the residents. Supportive housing is typically a shared accommodation arrangement such as group homes, and small rooming house settings; but can sometimes include a cluster of supervised self-contained apartments in the same building⁶.

On site staff in supportive housing options typically work towards creating a supportive community amongst residents and focus on housing issues such as group decision-making, cleaning, and conflict resolution.

The focus of supportive housing is providing a safe environment and the necessities of life. Ideally they also provide some skills development and assistance with community integration. Residents may receive support from both on site staff (usually staff of the same agency providing the housing) and those that support them individually (portable support usually from other agencies addressing specific issues).

(CAMH website, CMHC 2005, SDR 2005, 2007, Sylvestre et al. 2007)

4.2.2 Assessment

Several studies (Chipperfield et al 1990, Johnson 2001, CAMH 2001, Fitzpatrick et al 2000, Nelson 1999, Schwartz 2003, Anucha & Hulchanski 2003) show a number of positive impacts on consumers with mental illness living in supportive housing. They include a reduction in rates of rehospitalization, lessening of psychiatric symptoms, greater independence, and improved self-esteem, social skills and quality of life.

Disadvantages of congregate supportive housing are related to residents’ limited privacy, lack of power and control and limited, if any, choice over who lives with them. Problems with living companions are common and residents may be expected to move to a new level of housing when they do well. In essence, they lose their home. (CAMH website, CMHC 2005, SDR 2005, 2007)

Since the emergence of supported housing, some supportive housing providers have modified their programs. These changes have led to consumers gaining access to independent and individualized support and a greater measure of autonomy and control over their housing, although they may still live in

⁶ *Crosswinds*, provided by The Ottawa-Carleton Association for Persons with Developmental Disabilities (OCAPDD), is an example.

congregate settings (Parkinson et al., 1999, Sylvestre et al. 2007). Staff of the Ottawa Carleton Association of Persons with Developmental Disabilities (OCAPDD) anecdotally concur with these findings in describing their *Crosswinds* program, even though this model continues to rely mainly on “on site” staff. Crosswinds is also proving to be more cost efficient in housing clients than the more traditional group home model.

4.3 Supported Housing

4.3.1 Description

Supported housing involves portable support tied to the individual not the housing site. In some instances this form of housing is considered permanent housing and not a step within a continuum. Typically, supported housing has been identified with⁷ apartments, housing co-ops or other government funded social housing for people with low income.

Those best placed in supported housing have the ability to:

- Direct their care;
- Make decisions;
- Live alone in an unsupervised setting
- Communicate sufficiently or have the physical mobility to extricate him/herself in an emergency

Supported housing may or may not involve shared living space. When living space is shared, roommates may not have control over whom they live with. Supported housing can also include private market housing options.

Agencies may deliberately scatter⁸ units when housing certain populations such as those with addictions to limit interaction amongst clients. As part of a continuum of care approach, clients are often required to make a commitment to participation in treatment and sobriety before housing is provided. Housing and support are usually provided by the same agency.

(CAMH website, Nelson 2007, CMHC 2005, SDR 2005, 2007)

⁷ Support can be made available on site as well as off site through linkages and partnerships.

⁸ Scattered site housing tenants are described as feeling more independent and have more responsibility for their actions. They enjoy increased control over their lives and have increased privacy and anonymity (Supportive Housing Corporation Website)

The scattered site housing model is considered effective with those seeking abstinence from substance use. Individuals who are in an early stage of recovery are more successful when separated from other individuals who are in recovery. This approach keeps individuals from being contaminated by relapses of others; and keeps the addiction out of mind (Central Massachusetts Housing Alliance Website)

Housing First

A model of supported housing called “Housing First” takes a slightly different approach in its application of supports: it separates housing from treatment.

Best known as the Pathways program in the U.S., this model is founded on the belief that housing is a basic human right for all individuals, regardless of disability. Clients are homeless, have severe mental illness and frequently have a co-occurring substance use disorder. Housing is seen as an immediate and practical solution to homelessness, not a reward or incentive for participation in treatment. This is facilitated through rent supplements and assistance with financial management that can include a representative payeeship.

Housing support staff develop relationships with landlords and housing management companies in order to secure apartments for new clients and rent is guaranteed. Staff also serve as liaisons to ensure that apartment repairs and emergencies are dealt with adequately and in a timely manner. Once an individual is placed in housing, he or she is encouraged to participate in treatment, vocational and rehabilitative programs

Pathways uses assertive community treatment teams to address problems associated with mental illness, addiction, and unemployment. Consistent with its client choice philosophy, the team uses a harm- reduction approach for clients with dual diagnoses. If clients are symptomatic or actively addicted they are provided with support or treatment. Clinical staff practice with a recovery focus. They will seek out the most difficult to reach clients— those who have failed in other programs, shelters, hospital, and jails—and base their approach on the belief that trust and relationship building are key to client success. The team puts the decision-making authority in the hands of clients, providing clients the opportunity to gain control over their lives and to determine their own path of healing and recovery. The team’s commitment is long term, and housing is permanent

(CMHC 2005, Gulcur 2003, Pathways to Housing Website, Nelson et al 2007)

4.3.2 Assessment

According to Geoffrey Nelson in his presentation in Montreal on housing (Nelson, 2004), 6 longitudinal studies on the impacts of supported housing, in general, for homeless people with serious mental illness show positive impacts on housing stability, reduction in hospitalization, greater satisfaction with housing, fewer housing problems, better housing quality, and better overall quality of life. Identified negative impacts include isolation and loneliness, and; little evidence of integration into the community through informal support systems, education, or work. The latter may speak to the need for access to supported socialization, supported education, and supported employment.

Housing First

Studies of the Pathways program are demonstrating its effectiveness in housing people with severe mental illness, addictions and a history of chronic homelessness. Many U.S. cities are adopting this model. Results reported by the Pathways Program challenge the commonly held view that people with severe mental illness and a lengthy history of homelessness are unable to live independently in the community without first receiving a course of rehabilitation. (Nelson et al, 2007)

A 2003 study by Gulcur et al comparing “Housing First” and “Continuum of Care” approaches with chronically homeless individuals with psychiatric disabilities found that the “Housing First” approach participants spent significantly less time homeless and in psychiatric hospitals and incurred fewer costs.

The article, *Life on the Inside*, notes that New York City could give each of its mentally ill homeless residents their own apartment or room plus access to support services for less than what is spent on emergency health care, prison time, shelters, and other services. Pathways spends about \$22,000 a year on each of its clients and a good portion of that is money already allotted to them through government benefits programs.

In 2002, Home Depot security guards cleared Tent City, a large squatter settlement in Toronto. In an effort to address the needs of those evicted, the City of Toronto took immediate action by initiating the Emergency Homelessness Pilot Project (EHPP). Similar to the Pathways program, it provided rent supplements to those evicted and assisted them in finding and maintaining housing. Local agencies facilitated tenant relationships with landlords, then provided personal supports and problem solving on an *as needed* basis.

The EHPP has provided housing in the private market for a group of people deemed homeless for extended periods and who struggle with issues such as addictions and mental illness. Despite many challenges, an evaluation of this project in 2004 found that 89% of the households remained housed, and that former Tent City residents expressed a high degree of satisfaction with their individual units. It also found that the EHPP costs of \$11,631 per person (including the OW/ODSP shelter component) per annum offered a cost effective alternative to accommodation and supports in the shelter system, estimated at \$16,156 per year. This was without factoring in likely cost benefits from EHPP participants returning to school, work or entering rehabilitation programs (Gallant, 2004).

5. PHILOSOPHICAL APPROACHES TO HOUSING WITH SUPPORTS

The models described on the previous pages have evolved along 2 philosophical approaches to assisting special needs individuals with housing following modern society's rejection of institutional care.

5.1 The Continuum of Care Approach

This approach is based on a 'continuum' paradigm in which different housing environments are available to residents. Each provides a different level of support that is rehabilitative or instructional in nature. Individuals are seen as requiring supervision and may be moved back and forth from one environment to another depending on need. The final stage of the continuum is reached when a resident either achieves independent living status or reaches his or her optimum level of development. Transitional and Supportive Housing are the mainstays of this approach.

The continuum approach in relying on a variety of housing and supports options fails to reach its potential in many communities as there are few communities capable of providing the quantity if not the array of models required for all client groups. A result may be individuals who remain stuck in inappropriate housing because the "next stage" is full or does not exist.

5.2 The Person-Centred Approach

The primary goal is to have individuals choose and settle in their own homes, and have them access resources with the assistance of supportive "relationships" as they see fit. This approach encourages tenants/citizens to be viewed by others as community members with "normal" tenancy and responsibilities rather than as residents/clients or patients.

Although "normal" housing is encouraged, some might choose to reside in housing that is custodial or supportive in nature. The most common models used, however, are the Supported and Housing First models. This approach requires access to sufficient affordable housing stock and community services to be successful in any community.

(Pathways; HUD websites; CMHC 2002)

6. HOW BEST TO PROVIDE HOUSING WITH SUPPORTS FOR THOSE WITH SPECIAL NEEDS

The literature identifies the need for a range of housing and supports options for special needs individuals, as it is only after assessment of the specific needs of each individual that one housing and supports model can be chosen over others. As such, combined expert opinion calls for a hybrid approach: merging of the

continuum of care and person centred approaches with attention to ensuring the following:

- A variety of housing with supports model options are available in each community similar to that expected of a continuum of care approach; but the type of support becomes the changeable aspect not the location of “home”. Such an approach supports consumer choice and control over where and how they are housed and what supports they may or may not need;
- Assessment of the housing needs of special needs individuals is person centred in that it is directed by individual preferences or their designated decision-makers, not rehabilitation or learning needs;
- Housing with supports options are continuously balanced and realigned in each community to meet the needs of its special needs populations.
- The need for transitional housing is carefully reviewed. Recently popular due to short term federal funding available to address homelessness, transitional housing has become a panacea due to a lack of other housing options. However, limited gains in positive housing outcomes have been documented - mainly in situations where subsidized housing could be guaranteed as the immediate next step.

(Chartrand et al 2002; Potter et al 2005, Nelson et al 1998; Parkinson et al 1999; Ridgway & Zippel 1990; Glauber 1996, Focus Consulting 2005)

7. COSTS/BENEFITS ASSOCIATED WITH DIFFERENT MODELS OF HOUSING WITH SUPPORTS

One of the desired outcomes for this paper was the assessment and report on published research related to the costs and benefits over both the short and longer term of different models of housing with supports, in particular, supports that are linked to the accommodation, versus supports that are attached to the person. Determining the comparative cost-benefit of providing housing with supports services across different models is extremely challenging⁹ and a

⁹ A presentation by Dr. Kenneth Watson from the Rideau Group to National Housing Research Committee, May 3, 2005 described the complexities around designing a cost-benefit analysis in the context of housing and supports. (Cost-Benefit Analysis of Renovations to Accommodate Aging and Disability, report prepared for Canada Mortgage and Housing Corporation)

The Office of the Auditor General of Ontario describes the difficulties in determining the cost of housing with supports in its 2007 report regarding housing within the Developmental Services Sector..... Because agencies submit only incremental budget requests for new spaces and one consolidated annual budget request for all the existing spaces they operate and services they provide, the Ministry cannot and does not track the average cost of individual spaces and services provided within a particular home. The Auditor General's calculation of the cost of

literature search on this topic produced no studies that examined both costs and benefits.

The authors did review several reports produced in 2005 and 2007 by Focus Consulting Inc. about the costs of homelessness in Vancouver, Toronto, Montreal Halifax, Waterloo, Peel and Ottawa. These analyses did not seek to compare costs between cities but rather to determine if the same pattern of costs across the continuum is evident within each city. The conclusion is a consistent pattern as evidenced by the following same key findings for the Ottawa, Waterloo and Peel studies:

- While community supportive housing is roughly equivalent in cost compared to the public expenditures incurred in the institutionalized emergency shelter system, housing with supports provides a much more stabilizing environment which likely reduces incidence of emergency service use (i.e. emergency hospitals, policing services, etc.) It also provides a more stable and higher quality of life for the formerly homeless and those at risk of becoming homeless.
- Use of various emergency services (policing, detention, ambulance and emergency hospital care) is at up to ten times more expensive than residentially-based responses to homelessness.
- For severely mentally ill and addicted persons that require more intense levels of service, the cost of institutional tertiary care is four times that of residentially-based responses, even when supplemented by more intense professional medical/psychiatric teams.

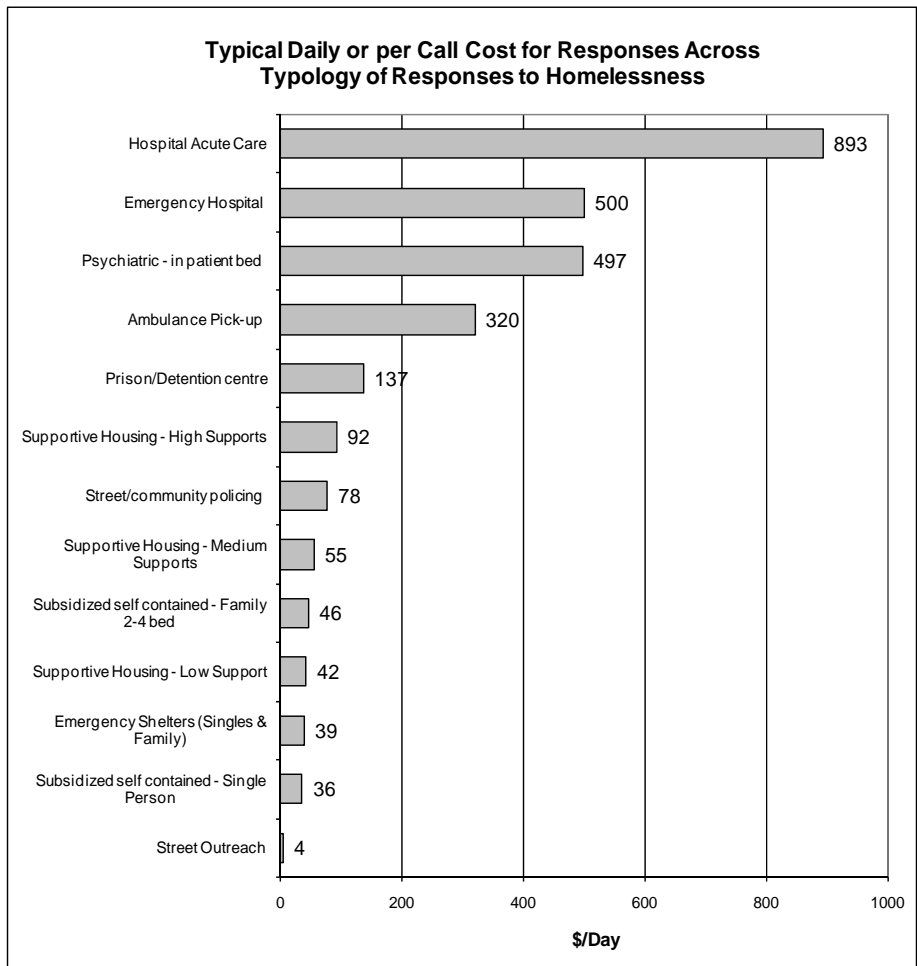
These are crude comparisons reflecting the cost of operating/providing a particular service for a single day – the comparisons do not take into consideration frequency or duration of service utilization.

The chart below clearly illustrates that institutional and emergency responses are much more costly than residentially/community-based options, even when including the costs associated with providing supports. Note that this reflects the public subsidy expenditure – actual costs incurred by operator may be higher and augmented by fund-raising or tenant payments.

spaces at individual homes for a sample of agencies visited found that the cost of these spaces varied significantly, from a low of \$30,000 to a high of more than \$200,000 per year. (Office of the Auditor General of Ontario, 2007)

It is also important to note that while there is a range of associated costs with serving someone for one day under different responses that might be identified as a saving” in most cases, these are not real savings. Most of the revealed costs in this study are fixed-costs and are incurred whether a person/patient is accessing services or not.

As a result, the real “saving” is accrued through decreased service utilization (cost avoidance) i.e. demand management (which would assist in addressing issues of growth), improved quality of life and preventive outcomes.



In other words, by reducing service utilization from the homeless and at risk population, emergency services such as ambulance and emergency hospital admissions can be freed up for other users.

There is also the possibility of deferring potential infrastructure expansion (i.e. development of new hospitals, institutions, etc.) if current use can be reduced through diversion to less costly approaches, for example by focusing on prevention and effective street outreach programs while ensuring a sufficient supply of supportive or comparative housing options at a lower cost to the taxpayer.

Furthermore, there are also benefits associated with investing in residentially-based approaches with adequate support services which can remove an individual from the debilitating effects of chronic homelessness, improve quality of life and in some cases, enable the individual to recover the ability to live and function independently, potentially returning to or entering the labour market – with associated productivity impacts and reduced use of social assistance. In many cases however, individuals traditionally housed in supportive or domiciliary housing may continue to need permanent supports for activities of daily living

and may not become fully independent, but will enjoy an improved quality of life and level of self-confidence.

There is however, the critical issue of a fiscal imbalance or who pays and who saves within the overall funding system. Stabilized housing can generate efficiencies in the health care and correctional systems, but these “savings” accrue to provincial and to some extent federal governments. For the most part the costs of social housing are incurred at the local level as municipalities often subsidize the development and day-to-day operations of these services at great cost.

As a result, greater efficiencies can only be stimulated and realized with strong inter-agency and inter-jurisdictional cooperation and with ongoing investment by all orders of government, as has been the case in the most recent Affordable Housing Program and the National Homelessness Initiative.

The following template provides a breakdown of the typical daily costs of different types of housing with supports based on information collected by Focus Consulting in 2007 from Ottawa facility operators.

Range of Cost Estimates for Housing with Supports ¹⁰								
		Approach	Support/Management Model	Accommodation	Meals	SDL	Medical support	Total (person/day)
1	Supported	Supportive housing - high supports	Communal living or self contained, meals, community supports for SDL; Staffing 24/7 (some ACT)	incl	incl	some	emerg only	80-140
2		Supportive housing - medium supports	Communal living or self contained, meals, community supports for SDL; Staffing 9-5 (excludes any ACT)	incl	incl	some	no	32 – 42
3		Supportive housing - Low supports	Communal living , group or self contained, occasional community supports for SDL; on call emergency support	incl	incl	some	no	20 - 30

Notes

1	Low end reflects standard per-diem/person subsidy from City of Ottawa for Domiciliary Hostel services plus ACT teams; high end reflects high support/high need supportive housing (24/7 on-site staffing) living in group homes or self contained support apt, support costs plus ACT teams for some residents, plus property operations
2	Medium supports (daytime on-site staffing, basic counseling services, etc.)
3	Low support/low need transitional housing

¹⁰ According to another study (Blouin et al, 2004) an assessment of services and supports consumed by 90 clients of a community mental health agency in Ottawa, Ontario show the average annual total costs of services and supports used by the clients to be \$24,878 per year (\$68 per day), with a wide range variability associated with total costs of services for the different clients. The model of supported housing in which these individuals lived is “Housing First” – similar to the U.S. cost the Pathways Program quotes as noted in section 4.3.2 of this report.

8. BENEFITS TO SOCIETY WHEN BEST PRACTICE HOUSING WITH SUPPORTS ARE UTILIZED

The documents reviewed for this paper collectively point to multiple short and long term benefits to the individual and ultimately society when special needs individuals are appropriately housed and supported. These are summarized in 8.1 and 8.2.

8.1 Short Term Benefits

Decreased	Increased
<ul style="list-style-type: none"> • homelessness • use of emergency shelters • use of emergency services (ambulance, ER, Police) • Potential harm to resident (violence, overdosing, etc.) • crises (suicidal behaviour, severe psychological distress, etc) • substance abuse • episodes of hospitalization • cost to society 	<ul style="list-style-type: none"> • awareness of needs • consumer satisfaction • understanding of contributing factors to homelessness (psychiatric disorder, etc) • awareness and motivation to improve life and to work towards goals • financial stability • health promotion behaviours (regular check ups, & medication use, etc) • formal and informal support and referral network • basic skills (hygiene, cooking, etc) • interest in recreational activities

8.2 Long Term Benefits

The ultimate long term outcomes are maintenance of stable housing and improved quality of life. Others include:

Decreased	Increased
<ul style="list-style-type: none"> • crisis situations 	<ul style="list-style-type: none"> • integration into the community • commitment to maintain safe, clean and sober living • maintenance of sobriety and/or abstinence • financial security • reliability in paying rent and of meeting resident obligations (keeping appointments, etc) and housing stability • efforts towards meeting needs and goals • mental health and personal well-being

	<ul style="list-style-type: none"> • solid formal and informal support and referral networks • effective management of illnesses, conditions, issues (mental illness, etc)and/or improved health • increase in life skills, leisure and social activities • independence, empowerment & gains in role achievement
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9. CONCLUSIONS

This literature review provides an overview of the current “state of knowledge” related to the provision of housing with supports. It also provides descriptions of several models common to the needs of a wide variety of individuals and families with special needs. Studies that assess the advantages and disadvantages of different approaches demonstrate that “one size does not fit all” and that the needs of potential residents must be considered a priority when developing a housing with supports program. What also seems clear is that communities should work together to coordinate existing programs and services to ensure that individuals do not fall between the cracks and to avoid duplication of services. Combining the best aspects of the “Continuum of Care” approach and “Housing First” model may be optimal and allow communities to offer a wide range of inter-related housing with supports options.

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HOUSING WITH SUPPORTS INFORMATION GRID*

Model Description	Recommended Client Groups	Recognized Best Practices	Pros & Cons	Costing per unit
<p>Transitional Housing Time-limited supportive or supported housing where people at risk of homelessness prepare for independent living**. (6 months to 3 years) with a mix of support services. Includes residential treatment programs, half-way houses, second stage housing for those leaving either an emergency shelter or a first stage health care facility.</p> <p>Frequently a beginning step in the Continuum of Care Approach where participation in treatment is a prerequisite to accessing housing.</p>	<p>Individuals & families requiring targeted support services to regain stability or to develop skills.</p> <ul style="list-style-type: none"> ○ Victims of domestic violence ○ Recovering substance abusers ○ Newcomers ○ Pregnant and parenting teenagers ○ Sex trade workers ○ Those leaving incarceration ○ Aboriginals requiring urban lifeskills, or pre or post addiction treatment 	<p>Individuals require good assessment to determine if this is an appropriate housing step. Most successful if a full array of 'next step' housing is available (continuum of care approach).</p> <p>With a high risk/need population there are significant benefits to having self-contained units to minimize criminal associations and allow clients to focus on their care plans.</p> <p>In communal housing, (for certain client groups), it is important to have 24/7 staff presence or to ensure that all residents are aware that 24 hour crisis intervention is available – this results in fewer crisis situations and less property damage.</p>	<p>Pros: More effective than service alone. Evidence of short-term success in improving housing status.</p> <p>Cons: Does not have a positive effect on longer-term housing status.</p> <p>Cons: The lack of security of tenure perpetuates uncertainty in client's life, as opposed to permanent housing with flexible mobile support.</p> <p>Subsidized permanent housing and transitional support services, not transitional housing, is recommended.</p>	<p>\$20 - \$140 per resident/day depending on amount of support provided (assume the \$20 per day does not include housing costs)</p>
<p>Supportive Housing Permanent housing with on-site supports, for individuals who need assistance to stay housed.**</p> <p>Either communal living situations (Group Homes, Domiciliary Hostels, small rooming house settings or clustered self-contained apartments.)</p> <p>Supports are linked to a specific accommodation unit and staff work on site supporting all who live there.</p> <p>Residents may also receive portable support for specific issues.</p> <p>May be an interim step in the Continuum of Care Approach, but ideally seen as a home, for as long as it suits the person's needs and preference.</p>	<p>Individuals who are unable to care for themselves or make appropriate decisions, and do not require more intensive residential or 24 hour nursing care</p> <ul style="list-style-type: none"> ○ Those with serious and persistent mental illness ○ Those with profound developmental disabilities 	<p>In clustered, supervised self contained units: OCAPDD's Crosswinds model for individuals with developmental disabilities is demonstrating (anecdotal) increased autonomy, empowerment and sense of quality of life for clients. This model is also more cost efficient than the traditional group home.</p> <p>Providing an on-site resource centre (at each site if more than one) with 24/7 staff on call decreases emergency hospital visits and enhances safety and security for residents.</p> <p>In communal, for certain client groups, it is important to have 24/7 staff presence or to ensure that all residents are aware that 24 hour crisis intervention is available – this results in fewer crisis situations and less property damage.</p> <p>For providers who target persons with substance abuse issues and have an abstinence policy, it is critical to offer longer term housing (at least one year) to increase success rate and improved health.</p>	<p>Pros: Reduction in rates of re-hospitalization, lessening of psychiatric symptoms, greater independence, and improved self-esteem, social skills & quality of life.</p> <p>Pros with clustered self-contained apartments: <i>greater autonomy and, more likely, security of tenure.</i></p> <p>Cons with communal model: Limited privacy, lack of power & control, limited choice over who one lives with, problems with living companions, Residents may be expected to move to a new level of housing if doing well (Continuum of Care Approach).</p>	<p>\$20 - \$140 per resident/day depending on amount of support provided (assume the \$20 per day does not include housing costs)</p>

HOUSING WITH SUPPORTS INFORMATION GRID*

Model Description	Recommended Client Groups	Recognized Best Practices	Pros & Cons	Costing per unit
<p>Supported Housing Housing provided to individuals at risk of housing loss where they benefit from housing support that is not tied to any particular housing location.** Provided in apartments, housing co-ops, social housing, Semi-Independent Living (SIL), etc.</p> <p>Portable support tied to the individual, not the housing site. Using support may be a requirement to accessing housing (Continuum of Care)</p> <p>May be the last step in a continuum of care approach or only step in a person-centres approach</p>	<p>Individuals who are able to direct their care; make decisions; live alone in an unsupervised setting; and, communicate sufficiently or have the physical mobility to extricate him/herself in an emergency.</p> <p>Includes:</p> <ul style="list-style-type: none"> ○ Those who are homeless with mental health and/or substance issues ○ Those with mental illness or concurrent disorder ○ Those with a developmental disability ○ Those with substance abuse issues ○ Those with other issues causing them to need assistance with daily living 	<p>Availability of rent supplements enhances access to supported housing.</p> <p>“Scattered Site Housing”: Scattered sites are recommended in housing certain populations, such as those dealing with substance abuse, to limit interaction amongst clients and to enhance client choice.</p> <p>“Housing First’ (U.S. Pathways Program): Can be any housing option preferred by client.</p> <p>Clients are offered immediate access to permanent independent housing of their choice before a support plan is set in place. Staff liaise with housing providers to secure accommodation & to assist with ongoing problem solving. Once housed, individual is encouraged to participate in treatment, vocation and rehabilitative programs.</p> <p>More successful in combination with Assertive Community Treatment (ACT) than Intensive Case Management (ICM).</p>	<p>Pros: In general, housing stability, reduction in hospitalization, greater satisfaction with housing, fewer housing problems, better housing quality, better overall quality of life, & security of tenure.</p> <p>“Scattered Site Housing” tenants are described as feeling more independent and have more responsibility for their actions. They enjoy increased control over their lives and have increased privacy and anonymity. The scattered site housing model is considered effective with those seeking abstinence from substance use. Individuals who are in an early stage of recovery are more successful when separated from other individuals who are in recovery. This approach keeps individuals from being contaminated by relapses of others; and keeps the addiction out of mind.</p> <p>“Housing First” outcomes are significantly better than the continuum of care service delivery model. No higher rates of psychiatric symptomatology or substance use.</p> <p>Participants spend significantly less time homeless and in psychiatric hospitals, and incur fewer costs.</p> <p>Cons: Potential isolation & loneliness. Little evidence of integration into the community through informal support systems, education, or work when only housing support provided. Speaks to the need for additional supports beyond those to maintain housing to achieve empowerment and community integration.</p> <p>Requires access to sufficient affordable housing stock and community services to be successful</p>	<p>“Housing First”</p> <ul style="list-style-type: none"> ○ U.S. Pathways - \$22,000/year/pers on (\$60.27 per day) ○ Ottawa’s CMHC - \$24,878/year/pers on (\$68 per day) ○ Toronto’s, Emergency Homelessness Pilot Project (EHPP) \$11,631/year/pers on (\$31.86 per day)

* Based on Social Data Research (Davis, C.) & Dinning, B. 2008 *Models of Housing and Supports Final Report*

**Definitions are from the 4th Report Card on Ending Homelessness in Ottawa Jan-Dec 2007, Alliance to End Homelessness