
**Integrating Housing, Healthcare and Employment Supports to Solve
Homelessness**

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EXECUTIVE SUMMARY

INTRODUCTION

Homelessness is a complex problem with far-reaching negative impacts in western economies, including Canada's provinces and territories. Homeless people suffer: high mortality, multiple morbidities, anxiety, depression, and behavioural problems; foregone economic and social contributions; poor nutrition and health; increased risk of substance abuse; lost social connections; isolation; loneliness; and incarceration. Being a complex issue, homelessness requires an array of responses delivered in unison. Unfortunately, few if any responses or solutions reside with a single organization or authority. As a result, cooperation across organizations and authorities is a minimum requirement for addressing homelessness.

Yet, services are separated (Hughes, 2012, p. 8). One federal department addresses housing and other separate entities deal with health, employment, and justice. Provincially, similar independent silos exist (Hughes, 2012, p. 11). To complicate matters further, a myriad of non-profit, municipal, and provincial government agencies provide front line supports.

Although billions of dollars have been spent managing homelessness over the last 35 years, there is little progress to show for it. In 2009, while assessing the results of \$1 billion directly funded to the Federal government's primary homelessness program between 2000 and 2010, Human Resources and Skills Development Canada (HRSDC) reported homelessness actually increased (Hughes, 2012, pp. 6-7).

Still, amidst discouraging data and disheartening results are strong threads of hope and progress. Some people present a convincing argument that homelessness can be successfully addressed (Gaetz, Gulliver, & Richter, 2014, p. 3) using tools and resources at our disposal right now (Hughes, 2012, p. 1). Gaetz et al. say the following six strategies can successfully address Canadian homelessness (2014, p. 7):

1. A new federal, provincial, and territorial affordable housing framework agreement;
2. Investments to target chronically and episodically homeless people;
3. Direct investments in affordable housing programs;
4. A housing benefit to assist those who face severe affordability problems in their current accommodation;
5. A new affordable housing tax credit; and
6. Investments in Aboriginal housing both on and off reserve.

For at least the last 50 years it has generally been agreed that health care is required, in addition to housing. Access to these services has been through a hard-to-navigate mix of federal, provincial, municipal, non-profit, religious, and philanthropic organizations. Those needing services have been left alone to navigate service-to-service.

Available health services focus on housing, health, and supportive services—historically associated with the homeless' needs. Each service provides multidisciplinary support to a range of people: from those experiencing chronic homelessness to people in immediate crisis. However, these services usually do not place a primary focus on employment services, despite it being a key piece of the homelessness puzzle (Putnam, Shamseldin, Rumpf, Wertheimer, & Rio, 2007, p. 2; Rio, Ware, Tucker, & Martinez,

2008, p. 1; Serge, Kraus, & Eberle, 2006, pp. 20-22; Shaheen & Rio, 2007, p. 343; U.S. Department of Health and Human Services, 2003b, p. 12).

The Streetohome Foundation (“Streetohome”) is a non-profit organization whose mission is to solve homelessness in Vancouver, British Columbia. Streetohome uses funds raised to leverage housing projects specifically geared toward the homeless population. For example, it might raise \$3 million to build a \$30 million housing project including programming for building residents.

Driven by evidence, Streetohome seeks to integrate employment into the services and programs it facilitates. As it has done with existing services, Streetohome also seeks to ensure such integration is done effectively. Effective employment integration is a key to improving results for Streetohome clients.

To address Streetohome’s mission, this research seeks to answer the question “What are international best practices of bringing housing, healthcare and employment supports together in planning and practice to meet the needs of the formerly homeless, sheltered and at risk for homelessness” (Turnbull, 2014, p. 6)

METHODS

This research looks to three information sources to determine best practices: a literature review, document review, and survey. The literature review examines scholarly and grey literature to determine what established or upcoming best practices are used for habilitating and rehabilitating homeless people. Additionally, literature is reviewed to gather principles for integrating services for the homeless. This research considers four characteristics to determine whether a method or process is a best practice:

- There is a body of evidence supporting efficacy of the model.
- The method has been tested across a diverse population in many locations.
- It has been accepted as a best practice by practitioners and professionals in the field and by government bodies.
- Tools are available to ensure the best practice is used correctly in diverse circumstances and populations.

The document review examines two handbooks, a guidebook and a report related to developing an employment service for homeless people. The documents are based on American vocational programs, and the lessons learned are reviewed for potential application in Streetohome’s effort to solve homelessness. A thematic analysis is performed on best practices to identify repeating and important topics.

The survey was designed to solicit responses based on practitioner experiences. It asks participants what best practices they use or have seen in their work and also solicits information on the challenges they face in planning and operating a service for homeless people. A thematic analysis is performed on the survey results.

Best practices, lessons learned, and integration principles are combined in an integration framework and presented as a list or integration “tree.”

Recommendations and options based on the best practices, lessons learned, and integration principles are offered at the conclusion.

FINDINGS

From a scientific point of view, there is no best practice when it comes to providing services to homeless people. Although research and data support some practices more than others, there simply is not enough empirical evidence to indicate any method is worthy of the moniker “best practice.”

Without a doubt, a single thread weaves through the research. Clients are central to all best practices and service integration. This would be a trite statement were it not for the extent clients are integrated into programs. Clients are an integral part of best practice programs, as well as the target of supports. They participate in planning and operation and are given ownership of many aspects, especially their own direction.

Using the four characteristics from the Methods section to determine best practices, the following practices are identified:

- **Assertive Community Treatment**—a widely accepted best practice for dealing with people having multiple issues, such as mental illness and substance abuse. Combined with Housing First, it has proven successful.
- **Comprehensive, Continuous, Integrated System of Care**—a systemic approach to providing care to people with multiple issues.
- **Critical Time Intervention**—a method for treating people with multiple issues focussing on crucial transitions as clients improve their lives.
- **The Foyer Model**—a method for addressing youth homelessness.
- **Harm Reduction**—an approach used to reduce harmful outcomes associated with risky behaviours, including illegal drug use.
- **Housing First**—probably the most widely-known and ascendant best practice for supporting homeless people. It is significantly more successful than standard care and emphasizes unconditional provision of housing.
- **Integrated Dual Diagnosis Treatment**—a widely used and accepted approach to providing care to people with co-occurring mental illness and substance use issues.
- **Individual Placement and Support**—a widely used and accepted approach to providing disadvantaged people employment opportunities.
- **Intensive Case Management**—similar to Assertive Community Treatment, but used for people with less intensive needs, also combined with Housing First.
- **Motivational Interviewing**—a widely used and accepted interviewing method used in many circumstances, including treatment of homeless people, used as part of Housing First.¹
- **Permanent Supportive Housing**—a support method similar to Housing First.
- **Recovery-Oriented Services**—an approach geared to treating clients in their own environment.

¹ Information about Motivational Interviewing is available in the Appendix on page 105.

Regarding integration of services, there is no single model for integrating health services. Moreover, because each program, location, service set, client population, and set of program partners vary, the type of integration and intensity is different every time.

However, there are guidelines to be followed when integrating services. The following principles and elements were gleaned from the work of Suter et al. (2007, p. 5) and Turner (2014, p. 9).

1. Planning and Strategy Development process follows a systems approach grounded in the Housing First philosophy.
2. System Mapping to make sense of existing services and create order moving forward.
3. Comprehensive services across the continuum of care recognizing the importance of providing seamless health care despite the multiple points of access.
4. Geographic coverage and rostering to maximize accessibility and minimize duplication.
5. Standardized care delivery through inter-professional teams and use of provider-developed, evidence-based clinical care guidelines and protocols.
6. Performance Management and Quality Assurance at the program and system levels are aligned and monitored along common standards to achieve best outcomes.
7. Integrated Information Management aligns data collection, reporting, intake, assessment, referrals to enable coordinated service delivery.
8. Organizational Infrastructure is in place to implement homelessness plan/strategy and coordinate the homeless-serving system to meet common goals.
9. Cohesive, organizational culture with strong leadership and shared vision of an integrated health care delivery system.
10. Physician integration, particularly primary care physicians, by a variety of methods such as compensation mechanisms, financial incentives, and non-financial ways of improving quality of life.
11. Strong governance structure that includes community and physician representatives.
12. Sound financial management.
13. Coordinated Service Delivery to facilitate access and flow-through for best client and system-level outcomes.
14. Systems integration mechanisms between the homeless-serving system and other key public systems and services, including justice, child intervention, health, immigration/settlement, domestic violence and poverty reduction.

Best practices and the 14 principles above are arranged under a structure developed by Konrad (1996, pp. 12-17)—a kind of skeletal structure for integration efforts.

- Partners
- Target Population
- Goals
- Program Policy and Legislation
- Governance and Authority for the Services Integration Initiative
- Service Delivery Model
 - Communications
 - Staff deployment and reporting
 - Training

- Geographic location and service configuration
- Case management
- Other aspects
- Stakeholders
- Planning and Budgeting
- Financing
- Outcomes and Accountability
- Licensing and Contracting
- Information Systems and Data Management
- Evaluation Issues and Questions

RECOMMENDATIONS

Housing

Consider the ten recommendations made by Wong, Hadley, et al. (2006, pp. 78-80).

Health

Where possible, ensure clients are able to access primary health care as any other person does.

Place more emphasis on mental health and addictions treatment.

Employment

As a first step to initiating an employment plan, ensure all partners commit to it.

Adopt IPS as the model for integrating employment services with other supports.

Ensure employment support workers develop a one-to-one relationship with their clients.

When structuring an employment program, ensure there is one person responsible, who has authority to direct the program and who also has strong business skills.

Ensure employment program staff have strong clinical skills for working with homeless clients with mental illness and substance use issues.

Employers need to be integrated into employment efforts.

Jobs alone do not ensure economic stability for consumers.

Vocational rehabilitation services should involve employment in integrated settings for minimum wage or above.

Vocational rehabilitation services should explicitly address financial planning and provider education/support around disability benefits and entitlements.

Vocational rehabilitation services should be made available to all mental health consumers.

Research the labour market.

Vocational services should involve family and friends in supporting clients' efforts to work.

Integration

Agreement on collaboration is paramount, from beginning to end.

Review the Houselink program and infrastructure to gain insights on housing retention and employment outcomes.

If not already in place, consider adding methods to gather housing retention, drug use, satisfaction with housing, satisfaction with life, and other data on a program-by-program basis.

Take the time to learn about other systems, how to best work together, and eventually integrate the services to achieve goals.

Set clear performance standards based on the evidence-based model and be prepared to remove staff who do not meet them.

Ensure program evaluation is a part of ongoing operation.

Create a training plan for the staff from different service systems.

Where possible, use clients and former clients (peer staff) as ambassadors to the community.

If an equivalent position does not already exist, consider establishing a “boundary spanner” position.

Advocate for integrated provincial and federal housing and poverty programs and policies.

Advocate to governments and funders for adequate and flexible funding.

Contact the Bissell Centre for information on how they operate their program to address poverty.

Connect with Calgary Urban Project Society for information on their program.

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1.0 INTRODUCTION

No money is better spent than what is laid out for domestic satisfaction. (Samuel Johnson)

Homelessness is a complex problem with far-reaching negative impacts in western economies, including Canada's provinces and territories. Homelessness means suffering: high mortality, multiple morbidities, anxiety, depression, and behavioural problems; foregone economic and social contributions; poor nutrition and health; increased risk of substance abuse; lost social connections; isolation; loneliness; and incarceration. The Canadian Observatory on Homelessness gives the following definition for homelessness:

Homelessness describes the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination. Most people do not choose to be homeless, and the experience is generally negative, unpleasant, stressful and distressing. (2012a, p. 1)

Given the very definition of homelessness includes a laundry list of systemic, social, and individual barriers and challenges, homelessness implicitly requires an array of responses. There is no single solution. Moreover, many homeless people experience multiple barriers and challenges all at once, meaning responses need to be concerted, not sequential. Unfortunately, few responses or solutions reside with a single organization or authority. As a result, cooperation across organizations and authorities is a minimum requirement for addressing homelessness, and an integrated response is warranted. The answer to homelessness is integration of housing, health², and employment services for the homeless, formerly homeless, and those at the margins of society.

Homelessness is a decades-long emergency. We have marginally housed people suffering from significantly higher mortality rates and comorbidities than the general population (Vila-Rodriguez et al., 2013, p. 1420). Homeless people get by without even marginal housing, making their plight all the more urgent. Homelessness begets suffering and cannot be ignored in Canada and other wealthy countries.

So, where are we now? How coordinated and integrated are services? How efficient is service delivery?

Federally, services are separated (Hughes, 2012, p. 8). One department addresses housing and other separate entities deal with health, employment, and justice. Provincially, similar independent silos exist (Hughes, 2012, p. 11). To complicate matters further, a myriad of non-profit, municipal, and provincial government agencies provide front line supports. Figure 1 illustrates the organizations and layers delivering homelessness services in Canada.

² "Health" includes physical health, mental health services, as well as substance use treatment.

Money is wasted. On average, a homeless person with severe addictions or mental health issues consumes approximately \$55,000 annually in social services³, while the same homeless person—housed and provided with services they require—costs approximately \$37,000 annually (Patterson, Somers, McIntosh, Sheill, & Frankish, 2008, pp. 10-11). Annually in Canada, \$7.05 billion is spent on managing homelessness (Gaetz, Donaldson, Richter, & Gulliver, 2013, p. 8).

Moreover, with billions of dollars spent managing homelessness over the last 35 years, there is little progress to show for it. In 2009, while assessing the results of \$1 billion directly funded to the Homelessness Partnering Strategy⁴ (HPS) between 2000 and 2010, Human Resources and Skills Development Canada (HRSDC⁵) reported homelessness actually increased (Hughes, 2012, pp. 6-7).

Still, amidst discouraging data and disheartening results there are strong threads of hope and progress. “Canada has a long way to go in order to end the homeless crisis, but it has also made some definite steps in the right direction” (Gaetz et al., 2013, p. 37). For example, the At Home/Chez Soi study show the Housing First⁶ (HF) approach implemented across five Canadian cities saves money while directly addressing the needs of homeless people at the same time. In the final report on the At Home/Chez Soi program, Goering et al. estimate that between \$3.42 (moderate needs clients) and \$9.60 (high-needs clients) were saved for every \$10 spent (2014, p. 5). Compared to treatment as usual, HF “produced greater improvements in housing stability, quality of life, and community functioning after one year of enrollment” (Aubry, Tsemberis, et al., 2015).

From a “macro” point-of-view⁷—addressing issues like provincial and federal government housing policy, income supports, affordable housing legislation, and so on—some argue homelessness is *not* a complex problem (Hulchanski, Campsie, Chau, Hwang, & Paradis, 2009, p. 9). Others present a convincing argument that homelessness can be successfully addressed (Gaetz et al., 2014, p. 3) using tools and resources⁸ at our disposal right now (Hughes, 2012, p. 1). Gaetz⁹ et al. say the following six strategies can successfully address Canadian homelessness (2014, p. 7):

1. A new federal, provincial, and territorial affordable housing framework agreement;
2. Investments to target chronically and episodically homeless people;
3. Direct investments in affordable housing programs;
4. A housing benefit to assist those who face severe affordability problems in their current accommodation;

³ For example, emergency room visits, longer term hospital treatment, transient shelter, police interventions, and court costs.

⁴ The Homelessness Partnering Strategy is a Canadian Federal government program for directly funding community projects aimed at ending homelessness.

⁵ The federal department renamed in 2014: Employment and Social Development Canada (ESDC).

⁶ Housing First is discussed in more detail further along in this document.

⁷ See Figure 1. “Macro” refers to policies and programs developed and executed by federal and provincial government organizations.

⁸ Albeit, resources must be re-allocated.

⁹ “Stephen Gaetz is a Professor in the Faculty of Education” at York University “and is the Director of the Canadian Observatory on Homelessness and the Homeless Hub.” [...] “[H]e has published a book on community-based responses to youth problems in Ireland and written numerous reports and articles published in a wide range of peer reviewed journals.” [...] He “has played a leading international role in knowledge dissemination in the area of homelessness.” (Homeless Hub, 2015)

5. A new affordable housing tax credit; and
6. Investments in Aboriginal housing both on and off reserve.

After all, homelessness is primarily a housing problem. David Hulchanski often uses a quote by Cushing Dolbeare to make this point (2009, p. 6).

The one thing all homeless people have in common is a lack of housing. Whatever other problems they face, adequate, stable, affordable housing is a prerequisite to solving them. Homelessness may not be *only* a housing problem, but it is *always* a housing problem; housing is necessary, although sometimes not sufficient, to solve the problem of homelessness. (Dolbeare, 1996, p. 34)

Of course, this is not the end of the issue. Even if Gaetz and others propose ready and feasible solutions, resistance exists across the country. Physical and administrative barriers are often suggested as important and very real barriers to addressing homelessness. Issues like where and how to build appropriate and safe infrastructure to support long term recovery need to be addressed. Mustering sufficient support from Canadian political parties to back changes and allocate resources is as much a requirement as the resources themselves. As we can see, past efforts have lent valuable clues about how to address homelessness in Canada. Yet as the problem grows each day, there is a pressing need to propose new solutions and inspire support for a strategy able to provide required levels of service to these very vulnerable people.

At this point, it is worth mentioning that housing alone will not *end* homelessness. As Cushing Dolbeare says (above), “housing is [...] sometimes not sufficient, to solve the problem of homelessness.” Homelessness is a complex social problem with social, economic, health, and addictions closely associated with it. Gaetz et al. acknowledge their six strategies “will not completely end homelessness in Canada,” though they assert “it will dramatically reduce chronic and episodic homelessness” (2014, p. 7). There is broad consensus among people studying homelessness and working with homeless clients that multiple supports are needed (DeCandia, Murphy, & Coupe, 2014, p. 93; Gubits et al., 2015, p. 45; Hughes, 2012, p. 6; McQuiston, 2012, p. 413; Pleace, 2013, p. 54; SAMHSA, 2013a, p. 17; Walsh et al., 2014, p. 33). As the definition of homelessness suggests, this is where homelessness turns complex—having to address complicated human experiences and circumstances through fragmented, uncoordinated systems not fully adapted to the full scale and depth of the problem.¹⁰

1.1 DEFINING THE PROBLEM

For at least the last 50 years it has generally been agreed health care is required, in addition to housing. Health care commonly includes primary care, mental health services, and substance abuse treatment. The need for these services is well-founded. In a five-year study of people living in marginal housing (including formerly homeless people and those on the cusp of becoming homeless), participants suffered significantly higher rates of mortality, substance dependence, mental and neurological illnesses, infectious diseases, multi-morbidity, and poor psychosocial functioning (Vila-Rodriguez et al., 2013, p. 1418). In rare cases, health and substance abuse services are augmented with social

¹⁰ For more detail, see section “1.4 Background.”

counselling, which may include life skills training and mentoring. This combination of services is often referred to as “standard care¹¹” (SC).

SC for many years has given homeless people access to housing and health services; though access has been through a hard-to-navigate mix of federal, provincial, municipal, non-profit, religious, and philanthropic organizations—few of which have been coordinated. Those needing services have been left alone to navigate service-to-service.

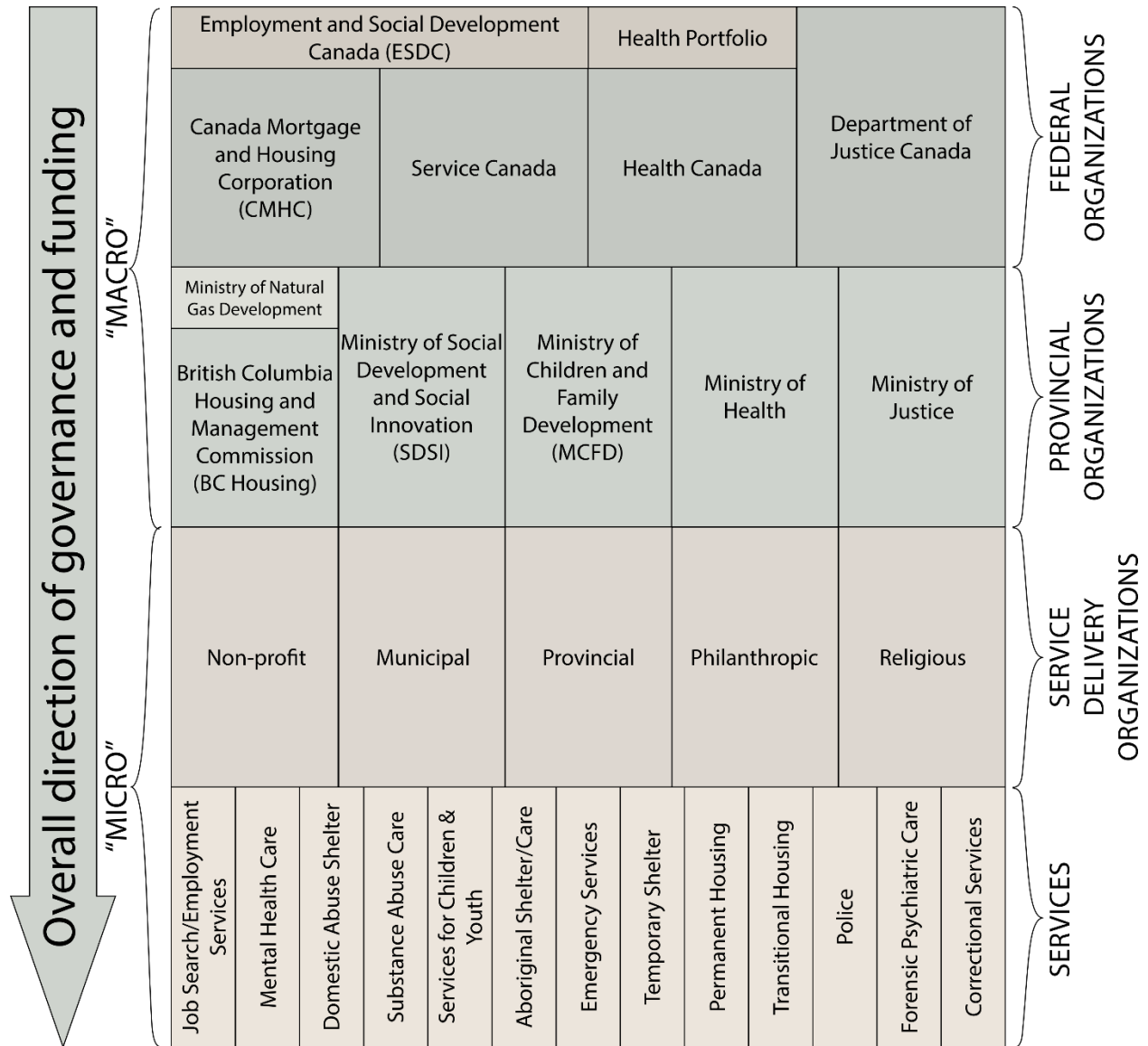


Figure 1 Organizations Serving Homeless Populations and Providing Services to Homeless People.

Figure 1 illustrates the layers of organizations and services involved in delivering homeless services in Canada. At the “macro” level, federal and provincial governments determine policy, set government funding, and regulate homeless service. At the “micro” level, various service delivery organizations

¹¹ Standard care refers to services currently available to homeless people through government and non-profit organizations. In other words, it is “as-is” or “treatment as usual”.

provide a spectrum of services within policy, regulatory, and funding constraints set out at the macro level. Other countries use similar jurisdictional layers and an array of services and service providers.

Many methods of coordination have been tried. For example, case management (CM) has been a common solution. Case managers assigned to individuals act as brokers who direct people to appropriate resources and assist in gaining access, for example, helping fill out paperwork.

More sophisticated and engaging methods are surfacing in the mainstream of homeless services. Assertive Community Treatment (ACT); Intensive Case Management (ICM); Comprehensive, Continuous, Integrated System of Care (CCISC); and Critical Time Intervention (CTI) are four such methods.¹² In practice, what these four methods, SC, and CM have in common is they typically focus on housing, health, and supportive services—historically associated with the needs of the homeless. Each service provides multidisciplinary support to a range of people: from those experiencing chronic homelessness to people in immediate crisis.

Among others, a difference between SC and emerging practices is an emphasis on employment. One of ACT's principles is "Emphasis on Vocational Expectations". "The [ACT] team encourages all clients to participate in community employment and provides many vocational rehabilitation services directly" (Ontario ACTT Association, 2015). Backing up ACT's employment focus, a study of literature from 1999 to 2003 by Kirsch and Cockburn (2007, p. 31) reports on ACT and vocational outcomes, concluding ACT generally has a positive employment affect when compared to SC. However, they also acknowledge that "firm conclusions about its efficacy" with regard to employment outcomes "cannot yet be reached" (Kirsh & Cockburn, 2007, p. 48)¹³.

Yet, there appear to be few programs integrating employment in an effective way. As far as SC programs are concerned, this may be due to an ingrained belief that homeless people cannot function in an employee-employer relationship and environment. It is certainly a widely-held belief, and perhaps a hard belief to dispel. Or, it could be a combination of factors. For example, it may be that "practitioners have historically focused on providing people with access to safe and affordable housing and supportive services, usually addressing employment later in the continuum"¹⁴ (Shaheen & Rio, 2007, p. 341).

In addition to increasing accessibility to housing and health services, employment is a key piece of the homelessness puzzle (Putnam et al., 2007, p. 2; Rio et al., 2008, p. 1; Serge et al., 2006, pp. 20-22; Shaheen & Rio, 2007, p. 343; U.S. Department of Health and Human Services, 2003b, p. 12). Recent research indicates homeless people are almost universally unemployed, though a large majority want to work¹⁵ (Poremski, Distasio, et al., 2015, p. 379). As a result, there is a strong argument for including vocational supports as one of the service pillars supporting the homeless—on the same level as health and housing services.

¹² These methods are described and discussed in more detail in the Literature Review portion of this research.

¹³ Kirsh and Cockburn reviewed 16 "studies, nine of which could be classified as experimental and seven were nonexperimental" (2007, p. 35).

¹⁴ In other words, getting them "ready" for employment, rather than trying to get them employment right away.

¹⁵ Counter to findings in the United States, this research also found that only one percent of the people involved in the study considered loss of social benefits as a disincentive to work (Poremski, Distasio, Hwang, & Latimer, 2015, p. 384).

1.2 PROJECT CLIENT

The Streetohome Foundation (“Streetohome”) is a non-profit organization whose mission is to solve homelessness in Vancouver, British Columbia.¹⁶ Streetohome brings new money (private sector), innovative ideas, and opportunities for collaboration to solve homelessness in Vancouver and prevent it from happening in the first place. The key to Streetohome’s success is their ability to leverage private funds raised from individual philanthropists, corporations, and foundations and broker evidence-based and sustainable solutions. Its board is comprised of recognizable individuals, with a passion for the issue, from the private sector, community organizations, and government (municipal, healthcare, and housing). Board members include an Honorary Chairman of Colliers International, the former CEO of Coast Capital Savings, the CEO of Vancouver Coastal Health,¹⁷ the City Manager for the City of Vancouver, the Executive Vice-President of Anthem Capital Corp., a former Premier of British Columbia, the CEO of Strand Properties Corporation, a partner at KPMG, and the CEO of BC Housing.¹⁸

Streetohome uses funds raised to leverage housing projects specifically geared toward the homeless population. For example, it might raise \$3 million to build a \$30 million housing project to include programming for building residents.

Service providers operating Streetohome funded projects provide mentoring, in-house supports, drug addiction counselling, mental health assistance, and life skills training that can be viewed as a two-pronged approach: housing and health. Many programs integrating these two supports are effective (P. Goering et al., 2014, p. 17; Nelson, Aubry, & Lafrance, 2007, p. 350; Rog et al., 2014, p. 287). Still as discussed earlier, employment has also proven effective when combined with housing (Marrone, 2005, p. 33; Shaheen & Rio, 2007, p. 356; Trutko, Barnow, Beck, & Rothstein, 1994, pp. ES-4-5).

Driven by evidence, Streetohome seeks to integrate employment with the services and programs it facilitates. As it has done with existing services, Streetohome also seeks to ensure such integration is done effectively. Effective employment integration is key to improving results for Streetohome clients.

Streetohome intends to use this research to add an effective employment component to programming in its facilities.

1.3 PROJECT OBJECTIVES

This research seeks to answer the question, “What are international best practices of bringing housing, healthcare and employment supports together in planning and practice to meet the needs of the formerly homeless, sheltered and at risk for homelessness” (Turnbull, 2014, p. 6)? It seeks to do this by integrating findings from a literature review and interviews with professionals who work with the homeless. Section two reviews literature dealing with best practices in delivering services to the homeless and evaluates best practices using the following four criterion:¹⁹

- There is a body of evidence supporting efficacy of the model,

¹⁶ Streetohome has an internet presence at <http://streetohome.org>.

¹⁷ Provincial government health authority.

¹⁸ Provincial government authority responsible for housing.

¹⁹ A detailed explanation of why these four criterion are used is presented on page 112 of the Appendix (section 9.5 – The Meaning of Best Practices and Integration).

- The method has been tested across a diverse population in many locations,
- It has been accepted as a best practice by practitioners and professionals in the field and by government bodies, and
- Tools are available to ensure the best practice is used correctly in diverse circumstances and populations.

Section three, the conceptual framework, explains how the concept of integration and best practices (plus lessons learned from the document review) fit together. Section five, Survey Results, presents and reviews coded survey responses. Section six, Discussion and Analysis, reviews the information gathered and provides commentary on best practices and integrating supports for homeless clientele. Section seven, Options to Consider and Recommendations, outlines recommendations related to integration of best practices. Section eight, the Conclusion, ends the research with thoughts on the current state of integrating homeless support best practices.

1.4 BACKGROUND

1.4.1 How did We get Here?

How did the system of servicing homeless clients become such an expensive and tangled network, apparently unable to deliver on its primary goal? It evolved.

First, homelessness as we know it did not exist until relatively recently. Throughout the 1900s and into the 1980s, the term *homelessness* was not used frequently. “A search of the New York Times historical database covering 1851 to 2005 reveals that the word homelessness was used in 4,755 articles, but 87% of this usage (4,148 articles) was in the 20 years between 1985 and 2005. Before the 1980s, it is rare to find homelessness used to designate a social problem” (Hulchanski et al., 2009, p. 1).

In 1960, for example, in a report titled Homeless and Transient Men, a committee of the Social Planning Council of Metro Toronto defined a “homeless man” as one with few or no ties to a family group, who was thus without the economic or social support a family home normally provides. The committee made a clear distinction between house and home. The men were *homeless*, not unsheltered. (Hulchanski et al., 2009, p. 2)

Thus, prior to the 1980s federal; provincial and state; and municipal systems were setup to deal with different problems. Not until the 1980s when homelessness became associated with being *homeless* (Hulchanski et al., 2009, p. 6), did service providers begin adapting to the new *homeless* reality. Not until the late 1990s did homelessness even appear as an issue in Canada’s federal political arena. In fact, only in 1997 was there a debate on homelessness in the House of Commons and it was 1999 before the federal government committed to addressing homelessness (Hughes, 2012, p. 4).

Second, the social care system of the 1950s, ‘60s, and ‘70s was not structured to handle the new homelessness problem. The fragmented system for supporting the homeless is rooted in separate service silos (Hambrick & Rog, 2000, p. 354; ICF International, 2009, p. 1; U.S. Department of Health and Human Services, 2003a, p. 16). Through the 1980s and into the 1990s efforts focused on managing the problem rather than ending homelessness. Provincial and federal money flowed into existing service silos with little improvement to show for it. This is why emergency shelter and health services—both expensive to deliver—are still primary modes of homeless shelter and healthcare. Separate silos result

in fragmented systems and overuse of expensive services (Gaetz et al., 2013, p. 8; Talen & Valeras, 2013, pp. 139, 161-162; U.S. Department of Health and Human Services, 2003a, p. 46).

Third, federal support for social and affordable housing fell off just as homelessness surfaced in the 1980s and '90s (Gaetz et al., 2013, pp. 15-16; Hulchanski et al., 2009, p. 5). This withdrawal of support for social and affordable housing came against a backdrop of deinstitutionalization that began in the 1950s and culminated in the 1980s (Buckner, 2014, p. 4; Montgomery, Metraux, & Culhane, 2013, pp. 59-60; U.S. Department of Health and Human Services, 2003a, p. 4). Deinstitutionalization saw clients formerly housed and supported in specialized institutions discharged with the goal of transitioning care to community-based facilities and programs. In the United States, the number of people treated in state and county psychiatric hospitals shrank from 559,000 in 1955 to 47,000 in 2003 (Montgomery, Metraux, et al., 2013, p. 59). A similar transition took place in Canada.

Finally, there has been a fundamental restructuring of western economies beginning in the 1980s and continuing today. The changes have led to stagnant and even falling earnings for middle-class and low income workers, while food, clothing, and housing costs have increased dramatically. Changes also led to elimination of many middle class and low income jobs, some of which shifted to low labour cost locations. Not surprisingly, those at the margins were hit the hardest.

Summarizing issues leading to the current homelessness situation, Trutko et al. explain:

A number of factors appear to be contributing to changes in the size and characteristics of the homeless population in the United States, including: economic restructuring, which has led to job loss and changing skill requirements; a lack of affordable housing; more restrictive eligibility requirements for welfare and disability benefits; the deinstitutionalization and lack of mental health care services for mentally ill persons; and the recent prolonged economic recession. (1994, pp. 1-2)

1.4.2 Chasing Service Integration

Seeking horizontal integration has been likened to a search for the Holy Grail (Peters, 1998, p. 295). Given its importance, there have been significant efforts to tackle the problem of uncoordinated service silos. Since the 1960s, people and organizations serving homeless populations have thought system integration would produce better results for clients (Greenberg & Rosenheck, 2010, pp. 184-185). In the 1970s, organizations began service integration as a way to prevent people from bouncing amongst service providers (Burt, The Urban Institute, Pearson, Montgomery, & Walter R. McDonald & Associates, 2005; Goscha, Rapp, Bond, & Drake, 2012, p. 294; Neale, Buultjens, & Evans, 2012, p. 246; U.S. Department of Health and Human Services, 2003a, p. 4).

Especially within the last decade, government, not-for-profit organizations, and private enterprises have tried to horizontally integrate²⁰ services for the homeless and formerly homeless. Writing in 2003 regarding service integration, Health Canada states, "Canada is just at the beginning stages of developing and trying out various strategies to better integrate services at the system level" (2002, p. xii). Writing more recently about Canadian service integration, Gaetz et al. point to New Brunswick, Ontario, and Quebec governments moving "towards strategic and integrated responses to homelessness" (2013, p. 9), adding that "Alberta leads the way." In 2008, Alberta released a plan to end

²⁰ Health (including mental health) services, housing services, and employment services.

homelessness in 10 years (Government of Alberta, p. cover). True to Gaetz et al.'s statement, Alberta's plan refers to "service integration" numerous times (Government of Alberta, 2008, pp. 7, 13, 16, 18, 26, 34).

In the United States, although homelessness surfaced earlier federally than in Canada, service integration evolved similarly. At the service delivery level, communities grappled with the new homelessness problem in the 1980s by providing services they could muster with the resources they had—not structured or geared to the diversity of homeless clients and their complex issues. Services for homeless people became a "cluttered landscape of organizations and programs" stretched thin with service gaps, little coordination, and no leadership (Hambrick & Rog, 2000, pp. 354-355). Over time, numerous approaches were tried: CM, housing locators or coordinators, service provider teams, service provider networks, housing authority-service agent agreements, coordinated intake, multiservice centres, electronic networks, coalitions, homeless coordinators, and coordinating councils (Hambrick & Rog, 2000, pp. 356-359).

Federally, the 1987 Stewart B. McKinney Homeless Assistance Act predates the Canadian response by more than a decade and included a coordination component from the outset—though from a planning perspective (Hambrick & Rog, 2000, p. 360). By 1994, coordination was more deeply entrenched and even more emphasis was placed on coordination, resulting in the "Continuum of Care" concept.

The ideal in the Continuum of Care model guiding HUD funding for homeless programs is a systemwide [sic] planning process in each city resulting in a seamless system of services that enables individuals and families to receive the appropriate set of services depending upon their needs. The goal is to stimulate united planning efforts that eliminate turf battles and establish community priorities. The hope is to bring some rationality to what often has been perceived as a chaotic "nonsystem [sic]." (Hambrick & Rog, 2000, p. 361)

Internationally, the Australian government has placed an emphasis on integrated service delivery (Neale et al., 2012, p. 244; Shergold, 2013, p. 11). The Finnish government, too, has adopted an integrated approach to homelessness, though other European Union countries have programs and organizations "relatively uncoordinated," "without a shared strategy," and "with different services having different views on what homelessness is and how it should be stopped" (Pleace, 2013, p. 8).

As discussed in following sections, many European countries have experimented with and implemented integrated supports as set out in best practices such as HF.

2.0 A LITERATURE REVIEW OF BEST PRACTICES

2.1 AN OVERVIEW OF INTEGRATION

The Canadian Council on Health Services Accreditation defines health service integration as “services, providers, and organizations from across the continuum working together so that services are complementary, coordinated, in a seamless unified system, with continuity for the client” (as quoted in Suter et. al. (2007) 2006).²¹

This research seeks to gain insights on integration of housing, health, and employment supports, as illustrated by Figure 2. The question is how to integrate these three complimentary services into a “coordinated, seamless unified system, with continuity for the client”.

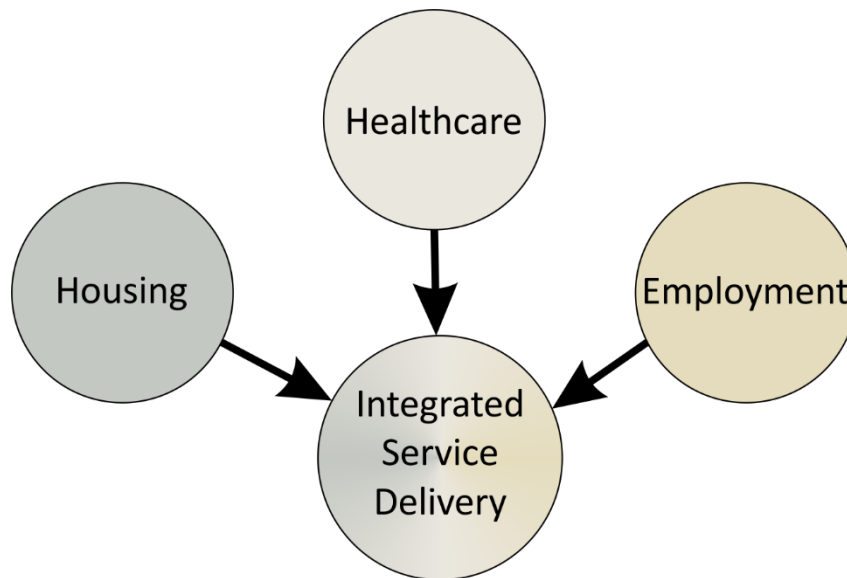


Figure 2 Integration of housing, health, and employment supports

Integration itself can be viewed on a spectrum. See Figure 3 below. At one end is complete separation of services—fully fragmented. Opposite is full integration, with cooperation, coordination, and collaboration between (Keast et al., 2007, p. 12). Complete integration implies a unified organization

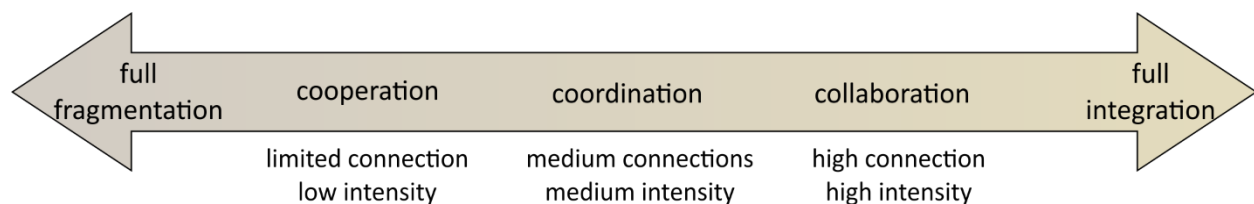


Figure 3 Horizontal Integration Continuum (adapted from Keast, Brown, & Mandell, 2007, p. 12)

with systems and resources to deliver practically any combination of services required. It also implies integration of internal systems geared toward service delivery. As mentioned earlier, horizontal

²¹ Although this definition works quite well, after reviewing articles for their research Suter et al. found 70 definitions and assert the term *integration* remains an ill-defined concept (2007, p. 17).

integration is considered the Holy Grail, and that being the case, it would appear an ideal arrangement. Anything in between would be compromise, perhaps stemming from pre-existing silos or competing goals or legislated mandates—something to be corrected. The fact we find our systems somewhere in the middle strongly suggests change is required. That is, it suggests we should focus on “developing new service delivery structures, creating new services, and eliminating conflicting program requirements” (Hambrick & Rog, 2000, p. 362).

So, should full integration be a primary focus? Keast et al. maintain that cooperation, coordination, and collaboration have “merit and utility” (2007, p. 26), and comment further that all three levels of integration “should be considered as complimentary approaches that can be engineered according to best purpose” (p. 28). If full collaboration is to take precedence (let alone full integration), they acknowledge “tangible outcomes (such as new projects and activities will have to take a back seat to intangible outcomes (relationship building, establishing trust, listening to each other)” (p. 26). Given that services to the homeless cannot stop while system changes are defined, planned, and implemented, it makes sense to arrive at a satisfactory level of cooperation, coordination, or collaboration instead. There is “merit and utility” in middle-ground.

As well, “[i]t is important to remember that **service integration, in and of itself, is not enough.**²² Coordination efforts must achieve the goal of actually helping participants” (Rio et al., 2008, p. 42).

High levels of provider integration do not necessarily result in high levels of user integration or vice versa. User integration requires that clients experience a seamless system of care and that may not occur even with high levels of provider integration. (Flatau et al., 2013, p. 17)

Hambrick and Rog point to research and government assessment indicating “point-of-service” is the most effective place to integrate services, as opposed to systems integration (2000, p. 363). This conclusion is echoed in subsequent research (R. A. Rosenheck et al., 2002, p. 966). Intuitively, this makes sense. It should matter little to clients whether systems are integrated behind the scenes—provided the services they receive are what they need when they need them.

This doesn’t mean integration at a system level is not important at all. Of course, it is. Intuitively it makes sense that integrated systems deliver services and products more efficiently than uncoordinated ones. Whether system level integration can be accomplished has been researched by Greenberg and Rosenheck, who found that “well-funded and organized initiatives can be associated with improved interorganizational [sic] functioning, specifically with regard to coordination and integration” (2010, pp. 194-195).²³ Reporting on their statistical analysis of health plans²⁴ in the United States, Gillies, Chenok, Shortell, Pawlson, and Wimbush write that comparative results suggest the type “of delivery system used by health plans is related to many clinical performance measures” and that “health plans that rely more on organized physician groups or internal (staff) physician groups perform at a higher level on many clinical measures than plans without this form of delivery system” (2006, p. 1181).

²² Rio et al. emphasis.

²³ Their research did not address client outcomes as they relate to systems integration.

²⁴ The study did not focus on service to homeless people; rather, it focused on general care as provided by various health plans and providers.

Moreover, systems integration at the policy level can be a core issue for organizations providing service on the ground. For example, different government and private entities can have conflicting funding guidelines or requirements. Accepting funding from one entity may mean having to forego funding from another. Policies related to welfare eligibility are another common example. The fact that even relatively small amounts of income can disqualify someone from eligibility is thought to deter people from entering employment programs.

Interestingly, the same Gillies, Chenok, Shortell, Pawlson, and Wimbush study also concluded the type of delivery system (i.e. organized versus less organized) “is not related to patient perceptions of care” (2006, p. 1181). This aligns with the view that operational integration should be an immediate focus of integration efforts. Patient perceptions of care are important whether the treatment addresses physical or psychological issues and may have an impact on outcomes.²⁵

It should be added here that the efficacy of systems integration versus operational integration is far from settled. Some research has found integrated systems do, indeed, result in better client outcomes. For example, an earlier study by R. Rosenheck et al. found a “significant relationship between service system integration and client outcomes” (R. Rosenheck et al., 1998, p. 1614).

2.1.1 Systems versus Operational Integration

Systems integration refers to “jurisdiction-level interventions typically undertaken by government, which bring together services from different support systems under purpose-built, centrally-funded and managed, coordinated programs of support and integration at the service level”. (Flatau et al., 2013, p. 15). In Figure 1, systems integration can be considered to occur “behind the scenes” and above the *Services* level.

Operational integration refers to “coordinated delivery of individual services within and/or across different sectors, irrespective of whether or not the coordination that occurs is part of a purpose-built, system-wide integrated service delivery program or reflects the actions of individual services working together at the local level” (p. 15). Operational integration can be viewed as happening at the *Services* level of Figure 1.

2.1.2 International Best Practices

One of the goals of this research is to uncover what best practices may be in use or under development internationally. However, there appears to be little evidence in the literature of new best practices in countries outside North America—at least ones being researched and analyzed by English-speaking practitioners. Arguably, the preponderance of best practices related to solving homelessness in western, industrialized countries appears to originate in the United States.

In fact, it appears North American practices are studied and put to use internationally. For example, Turner states “[i]ncreasingly, the notion of ‘Housing First’ has been promulgated internationally as the turnkey solution to homelessness” (Turner, 2014, p. 1). Writing in 2007, Toro found outside the United States “systematic research evaluating the impact of interventions assisting the homeless [...] is virtually nonexistent” (p. 468). Since Toro’s research, there have been a number of HF-related studies completed

²⁵ The relationship between patient perceptions of care and outcomes is beyond the scope of this research. However, it follows that a patient’s perception of care is related to the quality of care received: High quality care should be perceived as such and patients generally expect high quality care to result in better outcomes.

in European and other countries (Busch-Geertsema, 2013; Greenwood, Stefancic, Tsemberis, & Busch-Geertsema, 2013).

The Foyer Model (TFM)—targeting homeless youth—is a prominent exception.

[TFM] is a well-established model of transitional housing for youth that has been growing in popularity around the world over the past two decades, and can most certainly be adapted to the Canadian context. The real possibilities for community adaptation emerge when one considers how the model may be modified based on advancements in our thinking about housing and support developed in Canada and elsewhere [...]. (Gaetz & Scott, 2012, p. 17)

While youth homelessness is outside the scope of this research,²⁶ it should be noted limited research conducted by the author indicates TFM qualifies as a best practice.

- There is a body of evidence supporting the efficacy of TFM. In its *Foyer Toolkit #1: What is a Foyer*,²⁷ the Canadian Observatory on Homelessness lists 13 research papers and reports offering evaluations of TFM (2012b, p. 6).
- TFM has been tested across a diverse population in many locations. Gaetz and Scott outline how TFM has been implemented and evaluated in the U.K.²⁸, the United States²⁹, and Australia.
- TFM has been accepted as a best practice by practitioners and professionals in the field and by government bodies. In the U.K., Foyers are operated throughout the country and work in conjunction with local housing authorities, who refer young clients to Foyer housing (The Foyer Foundation, 2016).
- Tools are available to ensure TFM is used correctly in diverse circumstances and populations. The Canadian Observatory on Homelessness offers a toolkit for organizations wishing to implement TFM (2012b) and The Foyer Federation offers program accreditation (2016).

2.2 HOUSING SUPPORTS

2.2.1 Continuum of Care

The United States Department of Housing and Urban Development (HUD) has used the term Continuum of Care (CoC) since 1994 to refer to the full range of services available through a particular community or region, including emergency shelter, supportive housing, and permanent affordable housing with supports (Burt et al., 2005, p. 3). Some define the CoC model as providing housing with built-in support services where the service provider is landlord, and clients are often mandated to maintain sobriety and attend psychiatric counselling (Collins et al., 2012, p. 1679; Polvere et al., 2014b, p. 22). Still others refer to CoC as a “stepped system” where clients are expected to progress behaviourally until they are “fit” for housing (Busch-Geertsema, 2013, pp. 15, 62; Health Canada, 2002, pp. 26-27). Many define CoC simply as “treatment first” or “traditional” care.

²⁶ Streethome has engaged other researchers on the topic of youth homelessness.

²⁷ A Foyer is a building or complex operated similarly to a youth hostel, but with support services targeted to low-income and/or homeless youth.

²⁸ 130 sites (Quilgars, Johnsen, & Pleace, 2008 as quoted in Gaetz & Scott, 2012, p. 19).

²⁹ New York, NY, Philadelphia, PA, and another American city (Gaetz & Scott, 2012, p. 22).

HUD, itself, refers to CoC as an entity developing “a **long-term strategic plan and manage a year-round planning effort** that addresses the identified needs of homeless individuals and households; the availability and accessibility of existing housing and services; and the opportunities for linkages with mainstream housing and services resources” (HUD, 2009, p. 3). HUD also refers to city, county, regional, rural, balance of state, and statewide CoCs and outlines fundamental components: prevention, outreach and assessment, transitional housing, permanent supportive housing, permanent affordable housing, and supportive services (HUD, 2009, pp. 7-11). Wong, Park, and Nemon say CoC is broadly structured to deliver three programs: emergency shelter, transitional housing, and permanent supportive housing (2006, pp. 68-69).

HUD also references HF as a method for dealing with homelessness (HUD, 2009, p. 75). HF is a relatively new approach and not reflective of a “stepped” or traditional treatment environment.

Thus, from the HUD standpoint, CoC means all services and programs available to homeless people in a particular location at a given time. Over time, researchers have come to associate the term CoC with SC, rather than the current supply and state of services—its real meaning.

However, because HF and other progressive approaches are still not “the mainstream” of homeless service, it is still useful—especially for comparative purposes—to equate CoC with SC. As a result, throughout this research the terms CoC and SC are considered the same.

Clearly, CoC is not best practice.³⁰ It is the current state researchers, homeless workers, and homeless-serving organizations wish to improve upon. It is the system that has led to billions of dollars of expense with little if any reduction in homelessness and an inability to even determine what impact services are making (Hughes, 2012, p. 6). As discussed earlier, the current state of affairs leaves much to be desired.

2.2.2 Supported and Supportive Housing

Hopper and Barrow identify two “developmental traditions” or “genealogies” regarding supported housing (SH): “housing as housing” and “integrated housing development” (2003, p. 50). If distilled to a single concept, perhaps housing as housing can be said to allow clients the ability to blend into existing communities while being provided support in addressing their particular issues and circumstances, a client-oriented approach. Integrated housing development might be summarized as an approach that builds communities geared to support clients and their particular issues and circumstances, a more housing-oriented approach.³¹

³⁰ This will change over time. As more progressive and effective solutions are used by mainstream providers, CoC or SC will improve. At some point, these current new solutions may *be* the mainstream or CoC.

³¹ This does not mean integrated housing development is less client-focussed. Rather, it simply reflects the fact that integrated housing development develops purpose-built facilities and communities instead of relying on existing housing stock and options.

Table 1 (Hopper & Barrow, 2003, p. 51)
Comparison of two approaches to supported housing

Housing as Housing	Integrated Housing Development
Provides normalized housing, achieved by occupancy of conventional units	Increases the supply of affordable housing by adding new units and returning decrepit and unused units to working stock
Leverages tenants' access to scatter-site apartments in existing stock	Uses multi-unit buildings housing diverse constituencies, including "special needs"
Maximizes options, enhances consumer choice in residence and service use	"Builds community" both within a housing site and more broadly
Promotes individual unit affordability by improving purchasing power of tenants through rental assistance and warranties	Develops project-level funding for housing through cross-subsidy of units, multiple funding streams, and mixed use
Separates housing from mental health service provision	Makes services available on site to compensate for deficiencies outside

McHugo et al. examine SH but do not use the label, calling the term "imprecise." Instead, McHugo et al. create their own SH terms. They note that many programs use similar philosophical and technical underpinnings to the SH model, but are more "hybrid" programs combining SH with other methods as circumstances demand (McHugo et al., 2004, p. 970).

Writing in 2008, Chandler calls integrated housing development "Supportive Housing" (SvH) (p. 1). If SvH is integrated housing development, then housing as housing would be SH. Sensibly it would seem, SH and SvH are members of the same family, the slight difference in terms indicating which developmental tradition each belongs to. However, Chandler goes on to say that the term SvH is often used to encompass a wide range of housing options, including transitional housing, congregate housing with meals provided, and apartment buildings where all residents have a mental illness—a much broader range than integrated housing development (2008, p. 3).

Polvere et al. characterize SvH as CoC and say it provides "housing only in places with built-in clinical support services. This means that the landlord and service-provider functions are integrated in the same agency" (2014b, p. 22). Access to SvH may also be tied to behavioural prescriptions, such as abstinence from alcohol and drugs, mandatory rehabilitation, or attendance at a certain number of orientation sessions (Polvere et al., 2014b, p. 22).

It seems both terms—SH and SvH—have lost their original meanings and are now used to describe a broad range of integrated services. As a result, both methods have become more of a description than a solution. Perhaps a descendant or branch of either model provides a solution one can call a best practice.

2.2.3 Permanent Supportive Housing

One might expect SH and permanent supportive housing (PSH) would be similar. They are. Table 2 below compares key elements of SH and PSH and illustrates how closely related they are.

Table 2 Comparison of Supported Housing and Permanent Supported Housing	
Supported Housing (Chandler, 2008, p. 2) ³²	Permanent Supported Housing (Rog et al., 2014, p. 289)
Clients keep housing as long as they pay rent and don't violate lease terms; clients control their unit, pay rent, and hold the lease ³³	Tenants have full rights of tenancy, including a <i>market</i> ³⁴ lease in their name
Clients can accept or refuse treatment and support services without losing housing	Housing is not contingent on service participation
Clients have opportunities and assistance in exploring housing options/preferences, including choice of who to live with, and furnishings	Tenants are asked about housing preferences and provided the same choices available to others without a mental disorder
Clients receive assistance in obtaining and maintaining eligibility for subsidies that help cover rent costs if needed	Housing is affordable, tenants paying no more than 30% of income toward rent and utilities
Housing is (usually) in buildings including a mix of people with and without mental illness	Tenants live in scattered-site units located throughout the community or in buildings not reserved for individuals with mental disorders
Clients keep housing as long as they pay rent and don't violate lease terms; clients control their unit, pay rent, and hold the lease	House rules are similar to those found in housing for people without mental disorders
Housing and support services are provided by separate entities	Housing is not time limited, so the option to renew leases is with the tenants and owners
Services are flexible and may change over time	Tenants can choose from a range of services based on their needs and preferences, adjusted if needs change

³² Adapted from Chandler's study.

³³ This element is repeated below in Table 2 because it loosely addresses two key elements presented by Rog et al.

³⁴ This means the lease contains terms normally found in a tenancy agreement and does not contain terms related to the tenant's mental health or maintaining or abstaining from a certain behaviour or behaviours.

The only obvious difference between the two lists is PSH specifies “housing is not time-limited.” There is no such explicit SH parameter, though it is implicit in the statement: “clients keep housing as long as they pay rent and don’t violate lease terms.”

Similar to how SH and SvH have come to mean a spectrum of service models, Rog et al. in their review of PSH literature and studies use the term PSH to encompass a number of service delivery methods (2014, pp. 290-291). However, rather than deem the term PSH “imprecise” as is the case with SH and SvH, they conclude “the moderate level of evidence indicates that permanent supportive housing is promising” and “[p]olicy makers should consider including permanent supportive housing as a covered service for individuals with mental and substance abuse disorders” (Rog et al., 2014, p. 287). Rog et al. also say “research is needed to clarify the model and determine the most effective elements for various subpopulations” (2014, p. 287).

Policy makers *have* considered and accepted PSH as a tool for addressing homelessness. SAMHSA offers *Building Your Program: Permanent Supportive Housing* as part of its Evidence-based Practices Kit (2010a). PSH perhaps is a method one can consider a best practice—there being supporting research (evidence) and acceptance by professionals providing homeless services.

Because the method has been tried and tested, PSH offers more than a set of service delivery principles. To assist use of the model in varied circumstances a fidelity scale has been developed and is freely available (SAMHSA, 2010b, pp. 15-21).

In short, it meets the three of the four characteristics of a best practice outlined earlier in this research.

- There is a body of evidence supporting efficacy of the model.
- It has been accepted as a best practice by practitioners and professionals in the field and by government bodies.
- Tools are available to ensure PSH is used correctly in diverse circumstances and populations.

2.2.4 Housing First

Seeing as HF is a subset or descendent of PSH, one would expect HF to be similar to PSH. It is. Table 3 below compares the two methods and illustrates this fact.

Table 3 Comparison of Housing First and Permanent Supported Housing	
Housing First , adapted from (Polvere et al., 2014b, pp. 14-17) ³⁵	Permanent Supported Housing (Rog et al., 2014, p. 289)
<i>Standard tenant agreement</i> ³⁶	Tenants have full rights of tenancy, including a <i>market</i> ³⁷ lease in their name
Immediate access to permanent housing with no housing readiness requirements	Housing is not contingent on service participation

³⁵ Italicized elements are taken from text in the Polvere et al. toolkit (pp. 14-17), whereas elements in regular text Polvere et al. list as core elements of HF.

³⁶ Repeated below in the table, as the general meaning applies to more than one corresponding element of PSH.

³⁷ This means the lease contains terms normally found in a tenancy agreement and does not contain terms related to the tenant’s mental health or behaviours.

Table 3

Comparison of Housing First and Permanent Supported Housing

Housing First , adapted from (Polvere et al., 2014b, pp. 14-17) ³⁵	Permanent Supported Housing (Rog et al., 2014, p. 289)
Consumer choice and self-determination	Tenants are asked about housing preferences and provided the same choices available to others without a mental disorder
<i>Clients should not pay more than 30% of their income towards rent</i>	Housing is affordable, tenants paying no more than 30% of income toward rent and utilities
Social & community integration	Tenants live in scattered-site units located throughout the community or in buildings not reserved for individuals with mental disorders
<i>Standard tenant agreement</i>	House rules are similar to those found in housing for people without mental disorders
<i>Commitment to rehouse</i>	Housing is not time limited, so the option to renew leases is with the tenants and owners
Individualized, recovery-oriented, & client-driven supports	Tenants can choose from a range of services based on their needs and preferences, adjusted if needs change
Harm reduction	

In Table 3, the only difference between the two methods is HF explicitly includes harm reduction as one of its core principles. It should be noted, however, in practice PSH embraces harm reduction too.

As discussed earlier in this research, HF is currently widely considered a best practice, though it has not yet become mainstream. It has been used in multiple locations across the United States and Canada, plus Denmark, France, Hungary, Ireland, The Netherlands, Portugal, and Scotland (Polvere et al., 2014a), generally with solid results. The United States Interagency Council on Homelessness (USICH) lists HF as one of its Evidence Based Practice (EBP) solutions (2013). The Canadian Federal government requires HF as part of its HPS (Gaetz et al., 2014, p. 10). The provincial government of Alberta is using HF as an integral part of its 10 year plan to end homelessness (Government of Alberta, 2008, pp. 16-17).

We can safely conclude that HF has been shown to be effective in housing and maintaining housing for single adults with mental illness and substance use issues in urban locations where there is ample rental housing stock. There is no “best practices” evidence in the form of randomly assigned, longitudinal studies on families, youth, those with primary addictions, those coming from a period of incarceration, and those with diverse ethnic and indigenous backgrounds. (Waegemakers Schiff & Rook, 2012, pp. 17-18)

On the other hand, a 2013 longitudinal study, the At Home/Chez Soi Program, included more than 2,000 people randomly assigned to HF or SC³⁸ services. The two-year study included men (67%), women (32%), Aboriginals (22%), other ethnic groups (25%), people under 34 years of age³⁹ (33%), and people involved with the justice system⁴⁰ (36%) (P. Goering et al., 2014, pp. 14, 47). The inclusion of these groups addresses the “diverse ethnic and indigenous backgrounds,” and “those coming from the period of incarceration” Waegemakers Schiff and Rook refer to.

Given the high degree of variability across these different communities, this attests to [...] the adaptability of the model to all these different contexts, which included linguistic differences between and within sites, a significant proportion of Aboriginal participants in one site, and a high proportion of participants from diverse ethnoracial [sic] backgrounds in another. (Macnaughton et al., 2015, p. 289)

Perhaps it is also meaningful that the characteristics of those not responding as well to HF (13%) do not correspond with ethnicity, sex, age, or involvement with the justice system. Rather, “this group tended to have longer histories of homelessness, lower educational levels, more connection to street-based social networks, more serious mental health conditions, and some indication of greater cognitive impairment” (P. Goering et al., 2014, p. 7). Outside a very vulnerable homeless population, it appears HF serves diverse clients quite well. The final report does acknowledge a need to better understand using HF in the context of families, women, seniors, youth, or those experiencing short-term homelessness (P. Goering et al., 2014, p. 32).

Though its name “housing first” rightly connotes the importance of housing, HF is not housing only. It is itself an integrated approach to homelessness. Developed in the 1990s by Dr. Sam Tsemberis and based on the 1980s SH work of Dr. Paul Carling, HF combines SH and ACT⁴¹ (Polvere et al., 2014b, p. 12).

For the At Home/Chez Soi study, HF was combined with both ACT and ICM. Clients deemed to have high needs (HN) were assigned to ACT⁴² support, while clients with moderate needs (MN) were assigned to ICM support. Both supports produced similarly positive outcomes with regard to housing, quality of life, functioning, mental health, and substance use (P. Goering et al., 2014, p. 8). Using these two levels of support to achieve positive outcomes points to the flexibility possible with HF.

Similar to PSH, HF offers a clear method for determining whether a program is following HF principles, thereby achieving a standard level of effectiveness associated with the model. A fidelity scale has been developed (Stefancic, Tsemberis, Messeri, Drake, & Goering, 2013, pp. 246-250), along with a self-assessed survey (Gilmer, Stefancic, Sklar, & Tsemberis, 2013a, p. 911; 2013b) for service providers to use when assessing how closely their program follows the HF model.

³⁸ Denoted in the final At Home/Chez Soi report as “TAU,” standing for *Treatment as Usual*.

³⁹ Partially addressing the issue of youth, assuming there is a significant percentage of people in the cohort aged 18-25 years.

⁴⁰ Defined in the study as “arrested > once, incarcerated or served probation in prior 6 months” (P. Goering et al., 2014, p. 47).

⁴¹ ACT is discussed in more detail elsewhere in this research.

⁴² ACT has a lower client to support ratio (approximately 10 or 12 to 1) than ICM (approximately 20 to 1, though adjusted to 16 to 1 for the At Home/Chez Soi program).

From the perspective of determining whether HF is a best practice, it has the four key characteristics that help identify it such.

- There is a body of evidence supporting efficacy of the model (P. Goering et al., 2014, p. 33; Montgomery, Hill, Kane, & Culhane, 2013, p. 505; Padgett, Gulcur, & Tsemberis, 2006, pp. 74, 81; Waagemakers Schiff & Rook, 2012, pp. 17-18).
- The method has been tested across a diverse population in many locations (Macnaughton et al., 2015, p. 289; Polvere et al., 2014b, p. 25).
- It has been accepted as a best practice by professionals in the field and by government bodies (Government of Alberta, 2008, pp. 16-17; USICH, 2013).
- Tools are available to ensure HF is used correctly in diverse circumstances and populations (Gilmer et al., 2013a, p. 911; 2013b; Stefancic et al., 2013, pp. 246-250).

It should be added here that recent research has added perspective to the efficacy of HF related to addictions and generic quality of life measures. Through an analysis of 575 At Home/Chez Soi participants in Toronto, Canada, over a 24 month period, researchers found HF increased the probability of people remaining housed and contributed to reducing alcohol dependence, but did not impact illicit drug use, suggesting such clients may require “additional supports to reduce use” (Kirsta, Zergera, Misira, Hwang, & Stergiopoulos, 2015, p. 24). This information is particularly relevant to Streethome, as Vancouver’s population of homeless people has a high percentage of illicit drug users.⁴³ It suggests Streethome will need to either intensify mental health and addictions supports or adopt a more effective treatment.

An examination of the At Home/Chez Soi study related to quality of life states the program “did not result in significant improvements in generic quality of life,” though additional analysis suggested “significant gains in condition-specific quality of life” (Stergiopoulos, Hwang, et al., 2015, p. 911).

2.3 HEALTH SUPPORTS

In this research, health supports refer to supports for physical and mental health, plus substance use issues.

2.3.1 Assertive Community Treatment

Although ACT is now often associated with HF, it was first developed in the 1960s as a solution for people with multiple co-occurring disorders (SAMHSA, 2013a, p. 143). ACT principles are as follow (NAMI, 2007, p. 2).

- Services are targeted to a specific group of individuals with severe mental illness
- Team members directly provide individualized, flexible, and comprehensive treatment, support and rehabilitation services, including:
 - Mobile crisis interventions
 - Illness management and recovery skills
 - Individual supportive therapy
 - Substance abuse treatment

⁴³ The At Home/Chez Soi final report for Vancouver recorded 71% of participants as having substance abuse issues (Currie, Moniruzzaman, Patterson, & Somers, 2014, p. 16).

- Skills teaching and assistance with daily living activities
- Assistance with natural support networks
- Supported housing and supports in accessing benefits, transportation, medical care, etc.
- Medication prescribing, administration and monitoring
- Peer supports
- Team members share responsibility for consumers served by the team
- Small staff to consumer ratio (approximately 1 to 10)
- Majority of contacts are in community settings
- No arbitrary time limits on receiving services⁴⁴
- Services are available on a 24/7 basis

ACT shares all four best practice characteristics with HF.

- There is a body of evidence supporting efficacy of the model (Coldwell & Bender, 2007, p. 393; Cooper et al., 2010, p. 166; de Vet et al., 2013, p. e24; Goscha et al., 2012, p. 304; Kirsh & Cockburn, 2007, p. 31; Nelson et al., 2007, p. 350; Neumiller et al., 2009, p. 260).
- The method has been tested across a diverse population in many locations (Dates et al., 2009).
- It has been accepted as a best practice by professionals in the field and by government bodies (Goscha et al., 2012, pp. 295-296; SAMHSA, 2008b, p. 3).
- Tools are available to ensure ACT is used correctly in diverse circumstances and populations (SAMHSA, 2008a, pp. 27-54; Teague, Bond, & Drake, 1998, p. 218).

In short, ACT is widely accepted as a best practice by people working with homeless clients and people with co-occurring mental disorders and substance use issues.

2.3.2 Critical Time Intervention

As the name Critical Time Intervention (CTI) suggests, support focuses on critical times in a person’s mental health and substance issue recovery. CTI is “a new service approach explicitly designed to improve continuity of care during the ‘critical time’ of transition from shelter to community” (Herman & Mandiberg, 2010, p. 503). Like ACT, CTI has been used in combination with housing services to treat and rehabilitate homeless clients. CTI breaks a person’s transition from shelter to housing into three phases, as illustrated in Table 4. The table clearly shows a transition from dependency to independence.

Table 4 (Herman, Conover, Felix, Nakagawa, & Mills, 2007, p. 298)
Phased activities of critical time intervention

Phase	Transition	Try-Out	Transfer of Care
Timing	Months 1 – 3	Months 4 – 6	Months 7 – 9
Purpose	Provide specialized support & implement transition plan	Facilitate and test client’s problem-solving skills	Terminate CTI services with support network safely in place

⁴⁴ Although this principle is, in fact, still one of the criterion against which fidelity to the ACT model is measured, recent research and practice has moved away from this. Instead, more emphasis is placed on transition away from treatment for select clients for whom full independence is a realistic outcome (Finnerty et al., 2014, p. 92).

Table 4 (Herman, Conover, Felix, Nakagawa, & Mills, 2007, p. 298)
 Phased activities of critical time intervention

Phase	Transition	Try-Out	Transfer of Care
Activities	CTI worker makes home visits	CTI worker observes operation of support network	CTI worker reaffirms roles of support network members
	Accompanies clients to community providers	Helps to modify network as necessary	Develops and begins to set in motion plan for long-term goals (e.g. employment, education, family reunification)
	Meets with caregivers		Holds party/meetings to symbolize transfer of care
	Substitutes for caregivers when necessary		
	Gives support and advice to client and caregivers		
	Mediates conflicts between client and caregivers		

CTI core components are as follow (Silberman School of Social Work, n.d.):

- Addresses a period of transition
- Time-limited
- Phased approach
- Focused
- Decreasing intensity over time
- Community-based
- No early discharge
- Small caseloads
- Harm reduction approach
- Weekly team supervision
- Regular full caseload review

CTI shares three of the four best practices characteristics with HF and ACT:

- There is a body of evidence supporting the model (de Vet et al., 2013, p. e24; Herman et al., 2011, p. 719; Herman & Mandiberg, 2010, p. 506).⁴⁵

⁴⁵ De Vet et al. note that results from CTI studies are promising; however, CTI was the least researched method covered by their analysis (2013, p. e24).

- It has been accepted as a best practice by professionals in the field and by government bodies⁴⁶ (Herman & Mandiberg, 2010, p. 504; McQuiston, 2012, pp. 414-415; SAMHSA, 2014a).
- Tools are available to ensure CTI is used correctly in diverse circumstances and populations (Herman & Mandiberg, 2010, p. 504).

CTI has not been tried and tested as thoroughly as PSH, HF, and ACT; however, it has achieved a level of acceptance as a best practice. De Vet et al. speculates that CTI might be “applicable for a variety of settings and populations because of its practical and time-limited nature” (2013, p. e24).

It is worth noting here CTI’s focus on transition and time-limited support appears in stark contrast to ACT’s commitment to unlimited support. However, while ACT principles do include a commitment to time-unlimited support, ACT practitioners and researchers have begun adapting the model to “graduate” certain clients, in effect transitioning them to full independence (Finnerty et al., 2014, p. 92).

2.3.3 Comprehensive, Continuous, Integrated System of Care

CCISC is less a method of delivering services and more a system for planning service delivery with resources at hand. The four elements of CCIS are system-level change, efficient use of existing resources, incorporation of best practices, and integrated treatment philosophy (Minkoff & Cline, 2004, pp. 5-7).

CCISC shares three of the four best practice characteristics with HF, ACT, and CTI.

- There is a body of evidence supporting the model (Engelhardt, Hills, & Monroe, 2009, p. 116; Harrison, Moore, Young, Flink, & Ochshorn, 2008, pp. 256-257; Moore, Young, Barrett, & Ochshorn, 2009, p. 332; Young, Clark, Moore, & Barrett, 2009, p. 302).
- It has been accepted as a best practice by professionals in the field and by government bodies (McQuiston, 2012, p. 417; SAMHSA, 2013b, p. 35).
- Tools are available to ensure CCISC is used correctly in diverse circumstances and populations (Minkoff & Cline, 2012b, 2012c, 2012d).⁴⁷

It should be noted CCISC is the least well supported of the best practices discussed in this research, though this comment is not because evidence against its efficacy was discovered. Rather, the amount of research is relatively thin. It is also worth noting the primary promoters of the methodology are the program developers themselves, Minkoff and Cline.

The eight key elements to CCISC are outlined in Table 5. Table 5 presents two versions of CCISC principles: the eight on the left are from Minkoff and Cline’s 2004 paper, while the eight on the right are from their 2012 Zialogic Partners, Inc. website. If either version is compared to best practices elsewhere

⁴⁶ The government of Canada listed CTI as a best practice on its Best Practices Portal from 2006 to July 2014, when inclusion criteria was revised and CTI removed. CTI was excluded because the Public Health Agency of Canada determined CTI to be a clinical intervention, implemented by clinicians, and treatment-focused, as opposed to prevention-oriented. To be included on the portal, practices must “help public health practitioners plan programs for their communities for promoting health and preventing chronic disease. To be accepted for inclusion on the Portal, an intervention must address health at single or multiple levels including individual, community, organization, or societal levels. Clinical interventions, such as those that focus exclusively on one-on-one treatment recommendations for specific medical diagnoses or drug administration, are excluded from the Portal” (Lauzon, 2015).

⁴⁷ Note: tools for verifying compliance with CCISC are trademarked and licensed services.

in this research, there are a number of parallels, for example, individualized treatment, client-centred, simultaneous treatment of co-occurring disorders. The more recent version appears to be an effort to simplify the principles.

Table 5

Comparison of Original Eight CCICS Principles versus Updated CCICS Principles

Original Principles (Minkoff & Cline, 2004, pp. 7-11)	Updated Principles (Minkoff & Cline, 2012a)
1. Dual diagnosis is an expectation, not an exception	Co-occurring issues and conditions are an expectation, not an exception
2. All ICOPSD ⁴⁸ are not the same; the national consensus for quadrant model for categorizing co-occurring disorders can be used as a guide for service planning on the system level	All people with co-occurring conditions are not the same, so different parts of the system have responsibility to provide co-occurring-capable services for different populations
3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties	The foundation of a recovery partnership is an empathic, hopeful, integrated, strength-based relationship
4. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting	When co-occurring issues and conditions are present, each issue or condition is considered to be primary
5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended	Recovery involves moving through stages of change and phases of recovery for each co-occurring condition or issue

⁴⁸ An abbreviation of “Individuals with Co-occurring Psychiatric and Substance Disorders”.

Table 5

Comparison of Original Eight CCICS Principles versus Updated CCICS Principles

Original Principles (Minkoff & Cline, 2004, pp. 7-11)	Updated Principles (Minkoff & Cline, 2012a)
6. Both mental illness and addiction can be treated within the philosophical framework of a “disease and recovery model” with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change	Progress occurs through adequately supported, adequately rewarded skill-based learning for each co-occurring condition or issue
7. There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements	Recovery plans, interventions, and outcomes must be individualized. Consequently, there is no one correct dual-diagnosis program or intervention for everyone
8. Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions	CCISC is designed so that all policies, procedures, practices, programs, and clinicians become welcoming, recovery- or resiliency-oriented, and co-occurring-capable

Because CCISC is designed to work with the resources available, the system ought to adapt capably to diverse circumstances. Moreover, because it is a system for integrating services, it ought to work well with housing programs such as HF.

2.3.4 Intensive Case Management

The term ICM is often used in a very broad sense to mean a number of case management methods (Goscha et al., 2012, pp. 294, 297). In that respect, it would appear to have lost some of its usefulness, similar to SH and SvH. However, sufficiently precise and comprehensive descriptions and tools exist to allow consistent application of ICM across diverse circumstances (Ontario Government, 2005, pp. 12-27; SAMHSA, 2013b, pp. 157-160; Stefancic et al., 2013, pp. 246-250). As noted earlier in this research, ICM and ACT were successfully used as part of the At Home/Chez Soi program in five cities across Canada (P. Goering et al., 2014, p. 5).

Perhaps not surprisingly then, ICM is similar to ACT. In fact, some researchers consider ACT to be a subset of ICM methodology (Goscha et al., 2012, p. 297). Table 6 presents similarities and differences between the two methods.

Table 6 (SAMHSA, 2013b, p. 159)

Shared characteristics and differences between ICM and ACT

Similarities	Differences
<ul style="list-style-type: none">• Focus on increased treatment participation• Client management• Abstinence as a long-term goal, with short-term supports• Staged motivational interventions• Psychoeducational instruction• Cognitive-behavioral relapse prevention• Encouraging participation in 12-Step programs• Supportive Services• Skills training• Crisis intervention• Individual counselling	<ul style="list-style-type: none">• ICM is a less intensive support than ACT• Caseloads for ICM can reach up to 25:1, while ACT caseloads are typically 12:1 or lower⁴⁹• ICM programs typically offer fewer hours of support than ACT• ICM team functioning is not as defined as ACT, and cohesion is not necessarily a focus of team functioning; the ICM team can operate as a loose federation of independent case managers or as a cohesive unit, similar to ACT• ICM programs do not necessarily integrate family and friends into the program, whereas ACT does• Frequently, ICM involves service coordination across systems, while ACT teams coordinate within the team

ICM shares the four best practice characteristics with HF and ACT and three of the four same characteristics with CTI and CCISC.

- There is a body of evidence supporting the model (P. Goering et al., 2014, pp. 7, 8, 17, 27; Nelson et al., 2007, p. 358; Stergiopoulos, Gozdzik, et al., 2015, p. 16).⁵⁰
- It has been accepted as a best practice by professionals in the field and by government bodies (SAMHSA, 2013b, p. 157).
- The method has been tested across a diverse population in many locations (Stergiopoulos, Gozdzik, et al., 2015, p. 16).
- Tools are available to ensure ICM is used correctly in diverse circumstances and populations (Ontario Government, 2005, pp. 12-27).⁵¹

Within the terms of this research, it is safe to say ICM is a best practice, particularly when it is applied as it was in the At Home/Chez Soi program to clients with moderate needs.

⁴⁹ Other literature stipulates ACT ratios equal to or less than 10:1 (Goscha et al., 2012, p. 300; Kirsh & Cockburn, 2007, p. 41; SAMHSA, 2008a, p. 39) and ICM ratios of 20:1 (P. Goering et al., 2014, p. 12; Ontario Government, 2005, p. 8; Stefancic et al., 2013, p. 254).

⁵⁰ Note that some research has found weak if any support for ICM (de Vet et al., 2013, pp. e13, e24).

⁵¹ Plus, Stefancic et al. have developed a fidelity scale specifically geared to HF, ICM, and ACT (2013, pp. 246-250).

2.4 EMPLOYMENT SUPPORTS

2.4.1 Supported Employment

Writing in 2001, Bond, Becker, et al. summarize supported employment (SE) by saying the evidence for its effectiveness is “clear and consistent,” improving “outcomes across many types of settings and populations” (p. 319). They go on to note that over the previous 50 years no other method has achieved a similar level of evidence-based validity (pp. 319-320). Writing in 2004 on the results of 12 studies using two research designs, Bond reiterates the Bond, Becker, et al. 2001 conclusion by saying “[n]o other vocational model is as clearly defined, has been as widely studied, nor achieved a consistent pattern of positive outcomes regarding competitive employment” (p. 356).

Indeed, government has adopted SE as one of its evidence-based practices. In its “Evidence-Based Practices KIT,” SAMHSA⁵² outlines seven principles for SE (2009b, pp. 4-6):

1. Eligibility is based on consumer choice.
2. SE services are integrated with comprehensive mental health treatment.
3. Competitive employment is the goal.
4. Personalized benefits counselling is important.
5. Job search starts soon after consumers express interest in working.
6. Follow-along supports are continuous.
7. Consumer preferences are important.

Also, SE is integrated into HF. The Pathways Housing First Fidelity Scale outlines the use of SE as follows:

Supported employment services: Program FULLY provides all 4 listed services: (a) engagement; (b) vocational assessment; (c) rapid job search and placement based on participants’ preferences (including going back to school, classes); & (d) job coaching & follow-along supports (including supports in academic settings). (Stefancic et al., 2013, p. 249)

Interestingly, when it comes to ensuring fidelity to the SE model, although the scale is often referred to as the “Supported Employment Fidelity Scale,” it was originally referred to as the “Individual Placement and Supports Fidelity Scale” or IPS Fidelity Scale and many professionals still refer to it as the IPS-15 or IPS-25 scale (Bond, Peterson, Becker, & Drake, 2012, p. 758)—the numbered suffix referencing the number of dimensions used in the scale.

This nomenclature detail stems from the fact that Individual Placement and Support (IPS) is a SE method extensively tried, tested, and analyzed. As a result of this effort, the fidelity scale was originally developed to support IPS but is now used more widely for evaluating SE services.

When searching for and reviewing SE literature, by far the method most often researched and analyzed is IPS. Even while writing about SE as a method, Bond uses the core IPS principles in his analysis (2004, p. 346). In fact, it is probably safe to say IPS has become synonymous with SE.

⁵² SAMHSA uses the 2001 Bond, Becker, et al. research as the basis for presenting SE as an evidence-based practice (SAMHSA, 2009b, pp. 5-14).

As a result, though SE is certainly thought of as a best practice by professionals and government organizations, it is probably most worthwhile to evaluate IPS specifically.

2.4.2 Individual Placement and Support

IPS has been described as the “most clearly described, measured and empirically validated form of supported employment for persons with severe mental illness” (Drake, Becker, Clark, & Mueser, 1999, p. 294). Internationally, IPS is being used in The Netherlands, Italy, and Spain and has become national policy in the U.K. (Fioritti et al., 2014, p. 123), while also being proven successful in Sweden (Bejerholm, Areberg, HofGren, Sandlund, & Rinaldi, 2015, p. 63).⁵³

Seven SE Principles (SAMHSA, 2009b, pp. 4-6)	Six Core Principles of IPS (Moll, Huff, & Detwiler, 2003, p. 300)
Competitive employment is the goal	Competitive employment is the primary goal
Job search starts soon after consumers express interest in working	Rapid job search, meaning job-finding activities happen as soon as possible—within a month of entry into the program
SE services are integrated with comprehensive mental health treatment	Integration of rehabilitation with mental health services
Consumer preferences are important	Attention to client preferences, meaning that clients are assessed regarding their unique aspirations and skills
Follow-along supports are continuous	The client receives unlimited support to accomplish his/her goal of gaining competitive employment
Eligibility is based on consumer choice	Continuous assessment through trying competitive jobs, meaning each competitive job placement is considered to be an opportunity to assess the client’s fit
Personalized benefits counselling is important	

The first five SE and IPS principles in Table 7 are equivalent.

“Eligibility is based on consumer choice” refers to the fact there are no eligibility requirements. Clients may start with SE as soon as they express an interest. While eligibility requirements are not mentioned in IPS principles, in practice IPS clients are accepted into the program as soon as they express interest.

⁵³ The researchers note, however, that cultural differences—specifically the Scandinavian requirement for internships—limited the effectiveness of IPS.

⁵⁴ SE and IPS principles have been re-ordered from their presentation in the literature to allow a more direct comparison.

SE's last principle is "Personalized benefits counselling is important" and refers to the fact that many homeless or low income clients may receive benefits, but are reluctant to join employment programs for fear of losing benefits—quite possibly their only source of income. Again, in practice IPS programs provide the same type of support.

IPS shares the four characteristics with other best practices in this research paper:

- There is a body of evidence supporting the model (Bejerholm et al., 2015, p. 63; Drake et al., 1999, p. 294; Fioritti et al., 2014, p. 127; Lucca, Henry, Banks, Simon, & Page, 2004, pp. 256-257; Marshall et al., 2014, p. 21; Moll et al., 2003, p. 306; Poremski, Rabouin, & Latimer, 2015, p. 7; Viering et al., 2015, p. 3).
- It has been accepted as a best practice by professionals in the field and by government bodies (Fioritti et al., 2014, p. 123; McQuiston, 2012, p. 417; Rinaldi, Miller, & Perkins, 2010, p. 163).
- The method has been tested across a diverse population in many locations (Bejerholm et al., 2015, p. 63; Ferguson, Xie, & Glynn, 2012, p. 288; E. A. Latimer et al., 2006, p. 70; Michon et al., 2014, pp. 134-135; Oshima, Sono, Bond, Nishio, & Ito, 2014, p. 142; Rinaldi et al., 2010, p. 170).⁵⁵
- Tools are available to ensure IPS is used correctly in diverse circumstances and populations (Bond, Peterson, et al., 2012, pp. 761-762; Bond, Vogler, et al., 2001, p. 388).⁵⁶

Recent research suggests a rather amorphous factor is key to the success of IPS—trust.

When trust and a working alliance fail to develop or deteriorate, goals may be misunderstood and it appears that IPS is ineffective. When service users never deal twice with the same professional, promises tend to be broken and communication is fractured. This distances users from services and should be avoided. (Poremski, Whitley, & Latimer, 2016, p. 25)

In summary, there is good reason to consider IPS a best practice for delivering vocational services to homeless people and other populations, provided professionals build trust with clients.

2.5 A SUMMARY OF BEST PRACTICES PRINCIPLES

In reviewing core principles of the best practices, it is evident they are geared to service delivery. Principles are to be operationalized and reflect actions "on the ground." As a result, there is much material for guiding operations.

⁵⁵ Some research reports spotty IPS results in some locations outside the U.S. (Bond, Drake, & Becker, 2012, p. 38; Howard et al., 2010, p. 404), though the results may have been skewed by poor implementation. The At Home/Chez Soi Program final report for Montreal reported positive results using IPS; however, they could not rule out chance as the reason. The report also states "[f]inding, training, and keeping suitable employment specialists proved very challenging, and for only about a nine-month period was the supported employment program fully staffed and operating at a good level of fidelity to the IPS model. Both participants and employment specialists noted that continued substance use and criminal records posed significant obstacles to finding work" (E. Latimer et al., 2014, p. 29).

⁵⁶ The IPS fidelity scale has gone through a number of iterations since its original development. At one point it was called the "Supported Employment Fidelity Scale." Currently, it is called either the "Supported Employment Fidelity Scale" or "IPS-25."

A simple assessment of core principles involves categorization principles into themes and counting the number of times themes repeat. Table 10 presents the principles as categorized, along with the number of times categories occur. A list of all principles and themes used to develop the list in Table 10 are available on page 197 in the Appendix. The method used for arriving at the list is described in the Methodology section on page 47.

Table 8
Principle Categories and Frequency of Occurrence

Core Principle Theme	Description	Repeats
Individualized Support	Treatment must be tailored to each individual	5
Intensive Support	Support is intensive (e.g. 24/7/365)	5
Long Term Support	Supports do not arbitrarily stop	5
Socialization	Connection with community, workers, peers	5
Client Independence	Support focuses on client recovery	4
Harm Reduction	Support focuses on mitigating harmful behaviours	4
Client Control	Client is given control over treatment options	3
Normalization	Client is treated <i>normally</i> (e.g. given a standard lease)	3
Phased Support	Support follows/mirrors client progress	3
Targeted Support	Support is targeted to specific needs/clients	3
Affordable Housing	Housing is made affordable/accessible	2
All Conditions Primary	Each condition is treated as a primary	1
Dual Diagnosis Oriented	Program designed for dual diagnosed clients	1
Focused Support	Treatment focus on transitional phases of client progress	1
Integrated Supports	Supports are integrated	1
Trust Building	Program is designed to engender trust with the client	1
Support Reviews	Program caseloads are reviewed frequently	1
Team Support	Supports are delivered by teams of specialists	1

It is important to note here that Table 10 does not rank themes by their importance. To be clear, the table simply outlines the number of times a particular theme repeats when reviewing different best practice principles. For example, although affordable housing is a cornerstone of HF and has proven key in solving housing issues for many homeless people (i.e. it is an important principle), it only appears twice while other themes appear up to five times.

What Table 10 does do is highlight the similarities between best practices. Reviewing the table shows several themes repeat amongst best practices: Individualized Support, Intensive Support, Long Term Supports, Socialization, and so on.

We find Individualized Support is shared amongst all and is repeated five times. Likewise, Intensive Support, Long Term Support, and Socialization are share the same number of repetitions.

Similarly, we find Client Independence, Harm Reduction, Client Control, Normalization, Phased Support, and Targeted Support repeated frequently. Looking at the top 10 themes, we see another theme

emerge. Individualized Support and Client Control are Client Centred, in that they both reinforce the client's supreme role in treatment. While it is true all principles serve clients, these two themes emphasize how crucial clients are. Yes, the purpose of all principles is client-centred, but these two themes point to how *each client drives their own program*.

One principle has not been used in the above analysis because the HF philosophy hides it in plain sight. It is at the heart of HF and is what makes HF a departure from SC and other methods. And, it too is client-centred: simply give homeless people homes.

It works like this: First, prioritize the chronically homeless, defined as those with mental or physical disabilities who are homeless for longer than a year or have experienced four episodes within three years. They're the most difficult homeless to reabsorb into society and rack up the most significant public costs in hospital stays, jail sentences and shelter visits.

Then give them a home, no questions asked. Immediately afterward, provide counseling, a step research shows is the most vital. Give them final say in everything — where they live, what they own, how often they're counseled.

"People thought this was crazy," said Tsemberis, who today runs Pathways to Housing. "They said, 'You mean even when someone relapses and sells all the furniture you gave them ... [to pay for] drugs, you don't kick them out?' And I said, 'No, we do not.'" (McCoy, 2015a)

Many, if not most, SC programs either have sobriety preconditions or are designed in steps. Each step involves graduation to a new level of support, based on sobriety and other behavioural modifications.

Arguably, pre-requisites can damage some of the people programs mean to help. Pre-requisites skip people unless they achieve a certain standard. Stepped programs are similar, requiring goal achievement prior to accessing another program or support. Those who don't make the grade are turned away. They may risk being labeled "treatment-resistant," the implication being they cannot be helped: Beyond hope. Until HF, they had little recourse.

To be sure, obtaining housing and other supports is a great motivator, something many programs rely on. While such motivators may be strong, many homeless clients come with discouragingly little self-worth. Regressing into old patterns is a widely accepted phase of recovery and regressing behaviours set in such a high stakes environment may negatively impact client self-worth and outcomes.

Another way to analyze best practices principles is through simple word frequency. Figure 4 presents a word cloud based on the top 100 words used in the principles.⁵⁷ Words like services, support, and treatment occur frequently since service to the homeless is all about these three things. It is interesting to note how simple word frequency also indicates the presence of a high level of focus on clients.

⁵⁷ Excluding words with 3 letters or fewer and including similar words.

Word	Count	%	Similar Words
services	20	2.82	service, services
support	18	2.54	support, supported, supportive, supports
clients	15	2.12	client, clients
tenants	14	1.97	tenant, tenants
mental	12	1.69	mental
recovery	12	1.69	recovery
treatment	12	1.69	treatment
individualized	10	1.41	individualized, individualizing, individuals
consumer	9	1.27	consumer, consumers
interventions	9	1.27	intervention, interventions
occurring	9	1.27	occurring, occurs
disorders	9	1.27	disorder, disorders
lease	8	1.13	lease, leases
preferences	8	1.13	preferences
rent	8	1.13	rent
programs	7	0.99	program, programs
choice	6	0.85	choice, choices
competitive	6	0.85	competitive
condition	6	0.85	condition, conditions
management	5	0.71	managed, management, managers
needs	5	0.71	needed, needs
phase	5	0.71	phase, phased, phases
provided	5	0.71	provide, provided
skills	5	0.71	skill, skills
community	5	0.71	community

2.5.1 Operating with Best Practices

Principles generally direct how services should be delivered to clients. Through principles and their respective fidelity scales, they also direct what supports should be brought to bear when treating clients. However, best practices do not get into the nitty-gritty of how these services ought to be administered. How everything is put together is left to practitioners and administrators.

There are some exceptions. For example, CTI stipulates regular full caseload review and both CTI and ACT dictate a low support to client ratio (usually 1:10 for ACT).

2.5.2 Planning with Best Practices

Reviewing best practice principles from a planning and strategy perspective is more difficult. Even CCICS—designed to assist planning a system of care—focuses on how services are delivered. Almost all core principles, elements, or components outlined in best practices discussed here are externally focused. That is, principles are meant to deal with service delivery or the way service is delivered, not how the organization should plan. For example, CTI stipulates organizations perform “regular full caseload review.” While the principle dictates behaviour inside the organization, it still focuses on an operational aspect.

On the face of it, there is little to be learned from best practices principles that reflect how

an organization ought to strategize or plan. Of course, there is the obvious. Strategy and planning need to integrate best practices. With permanent housing as a foundation, services need to be client-oriented, client directed, individualized, flexible, multi-discipline, long-lasting, focused on harm reduction, and accepting of clients as they are when they enter a program.

Table 12 presents a categorized list of lessons learned through a review of employment guides and reports.⁵⁸ Some categories reflect topics covered in the previous section: “Client-Centred,” “Integrated Support,” and “Ongoing Support.” However, most of the categories differ from those presented from best practices. For example, “Inter-organizational Relationships,” “Leadership Quality,” “Planning,” “Performance Measures,” “Staff Quality,” and “Flexibility” do not appear in the summary tables for best practices. The differing categories point to higher level activities.

More information about planning services is provided in following sections.

2.6 HOW BEST PRACTICES ARE APPLIED

As discussed earlier, homelessness is primarily a housing problem, but supports are also required. You cannot provide one support and rely on clients to find other supports they require. All need to be presented to clients simultaneously at the start.

With that said, there is an initial sequence. Clients with the highest needs (chronically homeless) are identified. As soon as a client is identified, they are offered housing. Then, supports are added. Other supports do not come first. As the HF moniker implies, housing is first. Other needs are addressed second.

Table 10

Top Lessons Learned Categories

Category	Count
Client Centred	14
Integrated Support	9
Inter-organizational Relationships	9
Focus on Employment Market	5
Leadership Quality	5
Planning	5
Performance Measures	4
Staff Quality	4
Flexibility	3
Ongoing Support	3
Client Training	1
Commitment	1

⁵⁸ A table outlining how the categories were developed is available on page 201 of the Appendix. The method used for deriving themes is covered in the Methodology section on page 55.

2.7 A SUMMARY OF LESSONS LEARNED FROM REVIEW OF EMPLOYMENT GUIDES AND REPORTS

The lessons learned in this section come from employment-related guides, handbooks, and reports reviewed for this research.⁵⁹ Additionally, research-based advice for executing supported employment is considered.⁶⁰ As a result, lessons learned are clearly linked to employment-related efforts. However, because the lessons learned and advice are gleaned from SE programs—a best practice—information gathered is useful.

“Client Centred” appears most frequently by a fairly large margin. This theme permeates the best practices and points to the central role clients play in planning and operation of homeless services. It is tempting to gloss over this point because—of course it’s client centred—the program is *there* for homeless people. It is more than that, as Dr. Sam Tsemberis’ comment in the previous section alludes.⁶¹ Survey responses and transcripts in the Appendix show how practitioners believe clients have active roles to play in planning, implementing, and operating homeless serving organizations at executive, management, and staff levels.

“Integrated Support” is a fundamental idea behind the best practices discussed in this research. It is also the Holy Grail chased for more than half a century—to a great degree with little success when serving homeless clients. So, how is that helpful?

The next section discusses integration in more detail, so, perhaps it is sufficient here to point out that simply integrating services with the resources and circumstances at hand can be useful and effective. And, integration can be improved and intensified over time.

“Inter-organizational Relationships” follows only because Table 12 is alphabetical. Particularly where organizations are less than formally integrated, this theme is central to building a holistic service for clients. Resources are scarce and building relationships with those with complementary or missing-services is crucial.

“Focus on Employment Market” covers connecting with mainstream employment agencies, assessing the local employment market, and engaging employers directly. Reading through the lessons learned and research advice, it becomes clear working with employers is a two-way street where the homeless serving organization can be a conduit to the employer for information, as well as human resources. Being an excellent resource creates strong incentive for employers to work with a homeless-serving agency.

“Leadership Quality” is a theme that comes up very often as an integration topic and is sometimes referred to as “glue” holding together an integrated effort. “Strong,” “reputable,” “influential,”

⁵⁹ The four documents are *Employment and Training for America’s Homeless: Best Practices Guide* (1997), *Ending Chronic Homelessness through Employment and Housing* (2008), *Creating Community Employment Pathways* (2009), and *Opportunity Chicago: 2006-2010* (2010). A detailed discussion is on page 114 of the Appendix.

⁶⁰ This advice is available on page 130 of the Appendix.

⁶¹ See his comment regarding addicts who sell their furniture for drugs and, yet, operating a HF program means allowing them to continue living in their home.

“committed,” and “strong business skills” are some of the words used to describe leadership on an integrated effort. Leadership quality applies both to individuals and the lead organization.

“**Planning**” involves bringing together all collaborating organizations at the very beginning to discuss and understand philosophies, policies, practices, processes, roles, challenges, funding, priorities, governance, administration, and other issues central to defining, designing, implementing, operating, monitoring, and periodically changing the direction of a homeless-serving program. One lesson learned points out how organizations failing to plan thoroughly pay dearly for it in the long run.

“**Performance Measures**” are central to integrated efforts, as they represent an agreed-upon benchmark, acting like a corporate GPS. Without performance measures, no one knows what progress is made or even whether goals are missed altogether. Developing performance measures requires extreme care. Carelessly conceived measures can have perverse effects where measures themselves become the focus and outcomes become secondary.

“**Staff Quality**” means more than hiring good people. It means hiring staff who are familiar with the homeless, understand cultural and philosophical differences between their own organization and cooperating programs, are aware of service and care priorities, believe in the program, and commit to best practices and integration. Staff quality is also a reason training is an important topic.

“**Flexibility**” refers to an organization’s ability to change course as required and adapt resources to their most effective use. An interesting point made by one of the survey respondents—and echoed by implication in the Planning paragraph above—is organizations must *plan* to be flexible. This requires thorough planning, as a strategic, tactical, and operational course changes impact many moving pieces, none of which can afford to stall.

“**Ongoing Support**” is another foundational piece of best practices, meaning supports are provided as long as they are required. This doesn’t preclude programs from graduating clients to independence, as proposed by CTI. It simply means support is provided for as long as it is needed. In some cases, it may mean long term or lifelong.

2.8 INTEGRATING BEST PRACTICES

Despite practitioners and researchers chasing integration for over five decades, health professionals do not have a single model for service delivery integration in varying circumstances for different populations. Despite an “explosion of literature” and a flood of “interesting and innovative pilot studies” there are “few unifying themes, cohesive evidence-based factors, or sustainable organizational policies for implementing systems-based integrated behavioral health care⁶² initiatives” (Talen & Valeras, 2013, p. 4).

⁶² Integrated Behavioural Health Care is defined as “[t]he care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization” (AHRQ, 2013).

There is no one definitive model that is appropriate for all organizations and situations because the delivery of health care is too complex for a one-size-fits-all solution. (Suter et al., 2007, p. 5)⁶³

Table 11
Integration models (adapted from Suter et al., 2007, p. 19)

System Level	
Burke and Litwin (1992)	A Model of Organizational Performance and Change
Conrad and Shortell (1996)	Key Dimensions of Integrated Health Systems
Lukas et al. (2002)	Integrated Systems Scorecard
Markoff, Finkelstein, Kammerer, Kreiner, and Prost (2005)	Relational Systems Change Model
Miller (2000)	Burke-Litwin Change Model
Program/Service Level	
Batterham et al. (2002)	Physician integration
Byrnes (1998)	Population Health Management
King and Meyer (2006)	Service integration for children with disabilities
O'Connell, Kristjanson, and Orb (2000)	Shared Care, Case Management, Home Care, Collaborative Practice, Clinics, Cancer Centres
Weiss (1998)	Prevention-focused Model
Wulsin, Söllner, and Pincus (2006)	Hospital based models, Primary care based models
Progressive or Sequential	
Boon, Verhoef, O'Hara, and Findlay (2004)	Parallel – Consultative – Collaborative – Coordinated – Multidisciplinary – Interdisciplinary – Integrative
Conrad and Shortell (1996)	An Evolutionary Typology of Management Models and Clinical Integration Approaches
Fleury (2006)	Continuum of Inter-organizational Relations
Konrad (1996)	Levels of Integration
Leutz (1999); (Leutz, 2005)	Levels of Integration

Although there is no single model, there are model types available depending on circumstances, resources, and goals of the integration. Suter et al. identify three types: system level, program level,

⁶³ The 2007 Suter et al. research on integration was conducted prior to the Government of Alberta's amalgamation of many provincial health jurisdictions in 2009.

and progressive or sequential models (p. 5). Table 13 above lists integration models and research associated with each type, as identified by Suter et al.

The following sections draw from the work of Suter et al. and outline characteristics of each approach.

2.8.1 System Level

“System level models focus on change management and key system dimensions” (Suter et al., 2007, p. 5). Another way to look at this type of integration is its relative internal focus. Although the organization adapts to external changes and its ultimate focus may be service to clients, organizational systems and their various components are the target of leadership change management effort. System level can be roughly equated with system integration discussed earlier.

2.8.2 Program Level

“Program level models focus on case management, co-location, home care, population health management, and primary care” (Suter et al., 2007, p. 5). With a focus on home care, health management, and primary care, a program level model can be likened to operational integration, discussed earlier. Integration effort is directed at the service delivery level, as discussed earlier.

Given the delivery style associated with HF, ACT, ICM and other best practices, it can be said these delivery methods use a program level or operational integration model. Faced with the need to provide integrated services to a diverse population with complex needs and across multiple organizational silos, practitioners put effort into service combinations with the most impact.

2.7.3 Progressive or Sequential Models

“Progressive or sequential [...] models propose several steps to achieve increasing levels of integration which are adaptable to both system level and program level integration” (Suter et al., 2007, p. 5). That is, these models embrace change over time. Boon et al. suggest a transition from parallel practice to integrative, as illustrated by Figure 5.

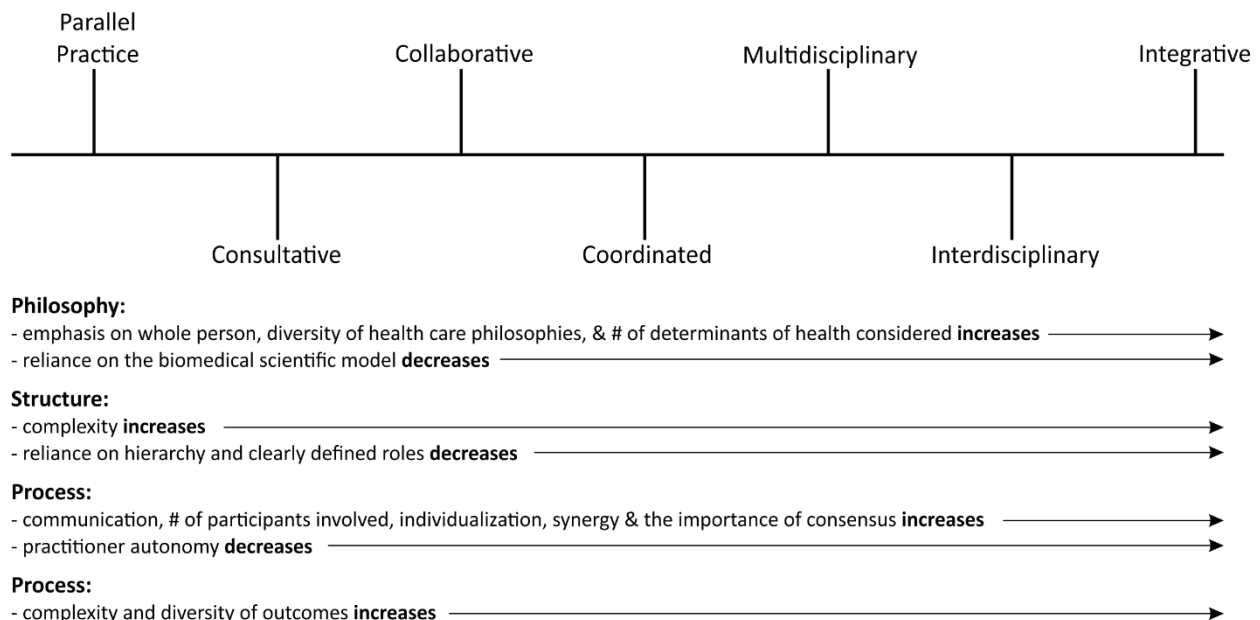


Figure 5 A continuum of team health care practice models (Boon et al., 2004, p. 4)

Boon et al.'s continuum is similar to the one presented earlier and put forward by Keast et al. Keast et al. propose each station along their continuum has value and can be used effectively. Boon et al. suggest their continuum may provide "helpful guidance on how to explore 'individualized care' – which models of care are the best for which kinds of patients and problems – something that has been elusive to date" (Boon et al., 2004, p. 4). Figure 5 represents the spectrum of possible integration possibilities Boon et al. put forward.⁶⁴

2.8.4 Integration Structure

Knowing or picking a position on the integration continuum is a very basic step. There is no structure.

As Konrad explains, although different people emphasize different aspects of integration, group them in different ways, or discuss only some key elements, "certain key dimensions are common to most [service integration] initiatives" (1996, p. 12). Konrad discusses 13 dimensions of human services integration (1996, pp. 12-17)—a kind of skeletal structure for integration efforts.

- Partners
- Target Population
- Goals
- Program Policy and Legislation
- Governance and Authority for the Services Integration Initiative
- Service Delivery Model
 - Communications
 - Staff deployment and reporting
 - Training
 - Geographic location and service configuration
 - Case management
 - Other aspects
- Stakeholders
- Planning and Budgeting
- Financing
- Outcomes and Accountability
- Licensing and Contracting
- Information Systems and Data Management
- Evaluation Issues and Questions

With the input and agreement of partners, stakeholders, clients, and staff, these dimensions can be used to help outline where an organization may end up on the integration continuum.

⁶⁴ Note that Boon et al. place "Collaborative" to the right of "Coordinated," opposite the positioning Keast et al. use for their integration continuum. While this opposite positioning implies Boon et al. consider collaboration less integrated than coordination, its placement is not significant. Both authors simply use the terms as semantic tools to describe their models. It is more important to recognize integration can be viewed as a continuum and that points along it are valid approaches, depending on existing circumstances, goals, and resources.

2.8.5 Principles for Integrating Health Services

Suter et al. outline 10 principles for planning and development of “successfully integrated health care systems” (Suter et al., 2007, p. 5). Suter et al.’s research and principles were developed with a large provincial organization in mind; however, most can be adopted by a smaller organization.

Drawing from “practical on-the-ground experience developing and implementing homeless system planning in Calgary (from 2008 to 2013), and through technical assistance provided to other communities,” Turner outlines seven “essential elements” for integrating services (Turner, 2014, p. 9).

When the two lists are amalgamated after eliminating duplication,⁶⁵ 14 principles and elements for integrating homeless services remain. For the balance of this paper, the principles and elements will be referred to as Integration Principles or “IP.”

1. Planning and Strategy Development process follows a systems approach grounded in the Housing First philosophy.
2. System Mapping to make sense of existing services and create order moving forward.
3. Comprehensive services across the continuum of care recognizing the importance of providing seamless health care despite the multiple points of access.
4. Geographic coverage and rostering to maximize accessibility and minimize duplication.
5. Standardized care delivery through inter-professional teams and use of provider-developed, evidence-based clinical care guidelines and protocols.
6. Performance Management and Quality Assurance at the program and system levels are aligned and monitored along common standards to achieve best outcomes.
7. Integrated Information Management aligns data collection, reporting, intake, assessment, referrals to enable coordinated service delivery.
8. Organizational Infrastructure is in place to implement homelessness plan/strategy and coordinate the homeless-serving system to meet common goals.
9. Cohesive, organizational culture with strong leadership and shared vision of an integrated health care delivery system.
10. Physician integration, particularly primary care physicians, by a variety of methods such as compensation mechanisms, financial incentives, and non-financial ways of improving quality of life.
11. Strong governance structure that includes community and physician representatives.
12. Sound financial management.
13. Coordinated Service Delivery to facilitate access and flow-through for best client and system-level outcomes.
14. Systems Integration mechanisms between the homeless-serving system and other key public systems and services, including justice, child intervention, health, immigration/settlement, domestic violence and poverty reduction.

IP above provide direction for developing an integrated program for serving homeless people. What IP does not do is outline why it is difficult to integrate services for the homeless. One of Leutz’s integration

⁶⁵ A more detailed review and discussion of Suter et al.’s principles and Turner’s elements is available on page 128 of the Appendix.

“laws” states “You can’t integrate a square peg and a round hole” (2005, p. 4). Leutz does a good job of explaining why. Table 19 below presents what Leutz calls “Square/Round Divisions.”

Table 12
Leutz’s Square/Round Divisions (2005, p. 5)

Aspect	Health Care	Social Care
Clinical orientation	Diagnose and cure disease	Access and mitigate functional status deficits, developmental delays
Financing	Universal entitlement	Multiple means-tested programmes
Administration	National and private insurance, or systems (e.g. NHS)	State-level or local authority bureaucracies
Provider organizations	Hospitals, physicians’ groups	Home care, day services, residential care
Provider staff	High and mid-level professionals: MDs, RNs	Mid-level professionals (MSWs) to paraprofessionals and family
Access	Relatively equitable: doctor’s orders	Lumpy: caps, waits, exclusions, local systems
Benefits	Relatively uniform core	Geographic differences in coverage and availability

Although Leutz draws his examples from the United Kingdom and United States, similar characteristics can be found in other jurisdictions like Canada. Health care and social care are structured differently and as long as these differences persist, perhaps service integration for homeless people will remain more a patchwork of supports than an integrated whole. Still, this do-the-best-you-can-with-what-you-have situation does not warrant acceptance of the status quo, but rather it points to how organizations need to work with the systems they find themselves in.

2.8.6 The At Home/Chez Soi Experience—Difficulties with Integration Projects

The At Home/Chez Soi program worked with the circumstances at hand, but of course adapted to the HF philosophy. It is instructive to review some of the issues encountered there. Recent research reviewed the Montreal At Home/Chez Soi experience, focusing on five areas: intervention characteristics (IC), implementation process, (IPr)⁶⁶ organizational characteristics (OC), context of implementation (CI), and strategies of implementation (SI).

⁶⁶ In the research this is referred to simply as “IP.” It is called IPr here to differentiate it from IP previously defined.

Fleury, Grenier, and Vallée point out the overall At Home/Chez Soi program was a “top-down” implementation, which led to several drawbacks. Strong arguments had to be made to get local stakeholders on side and the top-down approach made it difficult to make local adaptations. Also, in the Quebec context, social housing enjoys wide spread acceptance as the response to housing issues. When HF and At Home/Chez Soi was presented as the *solution* to homelessness, it led to conflict and rejection of the program by the provincial government, many professionals, and existing programs already working with the homeless (Fleury et al., 2014, p. 11). In the long run, it led to the Montreal program being unsustainable and Fleury et al. to conclude CI was the most serious obstacle to success (2014, p. 1). Both long term sustainability failure and difficulties with existing organizations point to the importance of gathering support and maintaining a cooperative and sensitive stance when approaching existing organizations.

Troubles associated with the top-down approach need to be dealt with by bringing local professionals and organizations into the discussion as early on as possible. Doing so allows vertical and horizontal feedback to guide program design and development. It is also an excellent place to begin drawing on guidance from the homeless population.

Aside from the CI construct, the Fleury et al. research is instructive on a number of other fronts. Breaking down their analysis into its conceptual components, Figure 6 outlines Fleury et al.’s approach (Fleury et al., 2014, p. 1).

OC: The chief hindrances were numerous structures, divergent values among stakeholders, frequent turnover of personnel and team leaders; lacking staff supervision and miscommunication.

IC: The complex, unyielding nature of the project undermined its chances of success.

IPr: The greatest challenges were the pressure to perform, along with stress caused by planning, deadlines and tension between teams.

SI: Construct conditions (e.g., effective governing structures, comprehensive training initiatives and toolkits) were generally very positive even with problems in power sharing and local leadership.

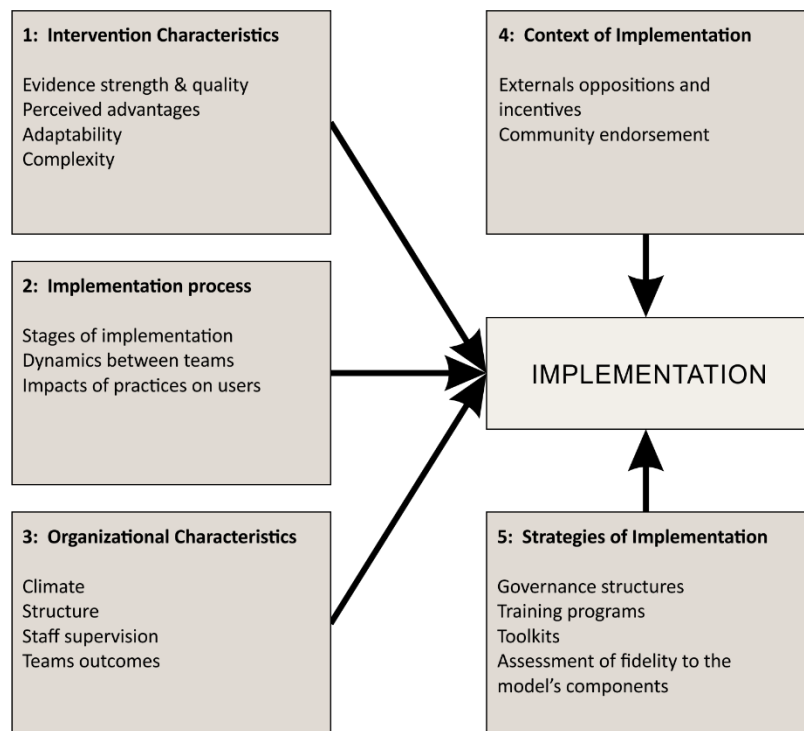


Figure 6 Conceptual Framework used for evaluation of Montreal At Home/Chez Soi implementation (adapted from Fleury, Grenier, & Vallée, 2014, p. 5)

While there are limitation [sic] in generalizing our results to other studies on implementation, the Montreal At-

Home/Chez Soi project thus served to emphasise the importance of identifying all the conditions that could hinder or enable a project and trying to fix most negative aspects before launching a project. It also showed the success of a project depends largely on achieving the following conditions: support of the key actors within the social network, especially government authorities and long-term coalitions in the field, adaptation of the project at the site level, and compatible visions and approaches among project stakeholders. Other factors of successful project implementation are close supervision and support of staff at all hierarchical levels, human resources stability, collaboration among teams and with the social network (promotion of boundary spanners) and adequate training and effective deployment and integration of tools into practices. Others are related to the governance of the project and the various levels of authority, namely a clear definition of the mandate of each authority, and collegial distribution of power among stakeholders to let them play meaningful roles. (Fleury et al., 2014, pp. 12-13)

Each integration effort features its own unique set of political, cultural, and logistical challenges. When compounded with the complexities of bringing individualized programs to a diverse population, it is no wonder ambitious change initiatives like At Home/Chez Soi fail almost two-thirds of the time (Beer & Nohria, quoted in Burnes, 2004, p.886).

3.0 CONCEPTUAL FRAMEWORK

The purpose of this research is to establish what practices are best for delivering housing, health, and employment services to the formerly homeless, sheltered, and at risk of homelessness. Literature reveals best practices for each of the core components. Figure 7⁶⁷ illustrates the principles involved in delivering each component and how all have to be integrated to provide a holistic service to clients. Each provider uses best practices in delivering services.

Service providers interact with each other to ensure seamless and effective service delivery without duplication or gaps. Providers also deliver supports to each client individually in such a way that the client is unaware there are separate systems delivering services. From the client standpoint, there is one team delivering services.

Integration is represented by the horizontal arrows between providers. How closely providers integrate is determined by provider goals and culture, funding, funder directives, provider capabilities, and other factors unique to the cooperating partners and their economic, legislative, and cultural environment.

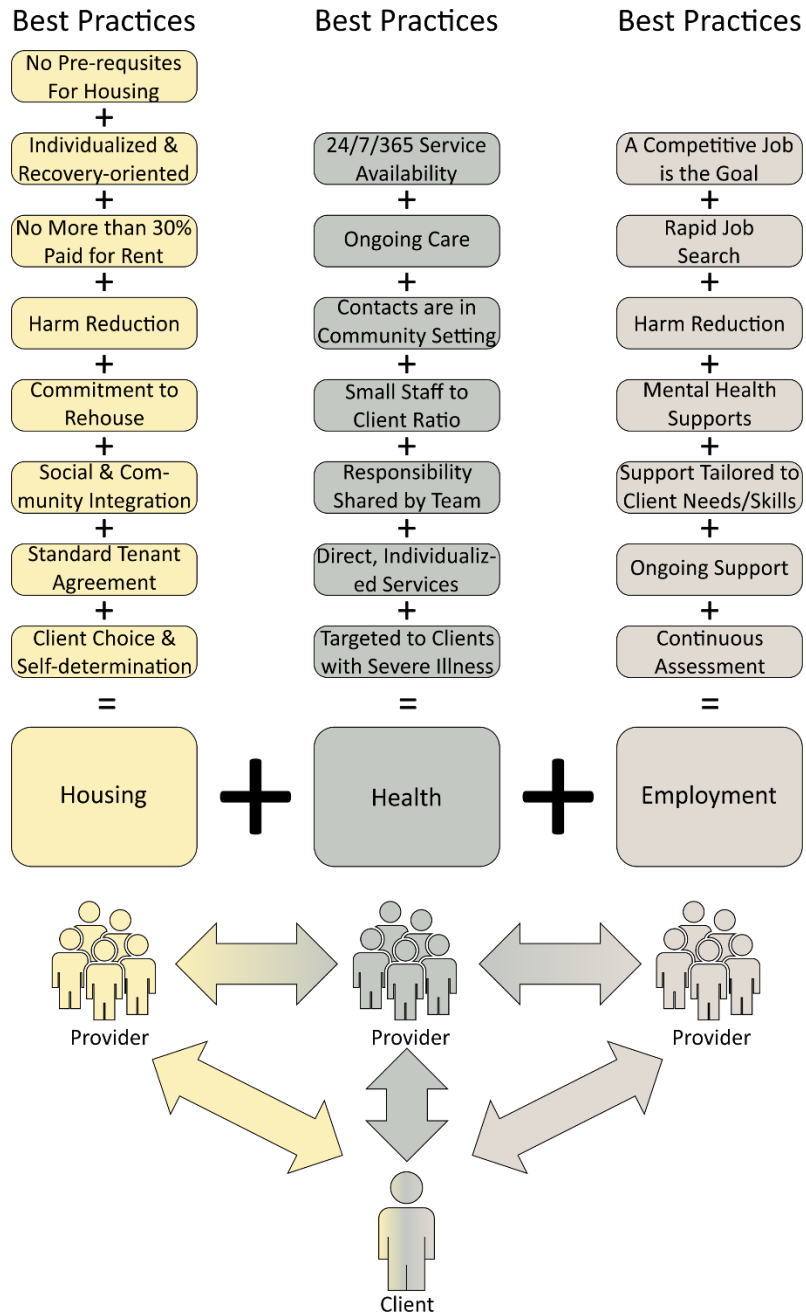


Figure 7 Conceptual Framework for best practices in integrating service delivery to homeless clients

⁶⁷ For the purpose of this illustration, Figure 7 shows HF principles as best practices for providing housing. Best practices for providing health services are represented by ACT principles. And, IPS principles are used for employment. Note: the basic principles are used here for illustration but in practice the fidelity scales for each method needs to be applied.

4.0 METHODOLOGY AND METHODS

Figure 8 illustrates how the research question is approached. This research looks to three streams of information to determine best practices in integrating services for the homeless. A literature review identifies and examines scholarly and grey literature to determine what established or upcoming best practices are used for habilitating and rehabilitating homeless people. Because this research is biased toward gathering employment program information, a document review examines reports related to employment programs to determine what lessons learned researchers and practitioners have gleaned from programmatic experience. A research survey of people working for organizations serving homeless people seeks to identify integration best practices used by people in the field.

With all three streams of information gathered and analyzed, the research

further synthesizes and analyses the three streams, identifying any unifying or common themes or practices. Based on the synthesis of information, recommendations are made regarding possible program directions for Streetohome.

4.1 LITERATURE REVIEW

4.1.1 Literature Sources

With the goal of identifying best practices in integrating services to the homeless, the author performed

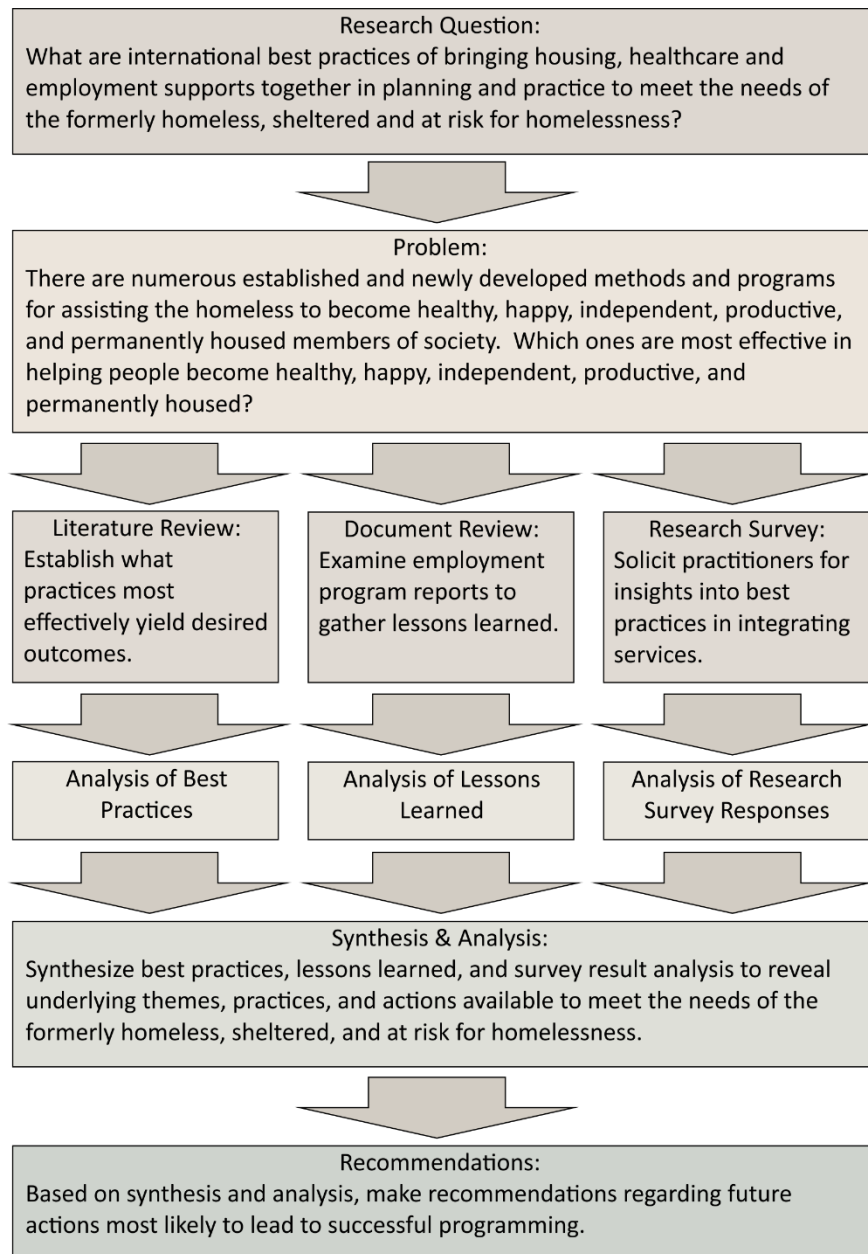


Figure 8 Methodology framework for determining best practices in integrating services for the homeless.

keyword and phrase-based searches of the University of Victoria’s Summon search facility. Searches included scholarly and peer-reviewed literature, as well as grey literature such as textbooks and government reports and publications. No restrictions were placed on disciplines included. Table 17 below outlines Summon searches performed.

Table 13
Summon search phrases and results reviewed

Search phrase	# of Results reviewed
homeless “supportive housing”	200
“best practices” for integrating services for the homeless	200
homeless integrated services	200
“best practices” homeless “integrated services”	200
“supportive housing” “best practices” homeless	200
“housing first” “best practices” homeless	200
Employment homeless “best practices”	200
Total	1,400

Searches of Google were also conducted using keywords and phrases. While performing Google searches and evaluating results, only result lines were first scanned for relevance. When titles appeared relevant, the result link was followed and the organization evaluated. Table 18 outlines Google searches performed. More Google results were reviewed than Summon searches due to the more condensed layout of Google results. More results could be reviewed when in Google than when using Summon over the same period of time.

Table 14
Google Search phrases and results reviewed

Search phrase	# of Results reviewed
homeless “supportive housing”	250
“best practices” for integrating services for the homeless	250
homeless integrated services	250
“best practices” homeless “integrated services”	250
“supportive housing” “best practices” homeless	250
“housing first” “best practices” homeless	250
Employment homeless “best practices”	250
Total	1,750

Where potential research documents were located using Google and the document was located at a website requiring payment, the author returned to Summon and accessed the document there.

From a review of document titles, descriptions, and abstracts documents were selected for relevance to best practices in integrating housing, health, and employment services to homeless people. Review of selected documents led to selection and use of additional research documents.⁶⁸

4.1.2 Literature Analysis

4.1.2.1 Best Practices

As well as using literature to identify and determine best practices, principles of each best practice were reviewed for themes. Principles for each best practice presented in this research was added to a list, creating a list of 72 principles. Then, duplicate best practices were eliminated, leading to a final list of 49 principles.

For example, HF and PSH are very similar. So, PSH was eliminated, leaving only HF principles. Likewise, SE and IPS are very similar. IPS was kept. The resulting best practice list included ACT, CCISC,⁶⁹ CTI, HF and IPS. That final list was used to develop themes. A table on page 197 of the Appendix presents the listed principles and corresponding themes.

4.1.2.2 Lessons Learned and Research Advice

All the lessons learned outlined in section 2.5 – Employment Guides, Handbooks, and Reports were combined into a list with the research advice outlined in section 2.6 – Research Advice for Executing Supported Employment. Some lessons learned and research advice was deleted, as it did not lend itself to theme development. For example, “Greater alignment and collaboration exists with the Chicago Workforce Investment Council (CWIC)” from the OC research was deleted, as it applies to how the program impacted one of the participating organizations instead of client outcomes. “Stabilize Homeless Individuals Prior to Enrollment” was deleted from BPG lessons learned, as it contradicts SE, IPS, and other best practice principles generally.

Each lesson learned and research advice line was reviewed and coded into a category column. Coding involved simply shortening the line into a meaningful phrase that still conveyed the essence of the line. Once the initial category column had been coded, a second category column was created and higher level category or more general theme was assigned to each.

A copy of the resulting list, the categories, and higher level categories (themes) is available on page 199 of the Appendix.

4.2 RESEARCH SURVEY

A copy of the research survey, the text used to invite participants, and the consent form are included in the Appendix beginning on page 91.

⁶⁸ Research related to topics mentioned by survey participants added to the references listed in the Appendix.

⁶⁹ The more recent (2008) set of principles was used.

4.2.1 Survey Design

The survey’s four topics are best practices in operating a homeless-serving organization, best practices in planning a homeless serving organization, the challenges of operating one, and responses to challenges.

The survey was designed to solicit responses based on practitioner experiences. The author avoided references to best practices such as HF, ACT, ICM, SE, and others so that participants would not respond with already-established best practice principles or methodologies. Of course, this does not preclude respondents relaying HF, ACT, ICM, and other principles and practices.

The first survey section asks respondents for general information about themselves and their organizations, as well as their knowledge of other organizations that may offer housing, health, and employment services. The second section asks respondents for information on planning a program to deliver integrated services. The third section asks respondents for information related to operating an organization offering integrated services. The fourth and last section requires respondents to relay their knowledge of how to plan and operate programs specifically offering housing and health; housing and employment; and housing, health, and employment services.

Most questions ask respondents about a single principle or practice they use or know. These questions limit responses to single principles or practices to elicit answers dealing with core issues. It should be noted, respondents did not limit their answers to a single principle or practice. Question 14 did not limit responses so that respondents might add other practices and principles that might also be important.

4.2.2 Geographic Areas Selected for Survey Invitation Distribution

To select potential participants for the survey, the author performed Google searches focused on metropolitan areas using the phrase “homeless organizations.” For example, when searching for potential participants in Vancouver, British Columbia, the author used the phrase “Vancouver, BC homeless organizations.” Generally, the largest metropolitan areas were targeted. Table 19 outlines metropolitan areas included in Google searches.

Australia	Canada	New Zealand	United Kingdom	United States
Sydney	Vancouver, BC	Auckland	London	New York, NY
Melbourne	Victoria, BC	Wellington	Manchester	Los Angeles, CA
Brisbane	Edmonton, AB	Christchurch	Birmingham	Chicago, IL
Perth	Calgary, AB	Hamilton	West Yorkshire	Washington, DC
Adelaide	Winnipeg, MA	Tauranga	Glasgow	San Francisco, CA
Canberra	Toronto, ON		Liverpool	Boston, MA
	Ottawa, ON		South Hampshire	Philadelphia, PA
	Montreal, QC		Nottingham	Dallas, TX

Table 15

Metropolitan areas covered by Google searches

Australia	Canada	New Zealand	United Kingdom	United States
	Quebec, QC		Sheffield	Fort Worth, TX
	Halifax, NS		Bristol	Miami, FL
	Moncton, NB		Belfast	Houston, TX
			Leicester	Atlanta, GA
			Edinburgh	Detroit, MI
			Brighton	Seattle, WA

Although searches focused on metropolitan areas, search results often included outlying areas near the city. For example, while searching listings for Houston, TX, a potential participant was located in Baytown, approximately 42 kilometers (26 miles) from downtown Houston and having a population of 76,000.

For each metropolitan area included in a search, the first 150 listings were reviewed, leading to 7,350 results being reviewed. Result titles were scanned for relevance, and if they appeared promising, links were followed to allow a review of the potential participant organization’s website. Potential participants were selected based on whether their website indicated the organization offers a combination of services, rather than single services. Organizations providing single services within a multi-service environment were also considered.

4.2.3 Survey Invitation Distribution

From the websites selected using Google, the author obtained the names of senior executives—typically an executive director or chief executive officer—and personalized the invitation to them. Where the email address of the senior executive was available on the website, the author sent the invitation directly to that address. Where the address of the senior executive was not available, the invitation was sent to a general mailbox and customized to request the invitation be forwarded to the senior executive.

Where organizations did not publish senior executive information on their websites, invitations were directed to a general mailbox and addressed generally to “Dear Sir or Madam” with a request that the invitation be forwarded to a senior executive or other appropriate person.

Some organization websites use web forms to collect visitor feedback and handle requests for information. Where a web form was the only method offered for communicating with the organization, invitations were sent using the organization’s web form.

The invitation asked recipients to forward the invitation to others in their organization who might be interested in participating. An example of the invitation is available on page 94 in the Appendix.

Invitations were sent to 225 organizations in Canada, the United States, the United Kingdom, Australia, and New Zealand. A list of the organizations contacted is available on page 184 in the Appendix.

4.2.4 Survey Responses

Nineteen organizations initially responded by saying they would participate. Of the 19 respondents, 12 actually responded either in writing or by participating in the survey over the telephone, representing a response rate of 5.3%. While the response rate is disappointing, the responses, depth of information received, and diversity of respondents is more than sufficient to support evidence found in literature and assist in developing options and recommendations. Telephone surveys took between 25 and 55 minutes to complete and—once transcribed—range from 1,000 to 5,300 words each, adding depth to the data collected.

Eight of the 12 respondents opted to complete the survey over the telephone, while the remaining respondents filled out the Word document and returned it. Two of the 8 telephone respondents completed the majority of the survey by telephone, but finished the last two questions in writing.

Nine respondents identify as executive. The remaining three identify as managers.

Respondents did not answer all questions; however, coverage of the questions overall was sufficient to generate themes and meaning. Transcripts of the telephone surveys and written responses are available on page 99 in the Appendix.

4.2.5 Survey Analysis

On a question-by-question basis, survey responses were coded using NVivo.⁷⁰ Repeating coded responses were counted to track the number of times similar responses were given. For example for question 14 asking respondents for best practices in planning an integrated service, the following coded responses were developed.⁷¹

- Align Planning with Higher Level Plans (e.g. Nat. Housing Strat) ----- 1
- Ensuring Facilities are Well-designed - Appropriate ----- 1
- Involve Clients in Planning----- 1
- Involve Gov't Health Authority ----- 2
- Open, Transparent Understanding of Funds Between Partners ----- 1

Note: the trailing number on the right is not the number of times coding is repeated overall, but is the number of sources that repeat the coding. Respondents often gave multiple responses, even where the question called for a single answer.

Respondents mentioned a number of programs and methods as best practices. A brief overview is offered. Using material readily available,⁷² the overview gives a sense of whether the program or methodology might be considered a best practice.

Coding is then briefly summarized and brought under four broad categories: Best Practices in Planning, Best Practices in Operating, Challenges, and Responses to Challenges. Under each of these four categories, coding is further arranged by themes. For example, the following themes arise from coding grouped under Challenges: Client Challenges, Funds, Measurement, Need, Staff, and Svc Alignment.

⁷⁰ A software program for analyzing qualitative data.

⁷¹ Not the full list.

⁷² Literature and websites found using Summon and Google.

5.0 SURVEY RESULTS

Complete coded survey responses for questions 3 to 15 are available in the Appendix on page 170.

Sections 5.1 through 5.15 deal with questions individually. Section 5.16 summarizes survey responses into four groups: Best Operating Practices, Best Planning Practices, Challenges, and Responses to Challenges.

5.1 PARTICIPANTS' SUGGESTED BEST PRACTICES

5.1.1 Outcomes Star

One respondent indicates a strength of their organization is using the “Outcomes Star.” Triangle Consulting Social Enterprise Limited (TCS), who promotes the Outcomes Star⁷³ (also referred to as the Mental Health Recovery Star), calls it “an evidence-based tool for supporting and measuring change” (2015). The TCS website provides a long list of articles promoting, describing, and evaluating the tool and an impressive list of organizations using it.

Recent independent research describes the tool as “useful in service mapping and assisting recovery clinicians to identify areas that they needed to focus on when providing treatment and following service user’s progress. It complemented other outcome measures used by the service” (Lloyd, Williams, Machingura, & Tse, 2015, p. 1). An earlier evaluation of both the Outcomes Star and earlier research supporting it assesses the Outcomes Star as a tool that “may facilitate collaborative care planning,” (Killaspy, White, Taylor, & King, 2012, p. 65) but does not recommend it as a “routine clinical outcome tool” due to its “inadequate interrater reliability” (p. 70). In response, TCS adjusted the methodology for testing interrater reliability.

While the Outcomes Star may prove to be a best practice, given the criterion used in this research it cannot at this time be considered a best practice. Although it appears fairly widely adopted in the UK and Australia; there is research supporting it; and there is a method for ensuring the tool is used uniformly, it has not been as widely evaluated as best practices outlined in this research. Perhaps the Outcome Star can be considered a promising practice, which should be investigated and followed for further progress.

5.1.2 500 Lives – 500 Homes

500 Lives 500 Homes⁷⁴ is a three year campaign to break the cycle of homelessness for families, young people and adults in our community who are homeless or vulnerably housed. By getting to know each person by name and surveying their individual health, housing and support needs, we can respond in the best way to each person and prioritise the most vulnerable people who are sleeping rough, or who are at risk of death.

⁷³ The Outcomes Star is available to organizations through a license from TCS. A trial version is available through their website, which is listed in the References section on page 218.

⁷⁴ A link to the website is available in the References section on page 204.

500 Lives 500 Homes is a coalition of government and non-government agencies supported by the Queensland Government and Brisbane City Council. (500 Lives 500 Homes, n.d.-b)

According to the 500 Lives 500 Homes website, the coalition includes 34 organizations and is connected to the Queensland government's Homelessness to Housing Strategy 2020, a 12-page document describing the effort as "a renewed emphasis on 'bricks and mortar' initiatives" and "an overhaul of service delivery models" (Department of Housing and Public Works, 2013). This corroborates the fact Australian governments are attempting to integrate services, discovered as part of the literature review earlier in this paper. Common Ground—discussed in the next section—has had significant influence on the program (500 Lives 500 Homes, n.d.-a).

The 500 Lives 500 Homes website states that well over 300 homes have been provided to homeless people, as of the last website update. However, it appears the website has not been updated since late 2014.

If an ambitious program to solve homelessness is contemplated, this effort may provide useful information from the perspective of planning and implementation for aligning government, non-profit, and other services.

5.1.3 Common Ground

According to the Breaking Ground website, Common Ground is now called "Breaking Ground"⁷⁵ (BG) (Breaking Ground HDFC, 2016b). BG is a New York organization housing homeless people since 1990, primarily serving two populations: the chronically homeless and those in danger of becoming homeless through outreach and provision of affordable housing (Breaking Ground HDFC, 2016a).

BG targets the most vulnerable and uses a Vulnerability Index (VI) developed in collaboration with Steven Hwang and James O'Connell of the Boston Healthcare for the Homeless Program (BHCHP). The VI is used as a way of determining which people are at highest risk. Hwang and O'Connell "identified a cluster of risk factors predicting mortality among the homeless, and the VI was developed around these factors. The VI provides a framework to prioritize client need by identifying the most medically vulnerable individuals through a standardized assessment, which quantifies individuals' risk for mortality based on the presence of health problems" (Cronley, Petrovich, Spance-Almaguer, & Preble, 2013, p. 471).

BG say their program ensures more than 90% of the people in their program stay stably housed (Breaking Ground HDFC, 2016c). Given apparent impressive results, the BG model has been fairly widely adopted in the United States, is being adopted in the UK, and has seen a great deal of growth in Australia (Parsell, Fitzpatrick, & Busch-Geertsema, 2014, p. 70).

The Common Ground model has not, however, yet been subject to independent evaluation, hence its effectiveness in terms of housing retention and other outcomes for homeless people with complex support needs has not been tested fully. Rigorous assessment of the extent to which the model mitigates stigma, promotes community integration, avoids institutionalisation and so on would be invaluable – and arguably

⁷⁵ October 23, 2015. BG was contacted to participate in the survey but did not respond.

essential in light of its rapid expansion in other countries. (Johnsen & Teixeira, 2010, p. 14)

Some argue the method unnecessarily institutionalizes residents in a separate and peculiar setting, making residents highly visible, as opposed to scattered site housing, which integrates people more seamlessly into communities (Parsell et al., 2014, p. 71). It is also argued the approach is more expensive than it needs to be, the expense being related to the scale of such projects and the need for large common areas—typically expensive to operate (p. 71).

On the other hand, in some circumstances such facilities may be a better solution for populations with multiple barriers (Nelson et al., 2013, p. 15). While no one would want to see a return to the institutions housing such clients in the past, there is a niche for this type of housing.

Regarding the VI, Cronley et al. report “the validity and reliability of the VI remain unexamined by researchers and practitioners” (2013, p. 472) then conduct research comparing the VI and its components to hospitalizations of homeless people in Fort Worth, Texas. The study was done because “[w]hile the VI is based primarily on self-reported health status, it is unclear the degree to which perceived health status is an accurate and valid measure of medical vulnerability” (p. 481).

Cronley et al. conclude “for practitioners using the VI, it would be useful at this point to collect additional information regarding vulnerability, e.g., social supports (which other instruments collect), as well as prior health conditions and health risk behaviors such as smoking, rather than relying solely on the VI to determine medical vulnerability and service allocation” (pp. 483-484). Nonetheless, the authors recommend policy makers support funding of research examining VI’s psychometric properties (p. 484).

Although BG and the VI may prove to be best practices as more research verifies its effectiveness, BG is not considered a best practice for the purposes of this research. BG and the VI may be considered a promising practice.

5.1.4 Community Housing Partnership

Community Housing Partnership (CHP) was conceived in 1988, when four people from the Coalition on Homelessness wrote a paper. In it they “proposed that the basic premise of transitional housing be reconsidered – that housing be developed in which the tenants stayed permanently and the staff moved on as residents established the ability to manage their own community” (Community Housing Partnership, n.d.-a). The city of San Francisco later adopted the recommendations of their paper (Community Housing Partnership, n.d.-a).

Founded in 1990, [CHP] is an award-winning San Francisco nonprofit dedicated to helping homeless people secure housing and become self-sufficient. (Community Housing Partnership, n.d.-d)

Community Housing Partnership (CHP) offers a fairly comprehensive set of services, including housing,⁷⁶ health and counseling support, and employment services (n.d.-d). Their Employment Pathway program offers employment in the property management field, plus training and job placement through their

⁷⁶ 14 existing apartment buildings, plus three under development as of 2015 (Community Housing Partnership, 2015).

social enterprise, *Solutions SF* (Community Housing Partnership, n.d.-c). Figure 9 illustrates how the Solutions SF employment program is structured.

Employment Pathway

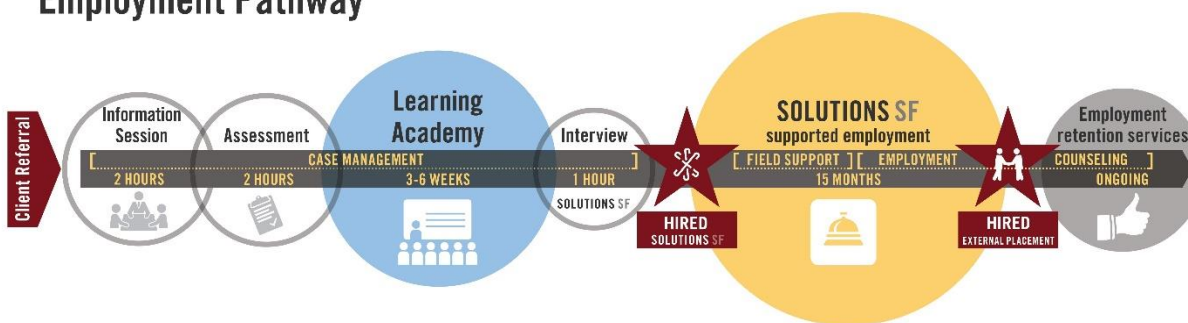


Figure 9 Community Housing Partnership - Employment Pathway Program (Community Housing Partnership, n.d.-c)

CHP also partners with REDF⁷⁷ to offer employment opportunities. REDF is a San Francisco-based non-profit organization investing in social enterprises employing people with multiple barriers to employment (REDF, 2016b). Though based in northern California, REDF has a portfolio of 22 social enterprises in Seattle, Portland, Los Angeles, San Diego, Denver, Austin, Chicago, Indianapolis, and Boston (REDF, 2016a).

CHP offers housing through a portfolio of 13 properties, providing supports for adults, seniors, and Transitional Aged Youth⁷⁸ who are homeless or at risk of becoming homeless (Community Housing Partnership, n.d.-b). Clients are supported through CM, health services, and youth and family programs.

CHP may be a program worth investigation, as it appears to integrate all three supports. REDF appears to be a good source for information on developing successful social enterprises.

5.1.5 Episcopal Community Svcs

Episcopal Community Services (ECS)⁷⁹ in San Francisco serves “over 8,300 homeless and low-income people every year,” providing “housing, jobs, shelter, and essential services to help” people “get off the street and stay off the street” (Episcopal Community Services, n.d.-b). Having adopted the HF philosophy (n.d.-c), ECS offers housing through several facilities. It also operates shelters, an adult education centre, a “navigation” centre, and CHEFS⁸⁰, a culinary based vocational program for homeless people. “CHEFS students intern in a variety of environments throughout San Francisco, ranging from fine dining restaurants to institutional kitchens and bakeries” (n.d.-a).

Of particular interest, ECS’ “supportive housing includes on-site social, health, and employment services, particularly important for people with multiple barriers to successful, independent living.” All of their sites “offer case management, mental health services, job counseling and access to adult educational and vocational services” (n.d.-d).

⁷⁷ Roberts Enterprise Development Fund.

⁷⁸ Youth aged 18 to 25 who have aged out of foster care and other child-focused supports.

⁷⁹ ECS was invited to participate in the survey, but did not respond.

⁸⁰ Stands for “Conquering Homelessness through Employment in Food Services.”

Again, because this program integrates all three supports, ECS may be worth investigating further.

5.1.6 Hamilton Family Services

As its name implies, Hamilton Family Services (HFS) serves families. Established in 1985 and based in San Francisco, HFS offers homelessness prevention and rapid rehousing; emergency and interim shelter; transitional housing; and children and youth services (Hamilton Family Center, n.d.-c). HFS bases its services on the HF philosophy (Hamilton Family Center, n.d.-a) and although its transitional housing program provides support services up to 12 months, its goal is to place families in permanent supportive housing for the long term (n.d.-b).

Its services are targeted to a specific population, which in general terms does not include the chronically homeless and those diagnosed with two or more conditions. As a result, the HFS program may not be of as much interest to Streethome as programs that deal with populations more analogous to Vancouver's. On the other hand, it is a good resource regarding serving families.

5.1.7 Houselink⁸¹

"Founded in 1976, and incorporated in 1977, it has served the mental health community in Toronto with a philosophy of 'housing as a right' from its inception" (Waegemakers Schiff, 2014, p. 21). Putting aside ACT integration, fidelity measures, and HF research, it can be argued Houselink was HF before there was HF. Houselink is a single-purpose organization focused on Housing. There are no separate departments or additional programs diverting attention from its focus (p. 24). Although Houselink focuses on housing, it employs approximately 25% of its membership in part-time jobs and a significant number of staff are former tenants⁸² (p. 25). Houselink administrative staff, direct service teams, and program staff collaborate to operate social recreational activities, supported employment efforts, and an educational/vocational program to facilitate internal and external employment opportunities (p. 26).

Houselink's organizational profile is unique in that [sic] way it blends the roles of clients and members of the organization. Each person who is housed becomes a member of Houselink. The term "client" is not used. This wording conveys the orientation of the agency to work in partnership with its service recipients to provide supportive housing while minimizing inequalities and eliminating, in so far as possible, services that are done to rather than with members. Members often wear multiple hats; leaseholder, operational committee member, Board of Director [sic], part-time contracted employee. (p. 29)

Despite its primary focus on housing, Houselink appears to have a significant impact on its tenants' employment status. Houselink reports two-thirds of tenants were involved in employment activities (p. 92). This is likely due to its policy of including tenants in program employment and other training opportunities (p. 92).

⁸¹ Houselink was invited to participate in the survey, but did not respond.

⁸² Thirty-nine respondents (out of 75) in a 2012 survey of employees identified themselves as former tenants.

Because Houselink has operated for more than 30 years, the program offers a unique opportunity to assess tenancy data. Figure 10 gives a snapshot of its 2014 tenancy profile.⁸³

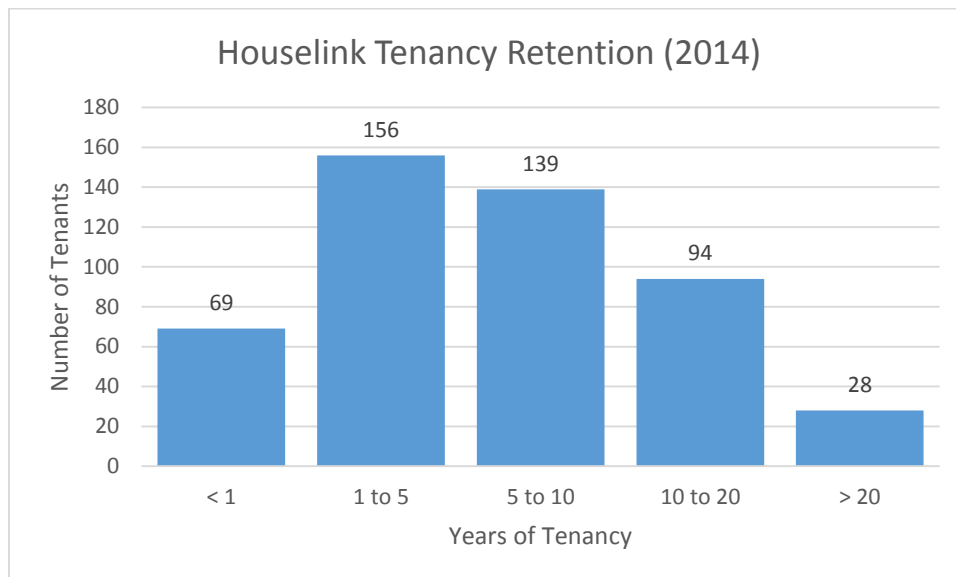


Figure 10 Houselink Tenancy Retention (2014) (Adapted from p. 30)

On the topic of housing retention, Waegemakers Schiff says “[i]n that regard, Houselink outperforms all of the other programs and the At Home/Chez Soi programs” (p. 75).

Houselink uses other unique strategies in running its program. For example, 50% of its board of directors are “agency tenant/members” (p. 55). Given its excellent housing retention outcomes and employment results, Houselink appears to offer an excellent opportunity to research and explore ways to integrate housing, health, and employment services for homeless people.

5.1.8 MPA

“MPA” stands for Mental Patients’ Association Society and has operated since 1971, “establishing and operating social, vocational, recreation, advocacy and housing programs that support people in their own communities” (MPA Society, n.d.-b). MPA is a mostly government funded organization offering SH and licensed housing services through 21 facilities across Greater Vancouver, three hotel outreach programs, and a number of other programs: Supported Independent Living (SIL), Super SIL, Supported Outreach Living Opportunity, MPA Housing Portfolio Development Program, and Advocacy and Social Justice support (n.d.-a).

MPA offers employment support, though limited to resume preparation and job search assistance. While its supports do include housing, health, and employment, it does not appear to offer a specific emphasis on placing clients in employment or ensuring employment tenure.

The MPA website states the “MPA Society has been practicing the guiding principles of Psychosocial Rehabilitation before it was being described in academic literature. The reason was simple; MPA was

⁸³ Waegemakers Schiff notes that while the stated cohort of tenants with a tenancy of more than five years represents 54.7% in the graphic, the actual percentage is higher because the 2014 count was based on a total resident count of 489 and 433 units, whereas the number of residents was 359 five years earlier.

formed by people experiencing the debilitating effects of mental illness during a time when stigmatization and shame resulted in only institutional services being available” (MPA Society, n.d.-c). As a result, it appears MPA is a good resource concerning specific mental health issues and topics like psychosocial rehabilitation. Research also finds Streethome already partners with MPA.

5.1.9 Parkdale Activity Recreation Centre (PARC)

PARC is a Toronto-based homeless-serving organization operating since 1980, offering a drop-in centre; community meal, case management, a Coop Cred, and community peer programs; Supportive Housing; and Parkdale People’s Economy (PPE) (PARC, n.d.-b). Coop-Cred is a unique program developed to assist homeless and other vulnerable populations.

The Co-op Cred program is an alternative currency program that facilitates access to the health benefits of local, sustainable and nutritious food *as well as* supportive work experience opportunities for low-income and marginalized groups facing food insecurity and economic marginalization. The program enables participants to earn “credits” in exchange for their hours of labour and to use them to purchase healthy food available at the WEFC.⁸⁴ In short, the program enables trade of labour for goods without converting that labour into wages.⁸⁵ (The Parkdale People’s Economy Project, n.d.-c)

PPE is builds local food economies through a community land trust model, a local currency program (Coop-Cred), “community-based food distribution and procurement initiatives through” their Community Flow Project (The Parkdale People’s Economy Project, n.d.-a). Parkdale Neighbourhood Land Trust (PNLT) is a resident-led community land trust with a goal of preserving “social, cultural and economic diversity of Parkdale. PNLT will acquire land and lease it to non-profit partners to “provide affordable housing, space for social enterprises”, “non-profit organizations”, and “furnish urban agriculture and open space” (n.d.-b).

Another unique PARC program is its PARC Ambassadors outreach. Work focus is “improving quality of life, using advocacy and leadership activity to support” by having PARC members reach out to community members. “Ambassador practices are based on sharing lived experiences to foster an ongoing dialogue, to inform and educate the public at large on what occurs when people are left behind on the margins of society, and within PARC to ensure it continues to develop paths back from marginalization towards personal recovery and equitable community citizenship” (PARC, n.d.-c).

PARC’s recreational activities are extensive, including knitting, writing, music, and art groups; Reiki; Karaoke; Yoga; Mindfulness; a soccer and hockey league; a chess club; a movie night; a camp, a gaming club, and a computer library (PARC, n.d.-a). PARC’s SH program is offered through 39 units at two Parkdale locations and is administered through the Toronto Mental Health and Addictions Supportive Housing Network.

It is hard to categorize PARC as simply a homeless-serving organization. PARC offers a wide range of activities and very unique methods for addressing poverty and homelessness. It does not directly offer

⁸⁴ West End Food Co-op.

⁸⁵ Though the “currency” can be spent at local businesses, earnings do not count toward income limits set by social service programs.

housing, health, and employment services, though all are available through its facilities. Certainly, the unique aspects of PARC may be worth investigation.

It should be noted that while PARC's Coop-Cred should be applauded for its ingenuity, such a program probably should not be relied upon as part of an employment program. Seen through the lens of SE and IPS, employment programs should focus on engaging clients in market employment, paying market wages.

5.1.10 The Bissell Centre⁸⁶

The Bissell Centre (TBC) is an Edmonton-based organization with a very long history, beginning as a Methodist mission in 1910, evolving into The Bissell Institute, and then The Bissell Centre by the 1970's (The Bissell Centre, 2014c). TBC programs offered are as follows (2014d).

- Individual
 - Outreach Housing Team
 - Walk-in Support Services
 - Housing Services (HF)
 - Employment Services (Casual Labour)
 - Mental Health Services
 - FASD⁸⁷ Permanent Supportive Housing
 - Fetal Alcohol Spectrum of Services
 - Inner City Victim Services
- Family
 - Early Childhood Development
 - Family Support Services
- Community
 - Thrift Shoppe
 - Drop-in Support Services
 - Recreation and Wellness
 - Moonlight Bay Centre

According to the list above, TBC offers housing, health, and employment services. Employment services appear to be more than a resume and job search support and include “assessments, referrals, life management workshops, employment counselling, safety courses, resume development, supported job searches”, “placement opportunities”, “casual labour, Jobs First,⁸⁸ skill enhancement, Moving Up,⁸⁹

⁸⁶ The Bissell Centre was contacted to participate in the survey, but declined.

⁸⁷ Fetal Alcohol Spectrum Disorder.

⁸⁸ A Government of Alberta program, “*Jobs First and the Transitional Employment Allowance* is a combination of short-term labour market attachment strategies and collateral supports which provide individuals support while they look for employment. Specifically, participants are given a general living allowance that covers food, clothing, household needs (e.g. furniture), personal needs, transportation” (R.A. Malatest & Associates Ltd., 2006, p. 55).

⁸⁹ Targeted to “[r]esidents of Edmonton’s inner-city, 18 years of age and older and experiencing homelessness or have a low income. This is a two-day a week program which runs for four weeks. One day a week is spent in class for pre-employment training” (Government of Alberta, 2016b, p. 3).

Strengthening our Spirit,⁹⁰ and Women’s Pre-employment⁹¹ programs” (2014b).



Figure 11 The Bissell Centre Program/Service Action Circles (The Bissell Centre, 2014a, p. 7)

As Figure 11 illustrates, TBC’s goal is broader than solving homelessness. Addressing poverty, rather than homelessness—a symptom of poverty and other factors—TBC is tackling an even more complex issue and one existing for millennia, not just a few decades. One can argue, then, that systems and general integration are tougher to accomplish. That being the case, it might be instructive to explore TBC’s plan to achieve its goal. Figure 12 presents TBC’s functional circles to facilitate and support internal operations.



Figure 12 BTC's Functional Circles Supporting Internal Operations (The Bissell Centre, 2014a, p. 8)

⁹⁰ Strengthening (Our) Spirit is a three-week program that brings together the elements of Aboriginal teachings, sharing circles, life skills training and pre-employment training. (Government of Alberta, 2016a, p. 2)

⁹¹ The Women’s Pre-Employment Program targets mothers who have young children and want to prepare to enter (or re-enter) the workforce. (Government of Alberta, 2016c, p. 1)

The functional circles look as though they belong in a typical corporate business plan. When reading through TBC’s business plans and other documents, it becomes clear the organization is run as a business, with a focus on ending poverty.

Given the complexity of TBC’s operation and services and the number of provincial government programs it ties into, TBC may be an excellent organization to investigate further.

5.1.11 The Kettle

The Kettle Society (TKS) is an East Vancouver organization focused on mental health and offering housing assistance, Supported Independent Living (SIL), Super SIL, Enhanced Supported Apartments, licensed care facilities, Transitional Housing, and Environmental Services. It also operates a mental health drop-in centre, advocacy services, an on-site health clinic, outreach services, the SEED employment program, volunteer programs, and recreational and life skill programs (The Kettle Society, n.d.).

Streetohome is familiar with TKS, in that TKS (in collaboration with Family Services of Greater Vancouver) operates an apartment building at 1134 Burrard Street in Vancouver, which was funded by Streetohome.

5.1.12 Calgary Urban Project Society (CUPS)⁹²

A respondent mentioned CUPS while answering question 11. However, this section addresses programs that may be best practices, and as a result, CUPS is presented here.

CUPS helps vulnerable and marginalized individuals and families in Calgary overcome poverty. CUPS was founded in 1989 as a grassroots response to inner-city poverty by medical professionals and faith-based groups. Today, CUPS is a vibrant, multifaceted, and innovative organization offering evidence-based programs and services spanning health, education, and housing. CUPS serves over 7,000 low-income Calgarians each year. (The Calgary Foundation, 2016)

CUPS uses three “pillars” to assist clients: housing, education, and health supports (CUPS, 2015, p. 2). Like the Bissell Centre, CUPS’ overarching mission is to address poverty (CUPS, n.d.-a). CUPS’ housing program is based on housing first (CUPS, n.d.-f) and offers three programs: Key Case Management & GRSP,⁹³ Community Development, and Supports (CUPS, n.d.-g).

Key Case Management & GRSP is geared to support homeless adults and families maintain housing regardless of their history—addictions, mental health issues, physical health and more. Case work aims at getting clients self-sufficient by finding them meaningful activities, improving their employability, and working on their relationship skills (CUPS, n.d.-h). Community Development focuses on housing and social connections and connections with the community through rent subsidies and the work of volunteers, who provide general and life skills support (CUPS, n.d.-b). Supports involves a broad range of services, such as financial support, assistance with documentation, and support for those fleeing domestic violence (CUPS, n.d.-l).

⁹² CUPS was contacted for participation in the survey, but did not respond.

⁹³ Graduated Rent Subsidy Program

Education services include a “Pre-natal to Three Child Development Centre & Parent Education,” “One World Child Development Centre,” “Family Development Centre,” and “Parent Education” (CUPS, n.d.-c). Pre-natal to Three Child Development Centre & Parent Education is offered to parents with children ranging in age from prenatal to 35 months and provides services like transportation, parenting programs, dietary guidance, and family support workers (CUPS, n.d.-k).

One World Child Development Centre dovetails with the pre-natal to three years program, in that it focuses on children aged three to six years. Services included are similar to the pre-natal to three years program, but adapted to deal with toddlers and their parents (CUPS, n.d.-i).

The Family Development Centre program is geared to a broader range of families than the two programs serving parents of young children and features services like parenting information and skill development, goal setting and ongoing support toward goals, referrals to community resources, and childcare for parents while attending CUPS appointments and groups (CUPS, n.d.-d). Parent Education offers various parenting programs, geared to both parent and child behaviour (CUPS, n.d.-j).

CUPS health supports include general care, blood tests, pre and post-natal care, pediatric care, mental health, dental, and services from visiting specialists including psychiatrists, neurologists, rheumatologists, cardiologists, gynecology, and more (CUPS, n.d.-e).

The services CUPS offers clients are fairly comprehensive. What appears impressive is the fact CUPS also puts significant effort into tracking outcomes. Reporting on their 204/2015 results, CUPS tells readers 94% of those referred to CUPS had stable homes (101 of 103 having been housed within two months); 71% of those housed by CUPS had “drastically” reduced “inappropriate use of public systems” (emergency room visits down by 27%, police interactions down by 76%, and emergency dispatches down by 72%); “74% of new tenants in the Community Development Program engaged in programming during their first 3 months;” and proportion of families eating meals together increased by 83% (CUPS, 2015, pp. 9-10).

As is the case for the other programs suggested by survey participants, there is no way this research can determine whether CUPS programming of itself is a best practice. However, the range of services offered, numbers served, apparent results, and outcomes-oriented approach strongly suggests CUPS is worth further research.

5.1.13 Women Building Futures

Established in 1998, Women Building Futures is a leader in trades training for women, with extensive experience recruiting women into the heavy industrial workforce at a consistent employment placement rate of 90 per cent. A Social Purpose Organization (SPO) and registered charity, WBF is valued for its uncompromising approach to meeting the needs of women and industry by recruiting the right people and providing them with the right training. Employers and women trust WBF’s methodology. (WBF, 2015a)

According to their website, WBF’s client is “any woman anywhere” (WBF, 2015a). Courses they provide include math skills and academic readiness courses and workplace culture awareness to support WBF programs in the oil and gas, electrical, welding, carpentry, sheet metal, heavy machinery operation, and

truck driving fields. While clients are engaged in the program, housing in one of 42 bachelor, one-bedroom, or two-bedroom units is made available (WBF, 2015b).

However, because the organization focuses on trades, understandably WBF has a zero tolerance policy regarding substance use (WBF, 2015e). As a result, the WBF program is appropriate for homeless clients who have already had success addressing substance use issues rather than those still addressing substance use. Still, since WBF's aim is to assist disadvantaged women the program could be a model for graduating clients to full independence.

Nonetheless, WBF provides a good example of how any employment program might approach collaboration with employers, as well as its clients. For example, WBF presents itself as providing "safety-conscious, motivated, qualified grads" (WBF, 2015d) to employers who partner with them, offering employers the opportunity to develop "custom training programs to meet [their] needs" (WBF, 2015c). Thus, WBF provides custom human resource solutions for employers.

WBF appears to be a great example of a well-run employment program focusing on a specific demographic. In that respect, WBF may very well be a promising practice.

5.1.14 Boston Healthcare for the Homeless (BHCHP)

BHCHP was put together by a coalition of homeless people, community activists, and shelter providers who were suspicious of the medical community. [...] The coalition members did not want to use volunteers because they wanted continuity of care delivered by full-time doctors who would be available to see their patients the same way we expect our primary care doctors to be available for us. [...] In retrospect, their demands were brilliant. (O'Connell, 2009, p. 80).

Founded in 1985 as a four-year pilot, BHCHP evolved into an ongoing program serving more than 12,000 vulnerable clients annually. BHCHP services are outlined in the following list (BHCHP, 2014):

- Medical and nursing care
- Pediatric care and family services
- Dental care and oral health services
- Medical respite care in our 24/7 Barbara McInnis House for patients who are too ill for the streets or shelters but not ill enough to qualify for hospitalization
- Mental health and substance abuse services
- HIV testing, education, counseling and treatment
- Case management
- Assistance with public benefits

No research evaluating the BHCHP model was discovered in literature.⁹⁴ Without research to evaluate the program and its results, there is no way to evaluate the program as a best practice. Still, it appears the program is widely respected and is considered successful by many professionals. The success attributed to BHCHP and program's wide acceptance points to the apparent wisdom of treating homeless clients with as much respect, attention, and care as anyone else.

⁹⁴ Dr. O'Connell was involved in developing the VI, discussed earlier in this research.

5.1.15 Ottewell Manor

Ottewell Manor (OM) is a 38 suite facility in Edmonton geared to vulnerable seniors (aged 55-65) (ASCHA, 2014). Although there are many internet resources referencing OM, there is little information related to programs and other specifics. As a result, there is little information to relay, let alone assess.

However, the survey respondent who mentioned OM brought it up as a model for working with other services to provide integration. They explained how the Greater Edmonton Foundation (GEF), which provides seniors' housing, had a lodge they no longer needed. GEF had the homeless-serving organization use the facility and its staff to create a new service for vulnerable seniors. Staff were retrained to become familiar with homeless clients. It is a collaboration between GEF, Alberta Health Services, and the homeless serving organization, which by the survey participant's assessment is a success.

5.1.16 Harm Reduction

Harm reduction theory (HRT) is defined as follows:

HRT is a concept and a standpoint that emphasizes asking and listening to individuals and groups to understand why and how they engage in risky behaviors. It provides guidance for helping reduce the health risks associated with those behaviors by communicating with individuals to develop a hierarchy of goals that, over time, protects the health of individuals and of those in their sphere of influence. (Haas & Mattson, 2014, p. 3)

HRT has five tenets (pp. 3-4):

1. Humanistic value, acknowledging people engage in risky behaviours and adoption of a non-judgmental approach.
2. Pragmatism, adopting a realistic attitude toward risky behaviours and a focus on a spectrum of harm-reducing steps.
3. Immediate goal-setting, meaning making goals to reduce the chance of harmful outcomes.
4. Empowerment, promoting individual choice in pragmatic goal-setting, based on a person's unique circumstances.
5. Community collaboration, developing settings and messages designed to cue harm-reducing actions.

HRT is used in many settings, from motorcycle safety to drug treatments.

In the HF context, harm reduction means “[p]articipants are not required to abstain from alcohol and/or drugs, and staff work consistently with participants to reduce the negative consequences of use according to principles of harm reduction” (Stefancic et al., 2013, p. 247). Harm reduction is a HF fidelity scale criteria (p. 247).

Research points to the effectiveness of harm reduction in reducing crime (Sadeghi, Habibi, Haghrrangbar, & Madanipour, 2013, pp. 499-500), reducing HIV infections intravenous drug users (Wodak & Maher, 2010, p. 71), and reducing drug use and improving attitudes (Habibi, Sobhi-Gharamaleki, & Bermas, 2011, p. 1548). Also, harm reduction is cost effective, though actual savings may ultimately depend on the provider and circumstances (Wilson, Donald, Shattock, Wilson, & Fraser-Hurt, 2015, p. S9).

There is considerable evidence for the effectiveness of harm reduction. There is also growing acceptance of harm reduction as an important tool and strategy for working with homeless youth (or those at risk) who are struggling with addictions. Vancouver's Insite program – a "safe injection site", is one of the most extensively researched addictions programs in the country, and the evidence of effectiveness is very compelling. Studies have identified that INSITE doesn't promote or lead to increased use or crime, but rather has had the impact of reducing HIV risk behaviours, improving public order and has led many participants to addictions treatment. (Gaetz, 2012)

In summary, based on the criterion used for this research, harm reduction can be considered a best practice. It meets all four characteristics.

- There is a body of evidence supporting efficacy of the model.
- The method has been tested across a diverse population in many locations.
- It has been accepted as a best practice by practitioners and professionals in the field and by government bodies.
- Tools are available to ensure the best practice is used correctly in diverse circumstances and populations.

5.1.17 Integrated Dual Diagnosis Treatment (IDDT)

IDDT is also known by the name Integrated Dual Disorder Treatment.

The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services. It helps people address both disorders at the same time—in the same service organization by the same team of treatment providers.

IDDT emphasizes that individuals achieve big changes like sobriety, symptom management, and an increase in independent living via a series of small, overlapping, incremental changes that occur over time. Therefore, IDDT takes a stages-of-change approach to treatment, which is individualized to address the unique circumstances of each person's life.

IDDT is multidisciplinary and combines pharmacological (medication), psychological, educational, and social interventions to address the needs of consumers and their family members. IDDT also promotes consumer and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation for many. (CEBP, 2011c)

Although the overall philosophy and service delivery of both ACT and IDDT are similar, there is a fundamental difference with regard to objectives and goals of the two models. In ACT, the overall goal is the reduction of hospitalizations, improvement of functioning, and retention of treatment. With IDDT, however, the overall goal is to assist the client in developing the motivation for treatment and change via stage-based interventions. (Neumiller et al., 2009, p. 251)

IDDT has been developed and researched for well over 30 years and is widely seen as best practice (Drake et al., 2001, pp. 469, 471). It is supported by research (Mangrum, Spence, & Lopez, 2006, p. 84; McGovern & Carroll, 2003, p. 1002; O'Brien et al., 2004, p. 707; Sacks, Chandler, & Gonzales, 2008, p. 141) and has been adopted by both professionals and government organizations (CEBP, 2011a).

IDDT also has a fidelity scale to ensure consistent application of the method (CEBP, 2011b).⁹⁵ However, since it was “developed to assess programs for people with severe mental illnesses (Quadrant II and IV), the developers do not recommend its application in addiction treatment populations (Quadrant III) or settings” (McGovern, Matzkin, & Giard, 2007, p. 114). Instead, the Dual Diagnosis Capability in Addiction Treatment (DDCAT) is put forward as a fidelity scale for use in treating people with less severe mental illness and more severe substance use issues (2007, p. 115; SAMHSA, 2011).

In summary, based on the criterion used for this research, IDDT can be considered a best practice. It meets three of the four characteristics.

- There is a body of evidence supporting efficacy of the model.
- It has been accepted as a best practice by practitioners and professionals in the field and by government bodies.
- Tools are available to ensure the best practice is used correctly in diverse circumstances and populations.

Curiously, researchers found programs delivering integrated supports to people with mental illness and substance use issues did not actually meet standards for delivering such care, though programs typically report they do (McGovern, Lambert-Harris, Gotham, Claus, & Xie, 2012, p. 209).⁹⁶ According to the findings, clients of such services have a one to two in ten (1:10 to 2:10) chance of getting appropriate treatment (p. 209).

5.1.18 Recovery-Oriented Services (ROS)

Recovery-oriented systems of care shift the question from, "How do we get the client into treatment?" to "How do we support the process of recovery within the person's environment?" (Dr. H. Westley Clark as quoted in Cotter, 2009, p. 43)

Eighteen elements of a recovery-oriented system of care were listed by leaders in the field at the 2005 National Summit on Recovery, organized by SAMHSA's Center for Substance Abuse Treatment (Center for Substance Abuse Treatment, 2007, pp. 7-9):

- Person-centered
- Family and other ally involvement
- Individualized and comprehensive services across the lifespan
- Systems anchored in the community
- Continuity of care
- Partnership-consultant relationships

⁹⁵ Motivational Interviewing (discussed on page 105 of the Appendix) is a component of the IDDT fidelity scale.

⁹⁶ The research used “standardized measures of program capacity to address co-occurring disorders, the dual diagnosis capability in addiction treatment and dual diagnosis capability in mental health treatment indexes, and sampled 256 programs across the United States.” (McGovern et al., 2012, p. 205).

- Strengths-based
- Culturally responsive
- Responsiveness to personal belief systems
- Commitment to peer recovery support services
- Inclusion of the voices and experiences of recovering individuals and their families
- Integrated services.
- System-wide education and training
- Ongoing monitoring and outreach
- Outcomes driven
- Research-based
- Adequately and flexibly financed

Many best practice principles found earlier in the literature review are clearly reflected in the 18 elements: person-centred, family and community involvement, individualized services, ongoing support, peer support, and outcomes-orientation. The elements also include some important integration topics: integrated services, system-wide education and training, and adequate and flexible financing.

Given the success of best practices outlined in this research, one would expect ROS to be similarly effective. Research supports this assumption. In an overview of the history ROS in the U.K. and the United States and a review of various ROS programs, Humphreys and Lembke say “in areas where rigorous research exists it indicates that recovery-oriented interventions improve individuals’ substance use and health outcomes in a cost-effective fashion, supporting the value of recovery-oriented public policy initiatives” (2014, p. 17).

ROS have been adopted by SAMHSA, which created a grant mechanism called Recovery-Oriented Systems of Care (ROSC) to “fundamentally transform existing treatment systems into networks of support for recovery” (p. 14). More recently, the Obama administration adopted recovery as “a cornerstone of US drug policy” (p. 14).

Is there a fidelity scale to ensure ROS are used consistently? Yes. However, Armstrong and Steffen note “[o]ne key challenge to fidelity assessment is lack of clarity in the model itself. Recovery is a highly idiosyncratic process that is difficult to operationalize and lacks consensus on key components” (2008, p. 167). They go on to assess the scale they developed as “rudimentary and, thus, requir[ing] more research to examine whether increased fidelity to the recovery model results in improved outcomes among persons in recovery” (p. 167).

Is it a best practice, then? Although there is no well researched and validated fidelity scale, the following can be said:

- There is a body of evidence supporting efficacy of the model.
- The method has been tested across a diverse population in many locations.
- It has been accepted as a best practice by practitioners and professionals in the field and by government bodies.

In fact, ROS are having an impact on existing best practices. For example, researchers have developed a more recovery-oriented version of the ACT fidelity scale, called the TMACT⁹⁷ (Monroe-DeVita, Teague, & Moser, 2011, pp. 22-23). Where the previous fidelity scale, DACTS,⁹⁸ was once the “gold standard” (Cuddeback et al., 2013, p. 319), more recently it has been criticized as missing some “critical ingredients” and suffering from a “emphasis on structure over process” (Monroe-DeVita et al., 2011, p. 19). TMACT is “a recovery-informed update of the DACTS” (Cuddeback et al., 2013, p. 319).

5.1.19 Social Impact Bonds

One respondent brought up “Social Impact Bonds.” Social Impact Bonds (SIBs) are an alternative method for government to provide social services.

Under the social impact bond model, a government contracts with a private-sector financing intermediary we’ll call a “social impact bond-issuing organization,” or SIBIO, to obtain social services. The government pays the SIBIO entirely or almost entirely based upon achieving performance targets. If the bond-issuing organization fails to achieve the targets, the government does not pay. In some cases, the government payments may be calculated as a function of government cost-savings attributable to the program’s success.

The bond issuer obtains operating funds by issuing bonds to private investors who provide upfront capital in exchange for a share of the government payments that become available if the performance targets are met. The bond issuer uses these operating funds to contract with service providers to deliver the services necessary to meet the performance targets. (Liebman, 2011, p. 2)

As of 2014, there were over 20 SIBs active in Australia, Canada, Germany, Japan, India, the United Kingdom, and the United States (G8 Social Impact Investment Taskforce, 2014, p. 14). Also, “Ireland, Israel, Korea, France, Italy, and Scotland are showing interest in this model” (Arena, Bengo, Calderini, & Chiodo, 2016, p. 1). In 2012, the British Columbia government passed legislation changing the province’s corporation law, allowing creation of the Community Contribution Corporation or C3—the equivalent of an SIB (Malcolmson, 2014, p. 3).

While being promoted as showing “real promise at driving better outcomes and spurring more rapid innovation,” (Liebman, 2011, p. 29) there is little evidence to date regarding the success or failure of the model (Loxley & Puzyreva, 2015, p. 8). Despite the “hype” of SIBs, the tool is still in its infancy and has a number of empirical, political, legislative, and logistical hurdles to clear before a model is available for generalization across jurisdictions, cultures, and economies (Arena et al., 2016, pp. 8-9).

5.2 THE PARTICIPATING ORGANIZATIONS

Seven respondents indicate they offer all three supports: housing, health, and employment. All seven appear to indicate they do not offer all three services directly, but in cooperation with other service agencies.

⁹⁷ Tool for Measurement of Assertive Community Treatment.

⁹⁸ Dartmouth Assertive Community Treatment Scale.

Three respondents indicated their organization offers housing and health supports. One respondent indicates their organization offers housing and employment. Another respondent indicates their organization offers a single service.

The most repeated self-identified characteristic of the organizations are “Offering Multiple Services,” (repeats five times). “Creativity” and “One Door for All Services” are characteristics repeated twice each.

The fact participants give multiple services as an organizational strength ties in with a fundamental of homeless services: multiple supports are required. So, it is positive to find organizations offer multiple services.

Two of the five respondents who indicate their organization offers multiple services also list “One Door for All Service” as an organizational strength—yielding one of the other coded repeats. Of course, this repeat is closely related to the first-most repeated coding and, again, a positive finding. Having a single access for all services keeps individual needs from falling between the cracks.

Creativity is the other repeat and, perhaps, not unexpected as a strength for homeless-serving-organizations. Dealing with multiple funding streams, multiple service offerings, and many clients with multiple issues would seem to require some creativity.

Three other non-repeating coded responses are worth bringing together: “Rapport – Relationship Building,” “Listen to Clients,” and “Offer Svcs in Sequence Clients Want.” All three are related and together build depth to the provider-client relationship. Rapport and relationship-building indicate the need for two-way communication and understanding, the way “Listen to Clients” and “Offer Svcs in Sequence Clients Want” cannot by themselves. Likewise, offering services to clients in the order they want provides direction where the other coded responses do not.

5.16 A SYNTHESIS OF SURVEY RESPONSES

Three things are striking about survey responses. One, responses are diverse, as varied as the organizations they come from. There is very little repetition in the base coding, though certainly some topics rise to the top.

Two, the advice and issues brought forward lead to a conundrum. How can themes be drawn from the whole without distracting from the value of each piece? Each is valuable and relevant. It behooves anyone planning or operating a homeless-serving organization to use all of it.

Three, stated clinically, clients are integral to programs. However, clinical terms do not convey how profoundly central clients are. In philosophical terms, at every step of a program, level of an organization, or dispensation of support clients are integral. They are to be woven into the fabric of programs and their governance, management, policies, systems, processes, supports, treatments, facilities, and locations.

With the preceding three thoughts in mind, the following sections focus on four survey topics: best operations practices, best planning practices, challenges in operating an integrated service, and responses to challenges.

5.16.1 Best Operating Practices

Regarding best practices in operating an integrated service, coded responses break down into the following categories: Client-Centred, Flexibility, Programs-Practices, and Training.

Client-Centred

This category is named after seven coded responses, “Client-Centred Focus.” The remaining coded responses in this category are “Acceptance of Clients’ States” (repeated three times), “Cooperative Operation of Facility” (repeated twice), “Individualized Programs” (repeated twice), “Dignity in Service to Clients,” “Engaging Clients,” and “Ensure Client Feedback is Built-in.”

Between the 12 respondents, “Client-Centred” approaches, activities, or outlooks were repeated 17 times, by far the most numerous response type. Respondents discussed the importance of having clients involved in all aspects of a homeless-serving organization—from executive functions to peer support, community engagement, floor staff, and property management activities. Others discussed involving clients in planning facilities, advising on operating practices and policies, and taking control of various aspects of facility operation.

Flexibility

Repeating once each, two responses fall into this category, “Adapt as Necessary” and “Learning Organization (flexibility).” While the concept of operational flexibility is an excellent philosophy to adopt, it is grounded in planning. A lot of forethought goes into developing an organization that can pivot and deal with whatever comes through the door.

Practices

Three coded responses are repeated twice each: “Excellent Communications,” “Harm Reduction,” and “Trauma-informed Practice.”

Training

Repeating once each, “Common Understanding Amongst Staff,” “Continuous Focus on Goals,” and “Staff Training” make up the Training category.

5.16.2 Best Planning Practices

Coding of best practices in planning results in a number of responses falling into a larger category “Collaboration.” Other responses do not fall under higher level categories.

Collaboration

As one might expect when contemplating an integrated program with independent actors, respondents mention collaborative activities or strategies most frequently—nine times. The repetition suggests a good deal of emphasis needs to be placed on planning collaboratively. Respondents recommended inclusive collaboration from start to finish on almost every aspect of a homeless-serving organization.

This category is comprised of seven coded responses, two of which repeat twice each: “Cooperative Planning of Facility” and “Involve Gov’t Health Authority.” “Cooperative Planning of Facility” refers to client involvement with planning facilities, another reflection of client-centred philosophy.

“Involve Gov’t Health Authority” is self-explanatory.

The remaining coded responses are “Align Planning with Higher Level Plans (e.g. Nat. Housing Strat),” “Ensuring Facilities are Well-designed – Appropriate,” “Integrated Planning,” “Involve Clients in Planning,” and “Open, Transparent Understanding of Funds Between Partners.”

Other Practices

Other practices include “Plan for Sustainability” (repeated twice), “Plan Grievance Process,” “Set Realistic Goals,” “Set Standards,” “Sketch Overall Plan Before Involving Others,” and “Who Leads the Program.”

While the remaining responses do not fall so easily into categories, they do have one thing in common. When inclusively and collaboratively planning, planners need to include all coded responses in the conversation.

“Sketch Overall Plan Before Involving Others” needs explanation. The respondent refers to how staff might be brought into the design and planning stages. Obviously, a new enterprise will not have staff at the very beginning and when they are brought on board they generally will expect some type of structure.

5.16.3 Challenges

Coded responses to questions addressing the challenges of planning and operating an integrated homeless-serving organization fall into six categories as follow: Client Challenges, Funds, Measurement, Need, Staff, and Svc Alignment.

“Svc Alignment” is the most broadly agreed-upon coding category, generating 16 repetitions amongst the 12 respondents. This is an interesting—if somewhat expected—result, in that it mirrors the top category generated in the previous section addressing best practices in planning. “Collaboration” is all about creating service alignment. Thus, the importance of collaboration and service alignment cannot be overstated.

Not surprisingly, the second-most populated coding category is Client Challenges, having 12 coded responses. It is not surprising to have client challenges at or near the top because programs are there to serve clients.

Likewise it is not surprising to see “Funds” near the top with 10 responses. Funding is an existential issue for all organizations, let alone those serving homeless people, and it often determines what services are offered.

Finally, it is worth addressing the coded response “Clients do not Wish to Work” listed under Client Challenges. While some clients may genuinely wish not to work, research discussed earlier contradicts this assertion. By-and-large, homeless clients wish to work (Acuña & Erlenbusch, 2009; Erlenbusch, Stevens, Towson, & Watts, 2010, p. 2; Poremski, Distasio, et al., 2015, p. 379). Many of those who may not desire work, instead may want to contribute in other ways—volunteering and peer support for example. Also, those not wanting to work may have arrived at that conclusion because of bad past experiences or a genuine belief they cannot meaningfully contribute. “People may not believe in their employment potential unless they have the self-determination to persist, or they have a trustworthy ally to bring possibilities to light” (Poremski et al., 2016, p. 24).

5.16.4 Responses to Challenges

Ten responses fall under four coding categories: Collaboration, Connecting with Community, Intensity of Service, and Staff. The remaining six responses are not categorized.

Overall, this question receives a fairly wide range of responses without much repetition. The coded category, Staff, has the most repeats; however, not by a significant margin. Coded responses falling under the Staff category include “Education for Staff & Sectors,” “Experienced Staff,” and “Peer Staff.” This points to the need for staff who are knowledgeable about homeless clients and educated about the organization, its goals, and approach.

6.0 DISCUSSION AND ANALYSIS

6.1 BEST PRACTICES

For decades, practitioners and researchers have worked and struggled to solve homelessness and—given limited successes in the past—there has been reason for discouragement. Thankfully, though, effort has yielded hope. From a macro point of view, we know what needs to be done. Gaetz et al. propose their six points (2014, p. 14) as addressing the majority of homelessness in Canada. Survey respondents echoed Gaetz et al.’s call for a national effort by proposing a national housing policy and program, along with a concerted effort to address poverty. The need for such a macro effort is supported by the earlier review of the history of homelessness—withdrawal of affordable housing support in the 1980s, deinstitutionalization in the 1950s through to the 1980s, and structural economic changes beginning in the 1980s and continuing today.

At the micro level, we have hope founded on real and reproducible successes. This hope is surfacing in popular culture. The *Washington Post* recently acclaimed Utah HF efforts as nearly ending homelessness. And, in Phoenix, AZ they declared HF as having ending veteran homelessness (McCoy, 2015a, 2015b). The Canadian Broadcasting Corporation has declared Medicine Hat the first city in Canada to end homelessness (Off & Douglas, 2015). Medicine Hat used HF.

Like any other methodology, HF is not perfect and the long run may not produce all the benefits we hope for. For example, after analyzing twelve published and 22 unpublished studies addressing cost savings related to HF, Ly and Latimer reveal we may find HF does not pay for itself after all (2015, p. 475). Other research of At Home/Chez Soi results concludes HF does not lead to a reduction in substance use after 12 and 24 months when compared to SC (Somers, Moniruzzaman, & Palepu, 2015).

Following a review of 67 HF research papers and analysis of five, Groton draws a similar conclusion: HF does not lead to a reduction in substance abuse. However, she also adds that mental health outcomes stay constant and finds the studies she reviewed lack the methodological rigor to conclude HF has “true merit” (2013, pp. 51, 61).⁹⁹ Her conclusion echoes 2012 research by Waegemakers Schiff and Rook (mentioned earlier) who stated there is “relatively sparse external scientific evidence or research on” HF and concluded designating HF a best practice was a political decision (p. 16).

Still, HF “is very successful, most especially regarding the primary outcome of enabling people with a mental illness who are homeless to find and maintain stable housing for an extended period of time” (P. N. Goering & Streiner, 2015, p. 1).

[...] HF can be successfully adapted to different contexts and for different populations without losing its fidelity. People receiving HF achieved superior housing outcomes and showed more rapid improvements in community functioning and quality of life than those receiving treatment as usual. (Aubry, Nelson, & Tsemberis, 2015, p. 467)

Of course, HF would not be HF without other supports like ACT and ICM.

⁹⁹ Groton also states HF “shows promise” (2013, p. 61).

The key principles of ACT – outreach, delivery of services in the community, holistic and integrated services, and continuity of care – continue to influence the structure of mental health services in profound ways over much of the world.

The structure and flexibility of ACT has permitted myriad adaptations. Thus, ACT remains relevant for service systems and clients with multiple needs in many settings. (Bond & Drake, 2015, p. 241)

However, these methodologies are not perfect either.

Among homeless adults with mental illness in 4 Canadian cities, scattered site housing with ICM services compared with usual access to existing housing and community services resulted in increased housing stability over 24 months, but did not improve generic quality of life. (Stergiopoulos, Hwang, et al., 2015, p. 905)

Nelson and Aubrey mention difficulties in engaging or re-engaging clients in work, volunteer, and educational activities. They also discuss the difficulty staff experience when having to deal with client crises, rather than focusing on client employment and how scarce educational and vocational opportunities are in the community (2014, p. 32).

Hopefully, these issues are simply teething pains on the way to developing a mature methodology for properly addressing homelessness. Hopefully, these methodologies (ACT, ICM, HF, and others)¹⁰⁰ will “continue to adapt over time, as new concepts, new environments, new stresses, and new empirically-supported practices emerge” (Bond & Drake, 2015, p. 241).

Regarding adaptation, one survey respondent currently using HF discussed the potential use of CTI in their programming. This brings up an interesting point. CTI focuses on transitioning clients from homeless to independent citizens. Although ACT principles dictate unlimited support, practitioners have moved away from that and are beginning to focus more on transitioning clients as well. ACT and CTI have similar principles but they are different approaches.

With housing as the lynchpin, perhaps it is possible to adapt programs to use different methodologies for the support aspect. It suggests that as long as methods are client-centred and adhere to best practices such as ACT, IPS, harm reduction, trauma-informed care, and others, programs can be more fully customized to particular needs or goals.

However methods evolve or are adapted, one thing appears central throughout. Programs cannot force people to change. Programs have to be client centred. Clients are the focus and supports must be delivered on client terms.

[...] [I]t’s all about listening and patience and realizing that you don’t have much control over the situation. You can serve, but you can’t control. (Dr. James O’Connell, as quoted in Bradley Ruder, 2016)¹⁰¹

¹⁰⁰ Note: In Bond and Drake’s paper, their quote refers only to ACT, not ACT, ICM, HF and others.

¹⁰¹ Dr. James O’Connell is the founding physician of the Boston HealthCare for the Homeless Program (discussed earlier), which has treated homeless people for more than 30 years.

Congregate Housing

A longitudinal report on housing retention at 28 HUD-sponsored congregate housing programs in Philadelphia says approximately half of tenants enrolled at the start left the program after 3 years. “More than ten percent, in fact, left within six months, and nearly a quarter left within the first year after entry” (Wong, Hadley, et al., 2006, p. x). Of the people who left their housing, only one-third did so for “positive” reasons (i.e. they obtained permanent rental housing, purchased a home, moved in with family or friends,¹⁰² et cetera) (pp. x,xi). As part of their recommendations, the authors state “[a]n array of permanent housing programs is required to match the diverse needs and preferences of homeless mentally ill persons and the extent of structure and supervision that consumers need” (p. 79).

For this reason, some argue congregate housing options need to be more thoroughly studied. They maintain more needs to be known about why people leave without achieving independence (Tsemberis, Henwood, Yu, Whoriskey, & Stefancic, 2012, p. 355). As discussed in section 5.7.2 regarding Common Ground, some object to the concentration of people with similar issues in a single location, along with the expense. Also, congregate housing facilities “are less likely to adhere to two important components of Housing First: housing choice and structure and the separation of housing and support services” (Polvere et al., 2014b, p. 18).

Still, congregate housing was successfully used in Vancouver as part of At Home/Chez Soi. Congregate housing is also capable of providing an intensity of care likely not possible in a scattered site setting (Nelson et al., 2013, p. 15). This is of particular concern for clients who have multiple and severe barriers to housing. Congregate care also provides a community environment and addresses feelings of isolation associated with the transition from street living to stable housing.

Also, Wong, Hadley, et al. offer a number of possibilities for mitigating the proportion of high-risk “leavers.” They propose additional client evaluations conducted at two points: 1) when clients seek housing and, 2) when clients indicate a desire for more independent housing (p. 79). They also propose creation of an “early warning system” housing agencies can use for identifying people at high risk of “unfavorable discharges,” whereby “hospitalizations, arrests, eviction notices, or behavior that places a resident at risk of these events” triggers an intervention (p. 79). In all, the authors make ten recommendations (pp. 78-80).

It should be noted, studies examining subjective quality of life among people with serious mental illness and living in “small congregate residences versus independent housing with supports” finds no differences in quality of life (Patterson et al., 2013, p. 1246).¹⁰³ This result is mirrored in Patterson et al.’s subjective quality of life analysis of the At Home/Chez Soi study in Vancouver (p. 1253). Arguably, positive quality of life outcomes are very important. Since congregate housing does not impinge on quality of life and since it provides similar benefits to scattered site housing, it should be an option available to homeless clients whenever they express an interest.

¹⁰² The authors state “departing to family and friends is characterized as a positive departure in some results and non-positive in others. Use of variant data sources has necessitated more ambiguity in this regard than certainly is preferable” (Wong, Hadley, et al., 2006, p. xi).

¹⁰³ Of course, quality of life is distinct from quality of housing. Earlier research concludes housing types and varying characteristics of housing used to support people with mental illness influence satisfaction with housing, though it does not change the “level of satisfaction with life” (Schutt, Goldfinger, & Penk, 1997, p. 192).

6.2 INTEGRATION

“All integration is local” (Leutz, 2005, p. 9). As there is no single model for integration, integration is a matter of developing a program in a particular location, for a particular set of clients with a particular set of needs, and with the particular partners and resources at hand.

Also, integration does not need to be complete to affect change in people’s lives. It is acceptable—and in many cases preferable—to work somewhere on an integration continuum. In fact, some researchers advise “[d]on’t try to integrate everything” (Leutz, 2005, p. 10).

In essence, integration needs to be accomplished with what is at hand. And, with that said, it can be designed in such a way to take a progressive or sequential approach to achieve better or fuller integration in the long run.

So how is this done? How are these principles and elements put into action?

Given the dimensions Konrad outlines, the IP discussed earlier can be fit to the structure. The IP does not complete the structure Konrad outlines, but it does add significantly to the picture. Where IP does fall short of filling in the blanks, it does so because IP is high level and is not geared to issues like staff training, case management practices, and financing.

To fill out the remainder of Konrad’s structure, earlier aspects discovered in the literature review and survey can be placed where they fit. Figure 13 illustrates how research findings can be arranged using Konrad’s dimensions. The following list lays everything out.

- **Partners**
 - Organizational Infrastructure is in place to implement homelessness plan/strategy and coordinate the homeless-serving system to meet common goals.
 - Ensure all required partners are engaged from the start.
 - Open, transparent understanding of funds between partners.

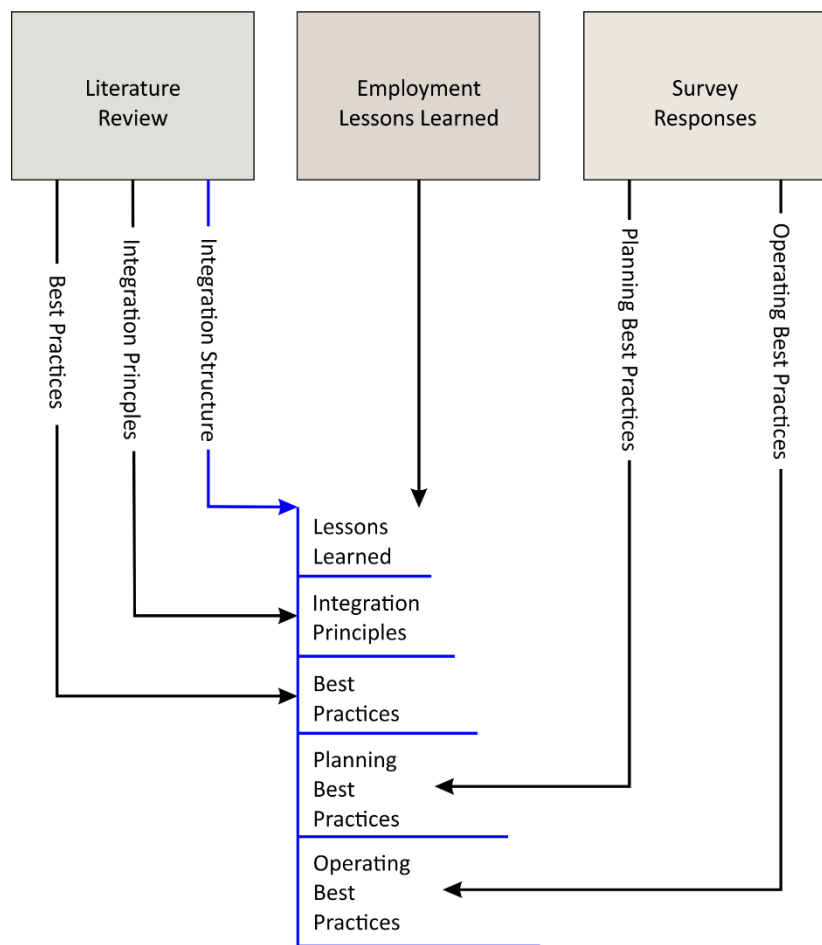


Figure 13 A framework for integration of best practices

- **Target Population**
 - Chronically homeless.
 - Program designed for dual diagnosed clients.
- **Goals**
 - Client Centred.
 - Housing is made affordable/accessible.
 - Integrated Support.
 - Harm Reduction.
 - Focus on the Employment Market.
 - Ongoing Supports available.
 - Ongoing integration with other providers.
 - Ongoing integration with municipal, provincial, and federal organizations.
 - Ongoing organizational learning to improve services in the long term.
- **Program Policy and Legislation**
 - Align with higher level policies, measures, terminology, standards, and other aspects to build a more integrated system.
 - Program built to address community (local) needs.
 - Program collaboratively planned with clients and stakeholders.
 - Partnership based on a well-understood Memorandum of Understanding covering all aspects of the program, including financing and outlining where responsibilities lie for all program dimensions.
 - Well-defined and agreed-upon roles and responsibilities.
 - Planning and Strategy Development process follows a systems approach grounded in the Housing First philosophy.
 - Periodic program evaluation and adjustment where performance measures indicate a need.
 - Advocate for municipal, provincial and federal service integration.
- **Governance and Authority for the Services Integration Initiative**
 - Strong governance structure that includes community and physician representatives.
 - Cohesive, organizational culture with strong leadership and shared vision of an integrated health care delivery system.
 - Client representatives included in governance structure/processes.
- **Service Delivery Model**
 - *Communications*
 - Program philosophy, policies, processes, standards, and other program fundamentals are communicated horizontally and vertically throughout the organization.
 - Good feedback mechanisms are built-in to ensure client issues are dealt with quickly and reliably (e.g. a good grievance process).
 - Good cross-shift and general communications mechanisms built into floor staff practices.
 - *Staff deployment and reporting*
 - Physician integration, particularly primary care physicians, by a variety of methods such as compensation mechanisms, financial incentives, and non-financial ways of improving quality of life.
 - Peer staff included.

- Staff should be experienced and committed to the program.
- *Training*
 - Staff must be trained on the services they provide and the clientele they serve.
 - Cross-training should be provided whenever possible (i.e. educated regarding services and cultures of other service organizations).
 - Each condition is treated as if primary.
 - Standardized care delivery through inter-professional teams and use of provider-developed, evidence-based clinical care guidelines and protocols.
- *Geographic location and service configuration*
 - Map services to determine existing resources and gaps.
 - Geographic coverage and rostering to maximize accessibility and minimize duplication.
 - Coordinated Service Delivery to facilitate access and flow-through for best client and system-level outcomes.
 - Systems Integration mechanisms between the homeless-serving system and other key public systems and services, including justice, child intervention, health, immigration/settlement, domestic violence and poverty reduction.
 - Supports are delivered by teams of specialists.
 - Program operated collaboratively with clients and stakeholders.
 - Plan service processes and policies to handle the diversity of clients and situations.
- *Case management*
 - ACT
 - ICM
 - CTI
 - Program caseloads are reviewed frequently
 - Treatment programs are individualized.
- *Other aspects*
 - Recovery-Oriented Services.
 - IPS
 - Outreach to engage homeless.
 - Trauma-informed care.
 - Use of paid peer staff.
 - Treatment must be tailored to each individual.
 - Support is intensive.
 - Supports do not arbitrarily stop.
 - Connection with community, workers, peers.
 - Support focuses on client recovery.
 - Support focuses on mitigating harmful behaviours.
 - Client is given control over treatment options.
 - Client is treated normally (e.g. given a standard lease).
 - Support follows/mirrors client progress.
 - Support is targeted to specific needs/clients.
 - Treatment focus on transitional phases of client progress.
 - Supports are integrated.
 - Program is designed to engender trust with the client.

- **Stakeholders**
 - Clients; client families, partners; executive; management; staff; peer workers; cooperating organizations; health authorities; local and extended communities; municipal, provincial and federal governments; funders; and others.
- **Planning and Budgeting**
 - Sound financial management.
 - Performance measurement is used to assess and guide operations.
- **Financing**
 - As much as possible, financing should be structured to allow programming flexibility.
 - Financing should be planned and structured to be sustainable for the long term.
- **Outcomes and Accountability**
 - Performance Management and Quality Assurance at the program and system levels are aligned and monitored along common standards to achieve best outcomes.
- **Licensing and Contracting**
 - Commit only to organizations that share the same vision and are committed to the same goals.
- **Information Systems and Data Management**
 - Integrated Information Management aligns data collection, reporting, intake, assessment, referrals to enable coordinated service delivery.
- **Evaluation Issues and Questions**
 - Choose performance measurements carefully to avoid focus on attaining measures instead of desired outcomes.
 - Where possible, align evaluation with common health and mental health measures to develop a wider integrated system.
 - Use best practices fidelity validation to ensure adherence to best practices.

As long as it is, the above structure is by no means exhaustive. Many general and pedestrian issues need attention and are not included. However, the structure gives a foundation or jump-off point for integration efforts.

In survey responses, Dr. Sam Tsemberis brought up an important issue relating to Gaetz et al.'s six strategies for ending homelessness in Canada—scale. Dr. Tsemberis said “if we were waving a magic wand here and you were going to develop a program to end homelessness, then I would say let’s stop tinkering around with housing 50 or 100 or 300 people. Let’s really end homelessness. Let’s bring this thing to scale.”

While it is important to integrate best practices with existing resources to support homeless people now, organizations like Streetohome can only do so much without higher level commitments in place. So, it is very important that organizations such as Streetohome advocate and lobby for more aggressive commitments to housing and poverty reduction strategies.

7.0 OPTIONS TO CONSIDER AND RECOMMENDATIONS

7.1 HOUSING

Consider the ten recommendations made by Wong, Hadley, et al. (2006, pp. 78-80), summarized below.

1. Permanent supportive housing is the “housing of choice” for clients and includes rent subsidies.
2. Thorough assessments should be used to match clients with appropriate supports and housing.
3. Additional evaluations should happen when clients seek housing and before they leave.
4. An array of housing choices should be made available to clients.
5. “Early warning systems” should identify clients at highest risk of unfavourable discharge.
6. Due to their high cost behaviours, “at risk” “leavers” may warrant an intensive program focused only on them.
7. Long-term housing is necessary but not sufficient to ensure continued independent living. Supports are crucial.
8. Housing locations should not be in neighbourhoods with high crime and drug use.
9. Clients at highest risk of unfavourable discharge should be tracked via an HMIS¹⁰⁴ to ensure they receive supports they need across jurisdictions.
10. Homeless-serving organizations should offer a variety of housing options allowing more independence.

7.2 HEALTH

Where possible, ensure clients are able to access primary health care as any other person does.

While this research could not find BHCHP to be a best practice, there appears to be much support for the humanity if not efficacy of programs offering primary care in a manner available to everyone else (i.e. not ad hoc walk-in clinics, volunteers, et cetera). One of the survey participants offered this as a recommendation. While this may be difficult to achieve because many physicians may not wish to work with high needs clientele and because it may be difficult to get clients to physicians, it ought to be part of a program to rehabilitate people who need the care most.

Place more emphasis on mental health and addictions treatment.

Based on a number of research studies, HF and other homeless-serving programs do not adequately address mental illness and substance use outcomes. HF is particularly effective in getting people housed and keeping them housed, but research indicates mental health and substance use remain status quo under a HF regimen. Supports may need to be more intense or other approaches developed.

7.3 EMPLOYMENT

As a first step to initiating an employment plan, ensure all partners commit to it.

In order for an employment program to be successfully implemented and operated as a support on par with housing and health, partners need to understand its place in the program and agree to

¹⁰⁴ Homeless Information Management System.

philosophies, policies, roles and responsibilities (i.e. a strong leader for each program aspect, including employment); funding structure and allocation; scope; budget; timing; and more.

Adopt IPS as the model for integrating employment services with other supports.

IPS is a well-documented best practice in wide use. It is entirely compatible with other best practices, in that it is client-centred; embraces housing, health, and addiction supports; promotes ongoing support; and is driven by client choice. Most importantly, compared to SC it improves the odds clients will have success.

Ensure employment program staff have strong clinical skills for working with homeless clients with mental illness and substance use issues. (Marshall, Rapp, Becker, & Bond, 2008, p. 892)

Staff turnover is a problem for many homeless-serving programs, an issue prone to aggravation when staff are unfamiliar with homeless clients and may not be fully educated about or committed to the program. Unfortunately, vocational staff with clinical skills and experience serving homeless clients are difficult to find. Most experienced employment staff serve clients with fewer and less intensive needs. The lack of experienced, trained staff requires a response: access to good training resources and incentives to retain experienced personnel.

When structuring an employment program, ensure there is one person responsible, who has authority to direct the program and who also has strong business skills.

Having strong leadership responsible for the program ensures the employment program does not become adjunct to the larger program, and not something for which responsibility is dispersed. If employment is to be as important as housing and health, it needs an equal part in program definition, design, implementation, operation, monitoring, and improvement.

Ensure program evaluation is a part of ongoing operation.

Descriptive evaluations as well as more rigorous evaluation designs, such as random assignment, can contribute to knowledge and practices regarding the provision of multiple services to chronically homeless individuals. (Rio et al., 2008, p. 81)

Employers need to be integrated into the process.

At a bare minimum, employers need to be actively engaged as program partners. Where possible, it may be better to involve employers in planning and operation of the program—thereby solidifying their understanding, commitment, and ongoing input.

The relationship needs to be two-way. Not only should the program offer human resources to employers, it should also offer assistance in other areas such as employment market intelligence, subsidies, grants, and other information that may be beneficial to employers. The Women Building Futures program offers an excellent example where they provide customized programs to support employers.

Jobs alone do not ensure economic stability for consumers. (U.S. Department of Health and Human Services, 2003b, p. 12)

While the IPS model accounts for this reality, it is important to ensure clients are not left to fend for themselves once employed. Experience shows placing homeless people in jobs can take one, two, three, or more tries before the one that “sticks.” People often need to have a number of different job experiences before they find one that works. Moreover, housing, health, and other supports should extend beyond employment.

Vocational rehabilitation services should involve employment in integrated settings for minimum wage or above. (U.S. Department of Health and Human Services, 2003b, p. 12)

Volunteer jobs may be suitable for some clients, but vocational supports need to focus on “real” jobs where clients contribute at the same level as others, thereby building confidence and ability to become independent.

Vocational rehabilitation services should explicitly address financial planning and provider education/support around disability benefits and entitlements. (U.S. Department of Health and Human Services, 2003b, p. 12)

As part of building client confidence and independence, learning life skills is important. It cannot be assumed clients will gain these skills on their own.

Vocational rehabilitation services should be made available to all mental health consumers. (U.S. Department of Health and Human Services, 2003b, p. 13)

Again, this point is part of IPS. Still, the overall program needs to ensure client awareness of employment possibilities at the outset, when they first come into contact with program personnel. Vocational supports should be “advertised” as strongly as other core supports.

This also involves establishing a “no-exclusion” policy. Anyone who expresses an interest in employment needs to have their interest addressed meaningfully.

Research the labour market.

Research can involve qualitative and quantitative methodologies, demand and supply side research, data gathering, focus groups, and assessing job desirability and accessibility. (ICF International, 2009, pp. 43-55)

Vocational services should involve family and friends in supporting clients’ efforts to work. (U.S. Department of Health and Human Services, 2003b, p. 13)

Involving family and friends may not always be possible, but where it is it engages and bolsters the support of those who often have a great deal of influence on clients.

7.4 INTEGRATION

Agreement on collaboration is paramount, from beginning to end.

Although there are various ways to structure an integration effort (e.g. Konrad), each integration effort has its own challenges and characteristics. Moreover, integrating services for homeless people is complex.

For these reasons, collaboration between all program partners is essential—from the definition and design stages to implementation, monitoring, and improvement. All program partners need to clearly understand philosophies, policies, roles and responsibilities; funding structure and allocation; scope; budget; timing; and more. To cement understanding and provide a framework for collaboration, all partners should sign a solid memorandum of understanding.

The most important tool that program planners and the community have to address impacts is a survey of all partners involved at the beginning of the project. Ask each to honestly define important issues, such as: program and organizational policies, cultural histories and philosophies, hiring practices, overall skill and experience of current staff, and other organizational issues that will ultimately impact this type of project. Once this survey is complete, it is an incredibly important foundation to use for discussions that will ultimately define the centralized, unified vision, mission, goals, and overall culture of the integrated employment and supportive housing project. (Rio et al., 2008, p. 55)

Review the Houselink program and infrastructure to gain insights on housing retention and employment outcomes.

Given Houselink outperforms other programs—including At Home/Chez Soi—regarding housing retention, its program is worth study. The fact the program also provides employment opportunities makes it all-the-more worthy of examination.

If not already in place, consider adding methods to gather housing retention, drug use, satisfaction with housing, satisfaction with life, and other data on a program-by-program basis.

By examining differing program outcomes, a database of key measures across programs may help identify practices that enhance or diminish positive outcomes. For example, data may be used to compare similar services and/or dissimilar services to pinpoint effective and detrimental practices. Of course, measures should reflect unique aspects of programs, but also should mirror commonly used measurements and benchmarks to allow ease-of-use for outside researchers and organizations.

Take the time to learn about other systems (Rio et al., 2008, p. 26), how to best work together, and eventually integrate the services to achieve goals.

Set clear performance standards based on the evidence-based model and be prepared to remove staff who do not meet them. (Marshall et al., 2008, p. 892)

Care must be taken to ensure performance standards are truly tied to outcomes and do not work against them. For example, using the number of job placements as a measure may lead staff to steer

away from the most vulnerable, as they often are the hardest to place and may be perceived as impediments to achievement of performance goals.

Also, since employment is influenced by circumstances beyond the control of a client, strategies should be available for job retention, labour market retention, and career advancement.

Ensure employment support workers develop a one-to-one relationship with their clients.

“Vocational services should be designed to allow clients to deal exclusively with 1 service provider to permit the development of a working alliance” (Poremski et al., 2016, p. 20). That is, employment support workers need to gain the trust of homeless clients in order to build the motivation and confidence necessary to apply themselves and obtain market jobs.

Create a training plan for the staff from different service systems.

Include training for managers and policy-makers that address the complex cultural and philosophical differences that exist between the systems.

Where possible, use clients and former clients (peer staff) as ambassadors to the community.

When resistance arises—either related to a particular project or to homeless services generally—usually it appears due to ignorance. Clients successfully dealing with mental health and substance abuse issues provide strong evidence of the power homeless services have on improving lives and the community at large. As mentioned by one of the survey respondents, PARC in Toronto has successfully had its clients represent the organization and particular projects.

The work of an ambassador does not have to be limited to community outreach and education. Clients and peers can be involved in other community activities.

If an equivalent position does not already exist, consider establishing a “boundary spanner” position.

A boundary spanner is someone who “conducts activities across the borders of the agency partnerships representing different systems. [...] This key staff person facilitates regular meetings of the partners, orchestrates activities across partner agencies, and instigates new activities, sometimes with allied organizations. These project leads are the glue, or the lynchpin, that hold projects together, keeps them on track, and facilitates progress toward agreed upon project goals” (Rio et al., 2008, p. 87).

Advocate for integrated provincial and federal housing and poverty programs and policies.

As pointed out by one of the survey respondents, Canada is unique in not having a national housing program. British Columbia is the only province to lack an anti-poverty program. Moreover, there is broad consensus that withdrawal of federal funds from affordable housing programs contributed to the current homelessness emergency. As a result, there is good reason to engage government in solving homelessness and poverty.

Advocate to governments and funders for adequate and flexible funding.

As outlined by ROS elements, funding needs to be adequate and flexible. Both inadequate and inflexible funding (i.e. tied to specific treatments) hamper efforts to apply recovery-oriented approaches and address outcomes.

Contact the Bissell Centre for information on how they operate their program to address poverty.

Because the Bissell Centre offers a wide variety of supports—including housing, health, and employment—and ties in with many Alberta government programs, their organization may provide insights into integrating diverse supports.

Connect with Calgary Urban Project Society for information on their program.

CUPS has a unique approach. While they do not directly address employment, they do so through a focus on education. Since Streethome wishes to focus on education, as well as employment, CUPS appears to be an ideal organization to exchange information with and explore the employment to recovery link.

8.0 CONCLUSION

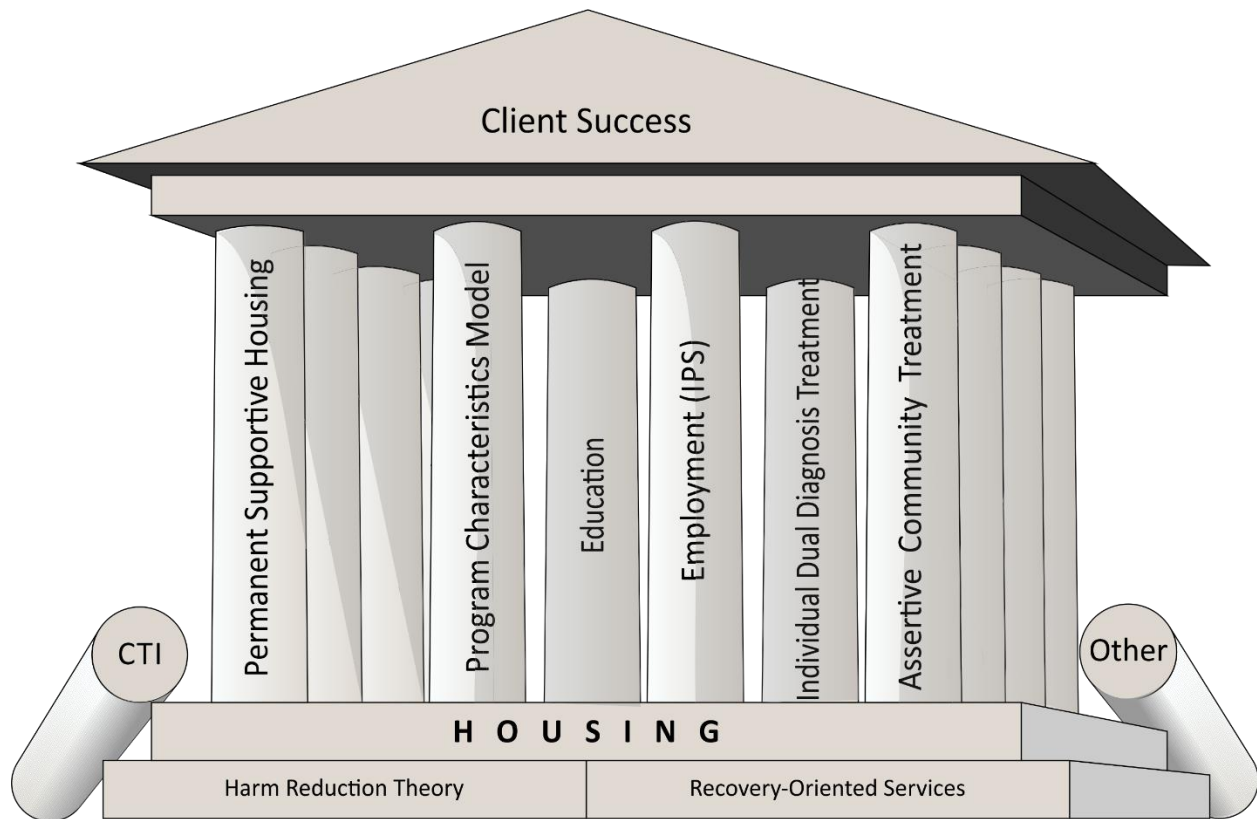


Figure 14 Building a Solution to Homelessness

Conceptually, Figure 14 illustrates a homelessness solution. The complete structure represents integrated supports. Client success is built on harm reduction theory, recovery-oriented principles and housing. Supports are delivered from that foundation by following HF philosophy, represented by the Permanent Supportive Housing, Program Characteristics Model,¹⁰⁵ and Assertive Community Treatment pillars—all of which are part of the HF fidelity scale.

The other pillars represent compatible methods to be applied as appropriate and as new and better methods become available. For example, education could be added to the supports delivered, provided the program is built on the three foundation pieces and alongside the other support pillars.

It should be noted, TMACT¹⁰⁶ includes SE (very closely related to IPS) as one of the evidence-based practices ACT practitioners are expected to use. TMACT also includes IDDT. The “Employment (IPS)” and “Individual Dual Diagnosis Treatment” pillars are presented for illustrative purposes.

So, there is good reason to be hopeful about solving homelessness. At the macro level, we have a good idea of structural changes required to address the bulk of our homelessness issue. With cooperation from federal and provincial governments, we can provide for the homeless and the marginally housed.

¹⁰⁵ The Program Characteristics Model (PCM) is from a “preliminary draft fidelity scale for supported housing that came out of [a] SAMHSA cross site study” (Stefancic, 2016). The HF fidelity scale uses aspects of the PCM.

¹⁰⁶ The most recent version of the ACT fidelity scale.

At the micro level, we have tried and tested tools to use. We can integrate services to create synergies. Sure, methods are not perfect, but what method is? Housing retention in many studies hover between 80 and 90%, a significant improvement over SC.

On the other hand, decades of relying on market forces for housing leaves a substantial affordable housing deficit. Inequality in western economies continues to worsen, gradually squeezing those at the margin from housing they once could afford. Ignorance-based stigma clouds many discussions of homelessness and the resources required to solve it. A quick search for online homelessness articles hosted on popular news sites and a subsequent read of article comments can be not just discouraging, but downright alarming. Gathering the required political support for housing and resources in such an environment appears daunting to say the least. Regarding our tools, they have a way to go when it comes to improving mental health, substance use, and enabling independence. None of even the most effective approaches are fully supported by rigorous scientific method.

What do we do then? Homelessness is an emergency—even if it continues decades later. Quite literally, lives are at stake, those never fully realized and those cut short. Obstacles and failings make it all the more urgent. It makes more sense now than ever before to apply what we know. Best practices are the way forward and integrating supports is the way to unify efforts. With new tools, homeless-serving organizations are in a better position than ever before to make a difference and lobby for resources. For once, compassion and dollars and cents are on the side of service providers.

Then again, it is unfortunate providers find themselves having to balance dollars and cents on one side and human lives on the other. Perhaps if best practices are distilled into a single thought, it is that all lives are worthy. Research is pointing to the need of treating our most vulnerable with the respect all lives deserve. Research is telling us to sincerely engage the homeless as equals and they will respond.

We have a plan. We have the tools. The solution to homelessness needs only will and resources.

9.0 APPENDIXES

9.1 BEST PRACTICE RESOURCES

Case Management

[Evaluating Your Program: Assertive Community Treatment](http://store.samhsa.gov/shin/content//SMA08-4345/EvaluatingYourProgram-ACT.pdf)

(<http://store.samhsa.gov/shin/content//SMA08-4345/EvaluatingYourProgram-ACT.pdf>)

[The Evidence: Assertive Community Treatment](http://store.samhsa.gov/shin/content//SMA08-4345/TheEvidence.pdf) (<http://store.samhsa.gov/shin/content//SMA08-4345/TheEvidence.pdf>)

[Intervention Summary: Critical Time Intervention](http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=367)

(<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=367>)

Employment

[Building Your Program: Permanent Supportive Housing](http://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-06-BuildingYourProgram-PSH.pdf) (<http://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-06-BuildingYourProgram-PSH.pdf>)

[Building Your Program: Supported Employment](http://store.samhsa.gov/shin/content//SMA08-4365/BuildingYourProgram-SE.pdf) (<http://store.samhsa.gov/shin/content//SMA08-4365/BuildingYourProgram-SE.pdf>)

[Creating Community Employment Pathways](https://www.hudexchange.info/resources/documents/CEPGuidebook.pdf)

(<https://www.hudexchange.info/resources/documents/CEPGuidebook.pdf>)

[Employment and Training for America's Homeless: Best Practices Guide](https://wdr.doleta.gov/opr/FULLTEXT/1997_09b.pdf)

(https://wdr.doleta.gov/opr/FULLTEXT/1997_09b.pdf)

[Employment and Training for America's Homeless: Report on the Job Training for the Homeless Demonstration Project](https://wdr.doleta.gov/opr/fulltext/94-homeless.pdf) (<https://wdr.doleta.gov/opr/fulltext/94-homeless.pdf>)

[Evaluating Your Program: Permanent Supportive Housing](https://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-05-EvaluatingYourProgram-PSH.pdf)

(<https://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-05-EvaluatingYourProgram-PSH.pdf>)

[The Evidence: Supported Employment](https://store.samhsa.gov/shin/content/SMA08-4365/TheEvidence-SE.pdf) (<https://store.samhsa.gov/shin/content/SMA08-4365/TheEvidence-SE.pdf>)

[Developing Community Employment Pathways](https://www.hudexchange.info/resources/documents/CEPGuidebook.pdf)

(<https://www.hudexchange.info/resources/documents/CEPGuidebook.pdf>)

[Ending Chronic Homelessness Through Employment and Housing: A Program and Policy Handbook for Successfully Linking Supportive Housing and Employment Services for Chronically Homeless Adults](http://www.csh.org/wp-content/uploads/2011/12/Report_CHETA_ProgramPolicy_Handbook1.pdf) (http://www.csh.org/wp-content/uploads/2011/12/Report_CHETA_ProgramPolicy_Handbook1.pdf)

[Opportunity Chicago: 2006-2010: Improving Access to Employment for Public Housing Residents in Chicago](http://cjc.net/wp-content/uploads/2012/06/OC-Evaluation_July2012.pdf) (http://cjc.net/wp-content/uploads/2012/06/OC-Evaluation_July2012.pdf)

[Supported Employment: A guide for mental health planning + advisory councils](http://usich.gov/usich_resources/solutions/explore/housing_first/)

(http://usich.gov/usich_resources/solutions/explore/housing_first/)

The Foyer Model

[Foyer Toolkit #1: What is a Foyer?](http://homelesshub.ca/resource/foyer-toolkit) (<http://homelesshub.ca/resource/foyer-toolkit>)

[The Foyer Foundation](http://foyer.net/) (<http://foyer.net/>)

[Live, Learn Grow: Supporting Transitions to Adulthood for Homeless Youth - A Framework for The Foyer in Canada](http://homelesshub.ca/sites/default/files/foyer_report23112012.pdf) (http://homelesshub.ca/sites/default/files/foyer_report23112012.pdf)

Homelessness

[A Plan for Alberta: Ending Homelessness in 10 Years](http://humanservices.alberta.ca/documents/PlanForAB_Secretariat_final.pdf)
(http://humanservices.alberta.ca/documents/PlanForAB_Secretariat_final.pdf)

[Strategies for Preventing Homelessness](https://www.huduser.gov/Publications/pdf/Strategies_for_preventing_Homelessness.pdf)
(https://www.huduser.gov/Publications/pdf/Strategies_for_preventing_Homelessness.pdf)

[The State of Homelessness in Canada: 2013](http://homelesshub.ca/resource/state-homelessness-canada-2013) (<http://homelesshub.ca/resource/state-homelessness-canada-2013>)

[The State of Homelessness in Canada: 2014](http://homelesshub.ca/resource/state-homelessness-canada-2014) (<http://homelesshub.ca/resource/state-homelessness-canada-2014>)

Housing First

[At Home/Chez Soi Project: Moncton Site Final Report](http://www.mentalhealthcommission.ca/English/system/files/private/document/at_home_report_moncton_eng.pdf)
(http://www.mentalhealthcommission.ca/English/system/files/private/document/at_home_report_moncton_eng.pdf)

[At Home/Chez Soi Project: Montréal Site Final Report](http://www.mentalhealthcommission.ca/English/document/32101/montreal-final-report-homechez-soi-project)
(<http://www.mentalhealthcommission.ca/English/document/32101/montreal-final-report-homechez-soi-project>)

[At Home/Chez Soi Project: Toronto Site Final Report](http://www.mentalhealthcommission.ca/English/system/files/private/document/At%20Home%20Report%20Toronto%20ENG.pdf)
(<http://www.mentalhealthcommission.ca/English/system/files/private/document/At%20Home%20Report%20Toronto%20ENG.pdf>)

[At Home/Chez Soi Project: Vancouver Site Final Report](http://www.mentalhealthcommission.ca/English/system/files/private/document/At%20Home%20Report%20Vancouver%20ENG.pdf)
(<http://www.mentalhealthcommission.ca/English/system/files/private/document/At%20Home%20Report%20Vancouver%20ENG.pdf>)

[At Home/Chez Soi Project: Winnipeg Site Final Report](http://www.mentalhealthcommission.ca/English/system/files/private/document/At%20Home%20Report%20Winnipeg%20ENG.pdf)
(<http://www.mentalhealthcommission.ca/English/system/files/private/document/At%20Home%20Report%20Winnipeg%20ENG.pdf>)

[Canadian Housing First Toolkit: The At Home/Chez Soi experience](http://www.housingfirsttoolkit.ca/sites/default/files/pdfs/CanadianHousingFirstToolkit.pdf)
(<http://www.housingfirsttoolkit.ca/sites/default/files/pdfs/CanadianHousingFirstToolkit.pdf>)

[Housing & Services Program Self-Assessment Survey](http://housingfirsttoolkit.ca/sites/default/files/Revised_HF_Self-Assessment_Survey_12-23-13.pdf)
(http://housingfirsttoolkit.ca/sites/default/files/Revised_HF_Self-Assessment_Survey_12-23-13.pdf)

[Housing First Europe: Final Report](http://homelesshub.ca/resource/final-reports-and-contributions-final-housing-first-europe-conference-amsterdam-june-2013) (<http://homelesshub.ca/resource/final-reports-and-contributions-final-housing-first-europe-conference-amsterdam-june-2013>)

[National Final Report: Cross-site At Home/Chez Soi Project](https://www.mentalhealthcommission.ca/English/system/files/private/document/mhcc_at_home_report_national_cross-site_eng_2.pdf)

(https://www.mentalhealthcommission.ca/English/system/files/private/document/mhcc_at_home_report_national_cross-site_eng_2.pdf)

[Performance Management in a Housing First Context: A Guide for Community Entities](http://homelesshub.ca/sites/default/files/CEGuide-final_0.pdf)

(http://homelesshub.ca/sites/default/files/CEGuide-final_0.pdf)

Integration

[A Framework for Measuring Integration of Behavioral Health and Primary Care](https://integrationacademy.ahrq.gov/atlas/frameworkIBHC)

(<https://integrationacademy.ahrq.gov/atlas/frameworkIBHC>)

[Beyond Housing First: Essential Elements of a System-Planning Approach to Ending Homelessness](http://policyschool.ucalgary.ca/?q=content/beyond-housing-first-essential-elements-system-planning-approach-ending-homelessness)

(<http://policyschool.ucalgary.ca/?q=content/beyond-housing-first-essential-elements-system-planning-approach-ending-homelessness>)

[Health Systems Integration - Definitions, Processes & Impact: A Research Synthesis](http://www.albertahealthservices.ca/assets/info/res/if-res-hswru-hs-integration-report-2007.pdf)

(<http://www.albertahealthservices.ca/assets/info/res/if-res-hswru-hs-integration-report-2007.pdf>)

[How integrated are homelessness, mental health and drug and alcohol services in Australia?](http://www.ahuri.edu.au/publications/download.asp?ContentID=ahuri_82013_fr&redirect=true)

(http://www.ahuri.edu.au/publications/download.asp?ContentID=ahuri_82013_fr&redirect=true)

Mental Health & Substance Use Treatment

[Behavioural Services for People Who Are Homeless: A Treatment Improvement Protocol TIP 55](http://store.samhsa.gov/shin/content//SMA13-4734/SMA13-4734.pdf)

(<http://store.samhsa.gov/shin/content//SMA13-4734/SMA13-4734.pdf>)

[Best Practices: Concurrent Mental Health and Substance Use Disorders](http://www.hc-sc.gc.ca/hc-ps/alt_formats/hecs-sesc/pdf/pubs/adp-apd/bp_disorder-mp_concomitants/bp_concurrent_mental_health-eng.pdf) (http://www.hc-sc.gc.ca/hc-ps/alt_formats/hecs-sesc/pdf/pubs/adp-apd/bp_disorder-mp_concomitants/bp_concurrent_mental_health-eng.pdf)

[Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and/or Co-Occurring Substance Use Disorders](http://store.samhsa.gov/shin/content//SMA04-3870/SMA04-3870.pdf) (<http://store.samhsa.gov/shin/content//SMA04-3870/SMA04-3870.pdf>)

[Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia](http://www.sfu.ca/content/dam/sfu/carmha/resources/hsami/Housing-SAMI-BC-FINAL-PD.pdf)

(<http://www.sfu.ca/content/dam/sfu/carmha/resources/hsami/Housing-SAMI-BC-FINAL-PD.pdf>)

[What Works: Effective Policies and Programs for the Homeless Population in Canada: Final Report](http://publications.gc.ca/collections/collection_2013/rhdcc-hrsdc/HS28-75-2007-eng.pdf)

(http://publications.gc.ca/collections/collection_2013/rhdcc-hrsdc/HS28-75-2007-eng.pdf)

9.2 SURVEY

Research Survey

GENERAL QUESTIONS:

1. What is your role in your organization? Underline one. Executive? Manager? Staff?
2. Does your organization integrate services for homeless people? For example, does your organization offer health care services (harm reduction, counselling, rehabilitation, etc.) or employment services along with housing?

If your organization does integrate services, what services are integrated?
3. Regarding your organization, what does it do best to serve the homeless?
4. If your organization were able to access additional resources to implement a new program or service, what would it be and why is that service important?
5. In your experience, what is the most difficult aspect of integrating services to serve the homeless?

How best is this challenge dealt with?
6. If you were to begin developing a new program to end homelessness, what would you do first and why would it be the first thing you did?
7. Are you aware of any programs for ending homelessness that integrate housing, health care, and employment services?

If so, what program is it and how well is the program working?

If the program is working well, why is that?

If the program is not working well, why is that?

PLANNING INTEGRATED SERVICES TO THE HOMELESS:

8. If you were to begin developing a new program to end homelessness and that program integrated housing, health care, and employment services, what would you do first?

Why would it be important to do first?
9. If you were to begin developing a new program to end homelessness and that program integrated housing, health care, and employment services, what do you anticipate would be the greatest challenge?

How would you go about overcoming that challenge?
10. What one planning principle or practice do you know to be essential in planning an integrated service for the homeless?

Why would you consider it essential?

OPERATING INTEGRATED SERVICES FOR THE HOMELESS:

Assume you are operating a service for homeless people that integrates housing, health, and employment services.

11. What one practice would you ensure is part of operational policy in order to most effectively deliver services and achieve your organizational goals?
12. What one operational challenge do you anticipate would be the greatest? Why would it be the greatest challenge and how would you address it?
13. What one operational principle or practice is essential in operating an integrated service for the homeless?

Why is it essential?

BEST PRACTICES IN INTEGRATING SERVICES FOR THE HOMELESS

When considering homelessness and best practices, assume that “best practices” means methods or actions having a two pronged effect. First, best practices affects process in such a way that those involved can do their jobs to the best of their abilities—without undue hindrance from poorly planned process or other administrative impediments. Second, best practices lead to desired outcomes such as permanent housing, good health, low or no relapses, independence, and so on.

14. In the table below, in right-hand columns (labeled “Best Practices”) please provide what best practices you have observed relating to the sets of integrated services specified in the left-hand columns (labeled “Integrated Services”).

Please provide answers for only those sets and types (Planning and/or Operational) of services you are familiar with. The table will expand as needed to accept more input.

	Integrated Services	Best Practices
Best Practices in Planning	Housing and Health Services	
	Housing and Employment Services	
	Housing, Health, and Employment Services	
Best Practices in Operations	Housing and Health Services	
	Housing and Employment Services	
	Housing, Health, and Employment Services	

15. If you have observed best practices that do not fit into the table above (question 14), what was it?
Why is it a best practice?
What were the impacts of the best practices?

9.3 INVITATION TO PARTICIPATE IN THE SURVEY (EMAIL)

Subject: Research - Best Practices in Integrating Housing, Health, and Employment Supports for the Homeless

Dear Mx Xxxxxx,

As a Master of Public Administration (MPA) student at the University of Victoria, I am conducting research and analyzing best practices in providing integrated services to the homeless. If my email should be directed to another person in your organization, please let me know or forward this email to them.

My research is being conducted for two reasons: To satisfy the requirements of ADMN 598, a graduate course completing my MPA degree, and providing information to the Streethome Foundation (Streethome). Streethome is a Vancouver, BC, Canada non-profit organization providing housing and related support services to homeless people. You may visit the Streethome website at the following location: <http://streethome.org>.

As part of this project, I will survey people working for organizations providing integrated services to homeless clients, and as such I am writing your organization today to request your assistance. It is important to gather data from people who have direct experience with homeless organizations and clients and day-to-day operation of organizations serving the homeless. Please forward this information-along with my email address-to people and organizations who may be interested in participating in this research. Survey participants will receive a copy of the completed research report for their information and use.

Participation in this research is important to my success and the ongoing success of Streethome. However, participation is entirely voluntary, and can be withdrawn at any time without explanation. The proposed survey takes approximately thirty to forty-five minutes, and addresses questions related to providing integrated services to homeless people. The survey can be filled out electronically (i.e. a Word document) or conducted over the telephone.

Any and all information collected during the survey will be treated confidentially, and responses will not be identified at the individual or organizational level in the final report. Specific examples or quotes may be cited anonymously, as will the overall data presented. As previously noted, if people decide to participate in this research they may subsequently withdraw at any time without reason or explanation.

Participants who have withdrawn will have their information destroyed and not used for the report.

I am excited to begin this project, and look forward to learning about experiences and knowledge regarding providing services to the homeless. I will follow up via email in the next week to confirm your receipt of this email.

If anyone in your organization would like to participate, please let me know. I look forward to hearing from you. If you wish, I will send a copy of the survey for review or use. I can also email a copy of the free and informed consent form for participation in this project. By doing so, I hope that your organization and other participants will feel at ease regarding the questions and subject matter covered. Please contact me if you have any questions or concerns, or require clarification. Thank you for your consideration.

Best regards,

Kerry Lange

MPA Candidate

School of Public Administration

University of Victoria

(250) 686-8195

UVic Email: krdlange@uvic.ca

Personal Email: kerrylange@islandnet.com7

PARTICIPANT CONSENT FORM

Integrating housing, healthcare and employment supports to end homelessness

You are invited to participate in a study entitled “Integrating housing, healthcare and employment supports to end homelessness” that is being conducted by Kerry Lange.

Kerry Lange is a graduate student in the department of Public Administration at the University of Victoria and you may contact him if you have further questions by email at krdlange@uvic.ca or by telephone at 250-686-8195.

As a graduate student, I am required to conduct research as part of the requirements for a degree in Public Administration. It is being conducted under the supervision of Dr. Barton Cunningham. You may contact my supervisor at 250- 598-9878. The research is conducted on behalf of the Streetohome Foundation (Streetohome), a non-profit organization providing permanent housing and supports to homeless people. You may visit the Streetohome website at www.streetohome.org.

Purpose and Objectives

The purpose of this research project is to discover best practices and policies that non-profit and other organizations use in delivering services to the homeless. Specifically, the research focuses on organizations integrating housing, health care, and employment services for the purpose of providing homeless people with permanent housing and ultimately independence. Research results will be used to inform the program of Streetohome. Research will also be shared with research participants so that their organizations can also benefit from the information gathered.

Importance of this Research

Research of this type is important because there is little available information regarding the integration of housing, health, and employment services in providing services to homeless people—although it is generally agreed that integration of these three services are essential parts of a solution for homelessness.

Participants Selection

You are being asked to participate in this study because your organization provides services to homeless people and it is important to draw from the experiences of people who work in such organizations.

What is involved

If you consent to voluntarily participate in this research, your participation will include either answering questions via telephone or filling out a survey. In either case, it is expected that your participation will require approximately 30 to 45 minutes. In the case of a telephone interview, a transcription will be made in order to capture the information provided. Filling out a survey will involve answering questions using a word processed document.

Inconvenience

Participation in this study may cause some inconvenience to you, including the time required for answering questions via telephone or by filling in a survey and returning it to the researcher.

Risks

There are no known or anticipated risks to you by participating in this research.

Benefits

The potential benefits of your participation in this research include receiving a complimentary copy of the completed research material, advancement of knowledge in the field of providing services to homeless people, and better informed practices and policies available for organizations serving the homeless.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will only be used if you give your explicit permission. Otherwise, if you withdraw from the study, your data will not be used and will be permanently deleted.

Anonymity

In terms of protecting your anonymity, you will not be identified unless you explicitly consent to receiving credit for participation in the research. If you do not provide your consent to receive credit for your participation, a pseudonym will be used to protect your identity and your data will not be linked to your organization.

If your participation requires permission from a supervisor, that supervisor, management, and executive will be aware of your involvement in the research. As a result, participants wishing to maintain anonymity must refrain from using information that could be used to identify them. For example, participants should refrain from referring to specific circumstances unique to them that others are aware of.

Confidentiality

Your confidentiality and the confidentiality of the data will be protected by storage on the researcher's computer. Data will not be shared with other people or organizations.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways:

- Drafts and final copies will be shared with the research supervisor,
- Drafts and final copies will be shared with Streetohome,
- A verbal presentation of the final copy will be made to Streetohome executive and staff, and
- Final copies will be shared with research participants.

Disposal of Data

Data from this study will be disposed of by erasure of electronic files once the study is complete. Final copies of the study may be kept indefinitely by Streetohome, the researcher, and study participants.

Contacts

Individuals that may be contacted regarding this study include the researcher and the research supervisor.

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

Name of Participant

Signature

Date

[WAIVING CONFIDENTIALITY] *PLEASE SELECT STATEMENT only if you consent:*

I consent to be identified by name / credited in the results of the study: _____ (Participant to provide initials)

I consent to have my responses attributed to me by name in the results: _____ (Participant to provide initials)

A copy of this consent will be left with you, and a copy will be taken by the researcher.

9.5 THE MEANING OF BEST PRACTICES AND INTEGRATION

9.5.1 Meaning of Best Practices

“Best practices” is a term used frequently in homelessness literature. However, there are few definitions in the literature.¹⁰⁷ From an academic or scientific perspective, it usually means a practice verified through rigorous experimentation. Unfortunately, ethical and logistical barriers make scientific experiments related to homelessness difficult if not impossible in most circumstances. Although there has been significant research completed on many aspects of homelessness and services, there is little—if any—research that conclusively points to a scientifically robust method of solving homelessness.

For example, while analysing research related to HF—widely accepted as a best practice—Waegemakers Schiff and Rook determine that HF became a best practice by political decision (2012, p. 17). Their research examined eighteen quantitative HF studies, concluding that there is “relatively sparse external scientific evidence or research on” HF (Waegemakers Schiff & Rook, 2012, p. 16).

Having “sparse external scientific evidence or research” to go on, this research defines best practices as a combination of “scientific evidence and/or expert consensus” (Health Canada, 2002, p. 23). “The approach used in developing this report [is] a detailed review and synthesis of the research literature, expert and key stakeholder opinion” (Health Canada, 2002, p. 23).

This research considers four characteristics to determine whether a method or process is a best practice.

- **There is a body of evidence supporting efficacy of the model.** This means there is a majority of evidence pointing to the effectiveness of the model in affecting the change it is meant to make.
- **The method has been tested across a diverse population in many locations.** This means the method has been successfully used (i.e. it produces the change it is meant to) in more than one or two circumstances and locations.¹⁰⁸ It is an indication the method will work in other circumstances and locations (i.e. it is generalizable). In some cases, this may mean it has been used internationally. In other cases, it may mean it has been used in many circumstances and locations within North America.
- **It has been accepted as a best practice by practitioners and professionals in the field and by government bodies.** This indicates the method is not simply a one-off success or perhaps an as-yet unverified promising practice.
- **Tools are available to ensure the best practice is used correctly in diverse circumstances and populations.** It is important the method is applied consistently across locations and time or the effects it typically produces may weaken. Fidelity scales are commonly used. Bond, Becker, and Drake write “Mental health reform rests on the wide-scale adoption of EBPs¹⁰⁹ that are faithfully implemented. Fidelity scales are the lynchpin of both scientific advances and quality improvement”(2011, p. 136).

¹⁰⁷ Waegemakers, Schiff, and Rook’s “Housing First: Where is the Evidence?” (2012) is an exception, as their research addresses the definition explicitly, though from a scientific-only point of view.

¹⁰⁸ This does not mean 100% effective. No practice the author has found purports or reports success levels of 100%.

¹⁰⁹ Evidence-based practices.

For the purpose of this research, if a method meets at least three of the four characteristics above, it is considered a best practice.

9.5.2 Bringing housing, healthcare and employment supports together

Although the word *integration* is not used in the research question, it is implicit, particularly in reference to delivering health-related services. Both because integration is implicit in the research question and because fragmentation of services is commonly seen as an impediment to properly serving homeless people, this research addresses service integration.

9.5.3 Meaning of Planning and Practice

In this research, “planning” refers to development of a plan of action related to delivering services. It also means overall guidance of an organization’s operation (i.e. strategic direction or leadership).

“Practice” means the delivery of services and day-to-day operation of an organization.

9.6 DETAILED REVIEW OF EMPLOYMENT GUIDES AND REPORTS

This section reviews four documents: *Employment and Training for America's Homeless: Best Practices Guide* (1997), *Ending Chronic Homelessness through Employment and Housing* (2008), *Creating Community Employment Pathways* (2009), and *Opportunity Chicago: 2006-2010* (2010).

9.6.1 Employment and Training for America's Homeless: Best Practices Guide

Employment and Training for America's Homeless: Best Practices Guide (“BPG”) is a ‘how-to’ guide for employment and training agencies on tailoring their service delivery” to be more effective in helping homeless people get and retain gainful employment. It is a “hands-on” guide, and it provides fairly detailed information on operating a vocational program for homeless people, even including telephone scripts for job seekers (Kessler-Beck, Trutko, Isabell, Rothstein, & Barnow, 1997, p. F-1). BPG material was gathered mostly from the experiences of 63 organizations across the U.S. who provided services to homeless people under the Job Training for the Homeless Demonstration Program¹¹⁰ (JTHDP) (Kessler-Beck et al., 1997, p. 1-1).

The BPG suggests the following services are required by homeless people seeking employment (Kessler-Beck et al., 1997, pp. 1-6 to 1-7):

- case management and counseling
- assessment and employability development planning
- job training services, including remedial education, basic skills training, literacy instruction, job search assistance, job counseling, vocational and occupational skills training, and on-the-job training
- job development and placement services
- post-placement follow-up and support services (e.g., additional job placement services, training after placement, self-help support groups, mentoring)
- housing services (e.g., emergency housing assistance, assessment of housing needs, referrals to appropriate housing alternatives)
- other support services (e.g. child care; transportation; chemical dependency assessment, counseling, and referral to outpatient or inpatient treatment as appropriate; mental health assessment, counseling, and referral to treatment; other health care services; clothing; and life skills training)

All suggested services above harmonize with best practices already discussed in this research. At the beginning of the document, the BPG states it emphasizes the following themes¹¹¹ throughout (Kessler-Beck et al., 1997, pp. 1-7 to 1-10):

Establish Linkages with Homeless-serving Agencies.

This theme, along with the accompanying explanation is fairly straightforward. When offering vocational services to homeless people, relationships with homeless-serving organizations is essential.

¹¹⁰ The program spent \$55.7 million and operated from September 1988 to November 1995, serving over 45,000 people.

¹¹¹ “Themes” is the term used in the BPG.

Stabilize Homeless Individuals Prior to Enrollment.

In explaining this theme, the BPG sets out an ostensibly solid recommendation—that homeless people should be housed prior to enrollment in a vocational program. However, the BPG explains the precondition, stipulating that people need to be “stable” before enrollment and then expands the meaning with a statement about “screening out serious substance abusers and those who are mentally ill and unlikely to benefit from participation in [a] program.” Indeed, when discussing recruitment, the BPG asks practitioners to screen for participants with the following characteristics (Kessler-Beck et al., 1997, p. 2-1):

- (1) are eligible for participation
- (2) are motivated to participate in employment and training activities
- (3) have a high probability of completing training and upgrading their basic and work-related skills
- (4) once trained, have a high probability of securing and retaining a job

The first two characteristics—eligibility and motivation—make sense and do not contradict any of the best practices reviewed earlier in this research.

Regarding the second two characteristics, the BPG specifies this type of screening because homeless outreach programs have limited resources and administrative capacity (Kessler-Beck et al., 1997, p. 2-1). The idea is to affect the largest change possible with the resources available. The BPG bolsters its argument by pointing to successes of the JTHDP and hammers home the idea *the program* will be successful if clients are properly screened.

The program is important of course, but it is more important that *the client* is successful. Screening in this manner goes against a core philosophy driving best practices—a client-centred approach. Best practices give a great deal of control to clients, including determination of the services they get and when they get them. While clients may lack one or more essential skills, stopping or delaying them from moving forward while motivation drives them will likely lower motivation and hope. Addressing their desire for employment immediately can lead to the client’s realization that other issues also need to be addressed. Interestingly, the BPG acknowledges that “[d]own time’ can be dangerous for a homeless person,” adding “most JTHDP sites found they had a greater chance of success if they began some type of training or education at once” (Kessler-Beck et al., 1997, p. 3-10).

Moreover, screening people because of substance abuse and mental illness directly contradicts the IPS principle of enrolling clients as soon as they express an interest in getting a job. IPS requires immediately working with homeless people to get employment while simultaneously addressing substance abuse and mental illness.

Provide Thorough Assessment and Ongoing Case Management.

Like the first theme, this theme is fairly straightforward and intuitively would seem a best practice. Indeed, HF, CTI, CCISC, ACT, ICM, and IPS require this support.

Arrange for Short-term Job Search Assistance.

Again, this theme is straightforward and is supported by IPS and ACT.

Provide Basic Skills and Work Readiness Skills Training.

The explanation for this theme stipulates “[s]ome homeless individuals need basic and/or work readiness skills training prior to training and employment.” There is no getting around the need for

basic workplace skills and behaviours like punctuality, working with others, basic math, and literacy. On the other hand, if made a prerequisite, this BPG condition puts a barrier between the homeless job-seeker and employment. If handled poorly, it delays entry into the vocational program and the workforce. Rio et al. provide an excellent explanation of how to go about this task (2008, p. 55), presented in the next section on page 106.

Provide Follow-up and Support.

This is another straightforward theme, agreeing with best practices discussed earlier in this research.

Provide Staff Training on Serving Homeless Persons.

This theme refers to the fact there are many vocational counsellors and volunteers performing similar functions not familiar with serving homeless people. Of course, it is essential to train people on the clientele they serve.

9.6.2 Ending Chronic Homelessness through Employment and Housing

Ending Chronic Homelessness Through Employment and Housing: A Program and Policy Handbook (ECH) “draws upon the lessons learned and best practices from five (5) pioneering communities”¹¹² and research to “assist and inform service providers, program planners, policy makers, and community leaders” in understanding “the key ingredients, operational procedures, and policy implications for establishing an effective approach to providing employment and housing services to formerly homeless individuals with multiple barriers to employment and housing stability.” The handbook is based on the results of the Ending Chronic Homelessness Through Employment and Housing program (ECHEH), a five year effort providing subsidies to 297 housing units, funded¹¹³ by three branches of the U.S. Department of Labor¹¹⁴ (Rio et al., 2008, p. 1). Programs operating through ECHEH were based on PSH principles (Rio et al., 2008, p. 3) and resulted in 59% of participants earning income, 44% gaining competitive jobs, 24% getting “protected or subsidized” jobs, and 4% becoming self-employed (Rio et al., 2008, p. 2).

ECH is divided into eight chapters. The remainder of this section is broken into eight sub-sections reflecting ECH chapters.

9.6.2.1 Getting Ready – People and Programs

This first section deals with initial coordination of people, organizations, and services. It covers the following topics: spanning boundaries in partnerships and making use of interagency strengths through collaboration, employment readiness and access to employment services, preparing qualified staff, and models of partnering with mainstream local vocational agencies.

The experience of these projects suggests that the success of the partnerships depended upon a lead organization identifying a person whose job it was to span the boundaries of these various organizations and the systems they represent. (Rio et al., 2008, p. 6)

¹¹² Boston, MA; Indianapolis, IN; San Francisco, CA; Los Angeles, CA; and Portland, OR.

¹¹³ \$23.6 million.

¹¹⁴ Office of Disability Employment Policy (ODEP), the Employment and Training Administration (ETA), and the Veterans Employment and Training Service (VETS).

ECH embraces the SE and IPS principle of offering immediate avenues to employment to anyone who displays an interest in work (Rio et al., 2008, p. 7).

Best Practices and Lessons Learned (Rio et al., 2008, p. 11)

- Planning an integrated supportive housing and employment services program requires careful consideration of shifting programs and practices from traditional linear approaches to a more customized foundation, in which services are responsive to the interests, preferences, and capabilities of chronically homeless individuals.
- In this approach, employment and housing services are offered concurrently, not sequentially.
- No single agency can meet all of the needs of the chronically homeless population.
- Better linkages with the mainstream workforce investment programs are essential for developing a long-term, sustainable employment services.

9.6.2.2 Integrating the Systems Required for Effective Service

As suggested by the title of this section, it deals with integration of systems, as opposed to service delivery integration. ECH presents the following information: programmatic lessons learned through ECHEH, building on local systems design, qualitative and quantitative program measures, connecting clients to the behavioural health and homeless assistance systems, supportive housing models to consider, understanding the impact of earned income on housing and other benefits, considerations in building a program, the importance of oversight committees, identifying a champion for the program, understanding legislation and regulations supporting employment, and common challenges and suggested solutions.

Best Practices and Lessons Learned (Rio et al., 2008, p. 26)

- Integration of all services begins at the beginning. It is crucial to ensure that different system policies, philosophies, and practices have been fully discussed, examined, and coordinated prior to implementing the project. Without this preliminary work, it is impossible for direct services staff to operate a truly integrated employment and housing project.
- Take the time to make sure all systems fully understand the target population of the project and their service needs. Examine these needs in the context of the different service funding available to the project. Map potential funding to each need, to determine where the gaps are and what a comprehensive, fully funded, system will look like.
- Create a training plan for the staff from different service systems. Include trainings for managers and policy-makers that address the complex cultural and philosophical differences that exist between the systems.
- Take the time to learn about other systems, how to best work together, and eventually integrate the services to reach the project goals.

9.6.2.3 Establishing the Employment Service in Supportive Housing – Helping Tenants Choose, Get, Keep a Job

ECH introduces the “No Wrong Door” approach, along with helping clients choose career goals, the “Work First” philosophy, career mapping, marketing job seekers and services to employers, types of jobs typically gained, and techniques for helping clients keep their jobs.

Best Practices and Lessons Learned (Rio et al., 2008, p. 41)

- Establish a no wrong door program orientation that not only allows access to services from almost any point but to do so regardless of how well prepared people are for competitive employment. Follow a zero exclusion policy: everyone who expresses the desire to work can access employment services.
- Marketing job seekers to employers requires building a professional working relationship with businesses in the community that acknowledges the needs of the employers, and also provide new information and resources to the employers.
- Helping participants maintain employment is influenced by a number of factors beyond the individual features of the worker. You can, and should, design program strategies for job retention, labor market attachment, and career advancement.

9.6.2.4 Essential Elements and Structure of an Integrated Services Team

This section addresses service delivery strategies at the operational level, as opposed to the systems level. ECH presents a number of concepts, including the role of the “champion,” training of staff and practitioners, and communication.¹¹⁵

As part of communications, ECH introduces another best practice, Motivational Interviewing (MI) (Rio et al., 2008, pp. 48-50) as both a philosophy and technique for motivating homeless clients. The *Handbook of Community Psychiatry* devotes an entire chapter¹¹⁶ to MI, calling it “an empirically supported intervention and a well-recognized counseling style [...] widely disseminated and implemented in a variety of physical and behavioral health practices” (Koutsenok, 2012, p. 202). In fact, it turns out MI is a best practice within a best practice. MI is included in the HF fidelity scale (Stefancic et al., 2013, p. 247). Also, one finds many references to MI in literature dealing with best practices (Bond, 2004, p. 351; Bond, Drake, McHugo, Rapp, & Whitley, 2009, p. 573; Collaborative Community Health Research Centre, 2002, p. 145; Engelhardt et al., 2009, p. 115; Herman et al., 2007, p. 308; Neumiller et al., 2009, p. 255; O’Campo et al., 2009, p. 974) and is listed in SAMHSA’s National Registry of Evidence-based Programs and Practices (SAMHSA, 2014b).

In short, MI meets all four characteristics of a best practice, as outlined earlier in this research.

MI has four basic principles (Koutsenok, 2012, pp. 204-205).

1. Express Empathy Through reflective listening, the counselor tries to understand the client’s feelings and ideas with-out criticizing, judging, or arguing. It is important to emphasize that understanding is not equal to agreement or approval.
2. Develop Discrepancy Instead of the professional taking responsibility for the patient’s change, telling them how important it is, how they could accomplish it, and why it is important for them to want to do it, it is critical to hear their own rationale, hesitations, and discrepancies.

¹¹⁵ The handbook goes so far as to cover how to hold meetings, conduct staff meetings, and how often meetings should occur (Rio et al., 2008, pp. 45-47).

¹¹⁶ The chapter is part of a section entitled “Practicing Core Clinical Competencies and Techniques,” indicating MI’s core role in modern psychiatry.

3. Roll with Resistance Resistance to change is a normal human behavior. It illuminates patients' desires and fears, and multiple expressions of resistance are valuable sources of information about the dynamics in the client–counselor interaction. [...] If a practitioner uses his/her power as the “expert” to make them change, the patients will immediately favor homeostasis, i.e., no change, and this is likely to become a power struggle rather than effective counseling.
4. Support Self-Efficacy In order to engage patients and maintain their level of active participation, it is important to support their belief that they are actually capable of making the change, and if they decide to do so, they may have a number of good ideas about how it can be done.

Best Practices and Lessons Learned (Rio et al., 2008, p. 51)

- Service coordination in and of itself is not enough. Coordination efforts must achieve the goal of helping participants—particularly those who may face significant barriers to working—receive the services they need to obtain and keep employment.
- It is important to start your program with looking at the other agencies and groups that serve the same population. Building partnerships at the beginning of a program allows for better integration and problem solving.
- Staff needs to be cross-trained to understand each other's functions and support each other. This cost and time needs to be built in up front.
- The best approach to work with participants is consumer focused. This requires listening to the participant and understanding the stages of change.

9.6.2.5 Factors Impacting Employment and Supportive Services for the Target Population

This section covers individual, organizational, and societal barriers and assets for homeless people seeking employment and support.

Best Practices and Lessons Learned (Rio et al., 2008, p. 55)

- It is important for staff to assist participants identify, understand, and potential issues and behaviors that will impact their ability to pursue and attain employment goals. In order to do this staff should take the time to work with participants to develop a Person-Centered or Individual Service Plan, which not only uncovers the participant's personal skills, interests, talents and gifts, but also highlight the specific steps, activities, and supports needed in order to pursue these goals.
- The most important tool that program planners and the community have to address impacts is a survey of all partners involved at the beginning of the project. Ask each to honestly define important issues, such as: program and organizational policies, cultural histories and philosophies, hiring practices, overall skill and experience of current staff, and other organizational issues that will ultimately impact this type of project. Once this survey is complete, it is an incredibly important foundation to use for discussions that will ultimately define the centralized, unified vision, mission, goals, and overall culture of the integrated employment and supportive housing project.

9.6.2.6 Administrative Operations and Funding Strategies

The administrative nuts and bolts of operating an employment service for homeless people are covered in this section. Topics covered include the basics of program administration (record keeping and file maintenance); data collection, management, and reporting; protecting client confidentiality; supporting and retaining skilled staff; and funding employment services in supported housing.

9.6.2.7 Evaluating a Housing and Employment Services Program

An overview of the ECHEH evaluation process, and the Portland location in particular, is used to illustrate the process of program evaluation. The section covers the following topics: conducting the evaluation and evaluation findings (expectations of clients, challenges, program strengths and challenges, and demographic findings).

Best Practices and Lessons Learned (Rio et al., 2008, p. 81)

- A formal program evaluation may not be required but may be in the best interests of program planners, funders, program participants, and others.
- Descriptive evaluations (e.g., Portland example) as well as more rigorous evaluation designs (e.g., LA example), such as random assignment, can contribute to our knowledge and practices regarding the provision of multiple services to chronically homeless individuals.

9.6.2.8 Lessons Learned and Policy Implications

The last section begins with information about ECHEH: its results, the investment made, and the evaluation. The bulk of the section is dedicated to the overall ECHEH lessons learned, summarized below. At the end of the section, ECH outlines suggested next steps to improve employment outcomes for chronically homeless job seekers.

Overall ECHEH Lessons Learned (Rio et al., 2008, pp. 85-91)

- *Community leadership from Workforce Investment Boards¹¹⁷ (WIBs) is a key element of improving employment services and outcomes for the chronic homeless population.*

ECH emphasizes that local WIBs are “cornerstones” for ECHEH-like employment programs (Rio et al., 2008, p. 85). Unfortunately, there is no direct WIB equivalent in Canada, making it more difficult to translate this particular lesson learned to a Canadian (or other national) context.

That said, part of this lesson learned relates to incentives to provide vocational services to homeless people and the potential tensions created for programs attempting to meet certain performance goals. Vocational program leaders may view homeless people as needing more

¹¹⁷ These Boards are charged with the responsibility of convening stakeholders and forming partnerships to create and implement viable strategic action plans for workforce services within each jurisdiction. 8 WIBs are established and funded by the Workforce Investment Act of 1998. The Act defines the overarching policy framework for the workforce system, the membership and responsibilities for WIBs, as well as providing a primary funding stream through state governments to each local WIB.

The local WIBs advance workforce systems in their regions by developing strategic action plans. In an effort to create “demand-driven” systems, WIBs must have a membership comprising more than 50% representation from the key business sectors of the region. Legislation also requires that business representatives on the WIBs are decision-makers within their company: either C-level (Chief Executive Officer, Chief Operating Officer, etc.) or Human Resources directors. In addition to planning, local WIBs also administer and oversee employment and business services delivered through “One Stop Career Centers”. (Yerichuk, 2009, p. 12)

intensive resources than a “regular” client, thereby reducing motivation to serve them. Efforts are needed to address attitudes that serving homeless people creates a drag on the organization, seeing as performance measures may create a disincentive to serve the homeless. As discussed in the previous section, for that very reason the BPG took an approach of pre-screening clients to ensure program success.

- *It is possible to effectively combine employment services with permanent housing assistance to improve the well-being of individuals who are chronically homeless.*

Although the earlier JTHDP program and ECHEH prove workforce systems and resources can be successfully targeted to homeless job seekers, necessary funding and performance incentives need to be in place to make the effort work. In the case of ECHEH, additional funding of over \$23 million was made available for the five city program. Similarly, future efforts will need corresponding financial commitments from the federal government.

- *The goal of ending chronic homelessness through employment and housing will only be realized through collaborations across multiple systems.*

ECH emphasizes the fact that no one system by itself can end homelessness, but takes multiple systems—making coordination the foundation of any program providing employment services to the homeless. In fact, some systems have built-in disincentives which need to be overcome through change management and collaboration.

ECH also introduces the concept of a “boundary spanner,” someone who “conducts activities across the borders of the agency partnerships representing different systems. [...] This key staff person facilitates regular meetings of the partners, orchestrates activities across partner agencies, and instigates new activities, sometimes with allied organizations. These project leads are the glue, or the lynchpin, that hold projects together, keeps them on track, and facilitates progress toward agreed upon project goals.” (Rio et al., 2008, p. 87).

ECH outlines how systems will vary from location to location, some requiring many relationships between many partners, and giving the Los Angeles project as an example having to coordinate services between 19 agencies. ECH lists three key lessons for building collaborations:

1. Give planning the time, attention, and respect it deserves. You will pay the price if you don’t.
 2. Be sure to include in planning people who are fully aware of the challenges posed by the target population and existing agency priorities and constraints, yet who are committed to the ultimate project goals and open-minded as to how they may be accomplished.
 3. Create a project governing structure that can handle issues at every level, from service delivery to individual participants to changes in agency operating procedures that affect many participants to policy development and long-range planning.
- *Access to training services and intensive services for chronically homeless job seekers through the Workforce Investment Act¹¹⁸ (WIA) funded One Stop Career Centers is limited because of a*

¹¹⁸ Superseded by the Workforce Innovation and Opportunity Act (WIOA) on July 22, 2014 (One Hundred Thirteenth Congress of the United States of America, 2014).

combination of competing priorities, limited funding, and high performance measures that create a disincentive to serving the chronically homeless.

Canadian and other national environments do not have a directly equivalent WIA. As a result, in the Canadian context (and other national contexts) this lesson learned is more of a general acknowledgement of how well-intentioned legislation can interfere with improving the welfare of homeless job seekers. As touched on in an earlier lesson learned, WIA creates certain performance goals for “One Stop Career Centers,” some of which create disincentives to serve homeless people because of their perceived inherent high-needs and difficult behaviours.

- *Targeting resources and services to people who are chronically homeless results in increased employment and more stable housing.*

This is the most important lesson learned. It can be done. ECH points to positive results across all five ECHEH locations, as well as other programs.

- *Mental health care and substance abuse treatment are essential to move people from unemployed street dwellers to permanently housed wage earners.*

This is emphasized earlier in the ECH through reference to the number of systems needed to serve homeless job seekers. ECH reinforces the need for mental health care and substance abuse treatment, adding that collaboration between the vocational programs and behavioural health care systems can be uneven if incentives are not there. ECHEH participants reported that their mental health partners did not entirely embrace employment as a core component of their efforts to end homelessness.

- *Federal housing programs for homeless people with disabilities, especially those funded by the McKinney-Vento Act, can do more to promote employment of tenants.*

This lesson learned cannot be translated directly into other national employment environments since the legislation is American. However, similar circumstances exist in Canada. ECH discusses the frequent difficulty homeless job seekers met while working toward employment. For example, a client might be cut from a program immediately once they are able to pay 100% of fair market rent for their home—ignoring the fact that many clients often fall back into homelessness after they initially achieve independence. Or, a client might have their program impacted if they received child support from a non-custodial parent.

Overall, this lesson learned reflects a reality in many jurisdictions. Eligibility rules for one program might prevent participation in another beneficial program.

9.6.3 Creating Community Employment Pathways

As is the case with ECH, this document is based on experiences and institutions in the U.S.

Creating Community Employment Pathways (CCEP) is a guide “to provide practical advice to communities seeking to create more effective means of helping people who are homeless obtain and maintain employment.” It is a “systems-level” guide for “program planning and design as well as how to manage systems change” (ICF International, 2009, p. 2). The guide presents information required to complete the following tasks (ICF International, 2009, p. 3):

- Clarify and verify the needs of your target population
- Envision an ideal system and create goals for your organization
- Create a CEP¹¹⁹ report with action steps to address employment for homeless people
- Evaluate current partnerships and clarify what your organization has to offer a partnership
- Think about and “map” resources in your community
- Increase buy-in from mainstream providers and other potential partners
- Create new partnerships with employment providers

CCEP opens with an outline of a CEP in a fictional town, as follows (ICF International, 2009, p. 8).

Community Employment Pathways, Anytown, USA

Anytown, USA has identified 350 people who are homeless on any given night, and estimates that nearly 800 become homeless over the course of a year. Eighty percent of the individuals interviewed stated that they either are working or want to work. The lead agency for the Anytown Continuum of Care and the local WIB decide to start a committee to create employment opportunities for this group. The research committee takes a closer look at the homeless population, and discovers that 12 percent of the individuals homeless over the course of a year meet the definition of chronic homelessness, and that 45 percent are homeless families. The research committee also investigates the local market, looking for needs within the business sector that can be met by this group. The committee’s research shows a severe labor shortage in the nursing home industry and a general lack of mid-range job opportunities (\$10 - \$20 per hour wages). The community is successful in attracting a new auto parts assembly plant to the community, but planners for that activity are not thinking about people who are homeless.

The Anytown planners identify the following three targets:

1. Create a sector initiative with business leaders in the nursing home industry.

Design industry specific training and certification for care aides, clerks, cooks, and groundskeepers. Make it accessible to people who are homeless. Provide it, if possible, on site at homeless shelters. Allow individuals multiple ways to meet performance benchmarks to streamline access to industry jobs. Obtain funding through the WIB and the nursing home industry. Set targets of 250 people trained and 100 jobs retained after six months.

2. Create job training programs that will lead directly to mid-range jobs offered by the new auto assembly plant.

Set a target of employing up to 60 people (including homeless families and people who are chronically homeless within this number). Use WIB funding, with city/county support.

¹¹⁹ Stands for “Community Employment Pathways,” an initiative with “three primary goals: Increase the number of homeless people in the workforce, expand access to existing employment services and expand investment dollars from multiple systems to address education and training needs of homeless job seekers, and improve critical cross-systems (housing, treatment services, and employment services) linkages so that homeless job seekers have the needed housing, support, and training to be successful” (ICF International, 2009, p. 2).

3. Create or provide access to transitional jobs for up to 35 people who are chronically homeless.

Apply for funding from the WIB to support transitional jobs in the construction industry, using Individual Training Accounts (ITAs) to secure individualized supports for individuals, which might include job coaches. Partner with SSA and other agencies administering benefits to ensure that homeless jobseekers understand the impact of work on their eligibility for benefits and take full advantage of available work incentives.

Chapter 1 of the CCEP is simply an introduction to the document, outlining what readers can expect and how to use the guide. Chapters 2 through 5 take readers through the steps of developing a CEP—from initiating and managing the change from SC to a collaborative system to strategies for overcoming barriers and meeting performance goals once the CEP is operating. Chapter 6 gives readers background information about homeless job seekers. Chapter 7 covers WIA and the agencies it funds. In chapter 8 readers will find guiding principles for maintaining momentum and enthusiasm for a collaborative enterprise. Each chapter includes relevant worksheets and forms readers can use to develop the CEP. See Figure 15 for a document overview.

The remainder of this section about CCEP is structured in sections following CCEP chapters two through eight.

9.6.3.1 Preparing for Change (Ch. 2)

Step 1: Build a Climate for Change

Step 1 deals with how to work with stakeholders in the Continuum of Care,¹²⁰ the mainstream employment system, employers, and allies such as local business organizations, charities, religious organizations, and other community bodies.

Step 2: Build Linkages between Service Providers and One-stop Career Centers

The second step addresses types of collaborative relationships an organization can develop with various partners: cooperative, coordinated, and collaborative models. Cooperative represents the least formal relationship, coordinated the middle ground, and collaborative the ideal situation where systems are well-integrated. See Figure 3 on page 10 for a graphic illustration.

Step 3: Build a Structure for Change

The third step outlines developing a structure to formalize collaboration across organizations. It recommends the following structure for the six to twelve month timeline it takes to develop a CEP:

- The initiative is led by a steering committee that sets the tone for the initiative, promotes it to important stakeholders, and ultimately sets the agenda for change.
- Three workgroups conduct research on the community's employment outlook, characteristics of homeless jobseekers, and services and supports available in the community. These workgroups report to the steering committee.
- A boundary spanner is assigned by his or her employer to staff the initiative, building bridges across agencies and systems.

¹²⁰ Continuum of Care in the CCEP guide means the service delivery agencies available at a particular time in a certain location.

- A community leadership group meets less frequently than the steering committee or workgroups, and includes stakeholders who are less involved in the initiative but provide valuable perspectives—local employers or faith-based organizations might participate, for example. This group advises the steering committee.

This section also brings up the “boundary spanner” role. As with the ECH boundary spanner, the CEP boundary spanner “engages members of the different systems to set into motion activities that bear on the vision of a better system. He or she works with and between partners to implement the CEP initiative’s goals and plans, troubleshoots when things are not going right, and keeps the process moving” (ICF International, 2009, p. 26).

Step 4: Secure Funding and Resources for the CEP Initiative

This step discusses developing a budget and finding sources of funding.

Step 5: Guidelines for the CEP Initiative

The fifth step addresses the steering committee, its role and initial tasks. This step also brings up the topic of “exemplary practices,” something it defines as “evidence-based” and “promising practices” (ICF International, 2009, p. 36). It recommends using the SAMHSA SE evidence-based practice KIT, which includes a number of SE documents, including two documents referenced elsewhere in this research (SAMHSA, 2009a, 2009b).

9.6.3.2 Researching Community Needs and Resources (Ch. 3)

Step 6: Research Your Labor Market

Step six covers research, including qualitative and quantitative methodologies, demand and supply side research, data gathering, focus groups, and assessing job desirability and accessibility.

Step 7: Learn the Services and Support Available to Homeless Job Seekers

Step seven discusses identifying employment supports, determining available community supports, and evaluating accessibility and eligibility.

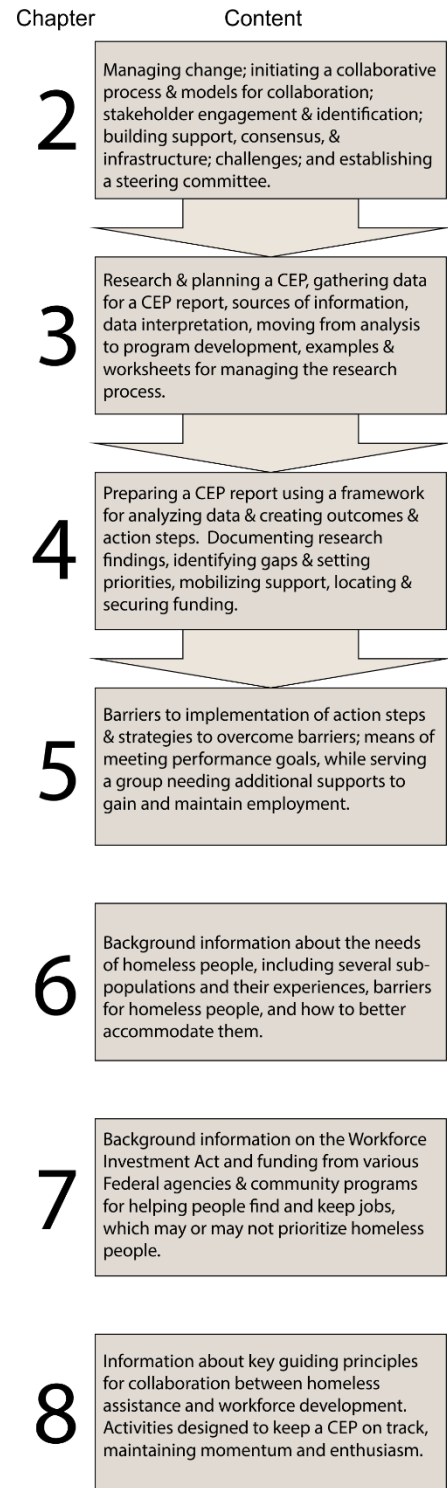


Figure 15 Outline of Creating Community Employment Pathways

Step 8: Identify Funding Streams for Community Employment Pathways

Step eight outlines the housing assistance system, the workforce development system, “braiding”¹²¹ of funding, and influencing workforce planning processes.

9.6.3.3 Developing a Formal CEP Report (Ch. 4)

Step 9: Look for Models in Other Communities

This step addresses only the process of reviewing funding models in other jurisdictions. It includes a number of examples.

Step 10: Set the Stage for Action

Step ten walks through the process of developing the formal CEP report, which the CEP initiative will be based on. It covers providing context for the report, presenting the material, acknowledging stakeholders and partners, and describing what field research revealed.

Step 11: Recommend Specific Action Steps

Step eleven describes the final CEP report as a roadmap, designed with “appropriate signage, mile markers, and rest stops along the way as well as opportunities for easy exit and entry ramps” (ICF International, 2009, p. 79). It discusses developing a graphic to illustrate how tasks and responsibilities are distributed amongst partners and stakeholders; setting goals or making recommendations regarding state and local policy, program development, access to One-Stop Career Centers, job placement, staff training, cross-system linkages, existing funding and expanding investments; prioritizing recommendations; developing a presentation; considering other plans to end or reduce homelessness; local workforce investment plans; involving government agencies; and approaching media about the plan.

9.9.3.4 Implementing Action Steps from the CEP Report (Ch. 5)

The last “action” step discusses pilot projects, barriers to effective implementation, addressing barriers, improving relationships among stakeholders, maintaining focus, engaging outside or different people for their perspective on the issue of homelessness, building the case for collaboration, finding champions, supporting the boundary spanner, and addressing concerns about WIA performance measures.

9.6.3.5 Understanding the Needs of Homeless Job Seekers (Ch. 6)

The first background chapter discusses homeless subpopulations, the experiences of homeless job seekers, the under and unemployed, and barriers to employment and addressing them.

9.6.3.6 Building Blocks for Community Employment Pathways (Ch. 7)

The second background chapter discusses resources for homeless job seekers, mainstream resources, and targeted programs.

9.6.3.7 Conclusion (Ch. 8)

The last chapter outlines keys to collaboration and key activities such as transforming organizational relationships, “under-promising and over-delivering,” and reporting on progress.

¹²¹ Braided funding means linking two or more funding streams paying for discrete component parts of a service, in this case employment services, while allowing for separate tracking and reporting of outcomes as these programs require. (ICF International, 2009, p. 62)

9.6.4 Opportunity Chicago: 2006-2010

Opportunity Chicago: 2006-2010 – Improving Access to Employment for Public Housing Residents in Chicago (OC) (Parkes, Holt, Lee, Theodore, & Cook, 2012) is a report documenting the results of a five-year program involving almost 7,000 public housing residents with the purpose of finding employment for 5,000 of them. The program spent \$80 million (Parkes et al., 2012, p. 9).

While circumstances of program participants were not as dire as homeless people, the program does address a population at the margins of society, some of whom may have been at risk of becoming homeless or who may have been homeless previously. At the beginning of the program, 68 percent of participants were either consistently unemployed or sporadically employed (Parkes et al., 2012, p. v), a characteristic shared with homeless populations, though not nearly to the same proportion. Being at the margins and being largely unemployed or sporadically employed, it may be argued these public housing participants were in a situation similar to people in a SE environment, though participants were not assessed with regard to mental illnesses or substance misuse.¹²²

An interesting and perhaps instructive aspect of the program is its use of different support types. Table 8 outlines the supports and provides a brief description of each.

Table 16

Opportunity Chicago Employment Programs (Parkes et al., 2012, pp. 4-8)

Support Name	Description
FamilyWorks	A voluntary case management program provided by six organizations. The program was designed to incorporate case management, employment assistance, education and training, children and youth services, housing, clinical and wellness services, and senior supportive services.
Transitional Jobs	This program for people with little or no work history combined skill development, supportive services, and temporary employment placements.

¹²² Based on available Chicago Housing Authority administrative data, the typical participant was 35 years old, non-Hispanic, African American, and female. More than half of participants (57 percent) had at least a high school degree, 4 percent were seniors (65 and older), and 12 percent were disabled. Across all participants (and including all sources of income), the median household income was \$14,359. More than a third (36 percent) of participants received wage income, with median annual wage earnings of \$14,897. Participants also received income from a variety of non-wage sources: 16 percent received Temporary Assistance for Needy Families (TANF), 16 percent received General Assistance, 10 percent received Social Security Insurance (SSI/SSDI), 9 percent received unemployment insurance, 8 percent received child support, and 6 percent received Social Security (SS). (Parkes et al., 2012, p. 9)

Table 16

Opportunity Chicago Employment Programs (Parkes et al., 2012, pp. 4-8)

Support Name	Description
Bridge and Technical Skills Training Programs through City Colleges of Chicago	This option included a variety of career programs with technical-occupational skills training (certificate and advanced certificate programs) in addition to more traditional Associate Degree programs. CCC also offered GED, ESL and Career Bridge Programs for those who needed to improve their reading and math skills while preparing to enter the workforce. Through Career Bridge, students prepared for entry into a particular career sector (like healthcare) by learning the vocabulary and basic concepts necessary for success in that field.
Workforce Investment Act Services (WIAS)	WIAS were provided through a system of partners and are divided into three levels as mandated by federal law: universal services, intensive services, and training. Universal services included access to job listings, self-guided resume and interviewing preparation, and career planning and exploration tools, among others. Intensive services included skills assessments, assistance with barriers to employment, case management, career development, and job retention/advancement assistance. Technical training was provided through a range of approved providers.
Industry Skills Training	Industry Skills Training targeted training efforts in specific high-demand industries and sectors, which initially included: transportation / warehousing / logistics (TWL), healthcare, manufacturing, hospitality, and basic office skills training.
Contextualized Literacy Services	Aimed at CHA's working-age residents with reading levels between the 4th and 9th grades, literacy services were contextualized to targeted sectors and occupations, with supportive services and established linkages to employers resulting in direct employment placements. Contextualized literacy was introduced because stand-alone literacy classes were not producing strong results.

Key results of the program are presented in Table 9.

Table 17

Employment Results of the Opportunity Chicago Program (Parkes et al., 2012, p. 14)

Support	# of Participants	# Who Worked after Exit¹²³	% Who Worked After Exit
All Participants	6,743	5,185	77%

¹²³ For all programs except FamilyWorks or Service Connector placement assistance, exit represents the last exit date a participant had from any part of the program. For FamilyWorks/Service Connector the exit date represents the same quarter that a participant's job placement started - i.e., the point at which the placement assistance stopped.

Table 17

Employment Results of the Opportunity Chicago Program (Parkes et al., 2012, p. 14)

Support	# of Participants	# Who Worked after Exit¹²³	% Who Worked After Exit
FamilyWorks ¹²⁴	4,532	3,720	82%
Transitional Jobs	1,793	1,359	76%
Bridge & Technical Skills Training ¹²⁵	1,403	989	70%
WIAS Participants	493	377	66%
Industry Skills	345	245	71%
Contextualized Literacy	64	35	55%

All but one support yielded two-thirds or more participants employed when they exited the program. Without the housing component, it is difficult to imagine how the program could have been as successful.

Perhaps significantly, FamilyWorks—including case management and wrap-around supports—produced the most impressive results. This is consistent with what researchers and practitioners have come to associate with best practices such as SE.

OC presents key findings and lessons learned through the program, as summarized below (Parkes et al., 2012, pp. vi-x).

Lessons Learned about Managing Partnerships

- Abandon individual silos and agendas and work together on a single goal and collective approach.
- Secure a reputable convener and facilitator.
- Build a strong collaborative with relationships across stakeholders.
- Secure commitments of leadership.
- Integrate and align restricted and flexible funds to support innovative program models.
- Learn from mistakes and make corrections.

Lessons about Aligning Supply and Demand

- Targeting a single population provides advantages and challenges.
- Consider “hooks” and incentives to increase program participation.
- Case management and wrap-around supports are essential program elements.

Lessons around Data Collection and Usage

Agree at the outset on how data will be collected, stored, and analyzed.

¹²⁴ Participants who received job placement assistance through a FamilyWorks or Service Connector Case Manager.

¹²⁵ Excludes 236 Bridge & Technical Skills Training participants (10%) who did not have a SSN and could not be matched to IDES data. In addition, participants exclude about 1,000 Bridge & Technical Skills Training students who participated in orientation but did not enroll in additional coursework or training.

Lessons about Replicability

- Moving to Work (MTW)¹²⁶ designation is essential, but is not available to all public housing authorities (PHAs).
- An ability to leverage and align resources is critical to maximize impact.
- Recruit leadership with the ability to shift (sometimes ineffective) public funds.

Lessons about Workforce Systems Change

- There is greater collaboration across a range of partners who did not work together historically.
- There is greater attention to the unique needs of public housing residents.

Greater alignment and collaboration exists with the Chicago Workforce Investment Council (CWIC).

¹²⁶ A demonstration program of HUD, Moving to Work provides public housing authorities the opportunity to design and test innovative, locally-designed strategies using Federal dollars more efficiently, helping residents find employment and becoming self-sufficient; and increasing housing choices for low-income families. (Parkes et al., 2012, p. 43)

9.7 RESEARCH ADVICE FOR EXECUTING SUPPORTED EMPLOYMENT

At the conclusion of their article *Key Factors for Implementing Supported Employment*, Marshall, Rapp, Becker, and Bond outline five recommendations for executing a SE program (2008, pp. 891-892):

1. Before initiating the supported employment implementation, ensure top-level administrators are committed to the initiative and are willing to carry out the range of actions included in this report.
2. Dismantle programs that contradict or interfere with supported employment (for example, prevocational, enclave, or agency-based employment programs).
3. Designate a full-time staff person to lead the supported employment program who has administrative authority. Give preference to candidates with strong skills in business and clinical supervision.
4. Hire employment specialists with strong clinical skills for working with people with mental illness who believe in recovery and supported employment principles.
5. Set clear performance standards based on the evidence-based model and be prepared to remove staff who do not meet them.

In their article *What Works: Effective Policies and Programs for the Homeless Population in Canada: Final Report*, Serge et al. conclude the following elements must be part of vocational programs for homeless people (2006, pp. 69-74):

- Holistic approaches work best
- The approach should be client-centred
- Employers need to be integrated into the process
- Housing and employment services need to be integrated
- Remedial programs are successful
- The quality of work is important

In *Supported Employment: A guide for mental health planning + advisory councils*, the US Department of Health and Human Services gives the following advice for operating a SE program (2003b, pp. 11-12):

Some vocational services are more effective than others.

- No single vocational program model was found to be superior to the others.¹²⁷ However, certain common characteristics among the models studied produced better outcomes.
- The programs with the best employment outcomes integrated mental health and vocational supports, focused on rapid placement into jobs of the participant's choice, and provided ongoing support. For these programs, the percentage of participants who worked was roughly 5-30 percentage points higher than for clinical programs that referred clients to outside vocational providers.
- Collaboration between support providers and the businesses who employed participants was associated with improved work outcomes. This result illustrates the importance of engaging employers.

¹²⁷ Referring to SE programs, as opposed to vocational programs in general.

Employment patterns indicate the need for long-term supportive services.

- On average, it took six months for participants in the study to obtain work; thus programs should not be overly focused on short-term attempts at placement.
- Most participants changed jobs at least once (with an average of 2.3 jobs per person) during the study.
- For those participants who did change jobs, most were not fired but left jobs for various other reasons.
- Jobs alone do not ensure economic stability for consumers.

Research-Based Principles of Successful Vocational Rehabilitation Strategies

The EIDP¹²⁸ Steering Committee articulated the following principles based on research findings from EIDP and other studies (U.S. Department of Health and Human Services, 2003b, pp. 12-13):

- People with serious mental illness can be successfully engaged in competitive employment.
- Vocational rehabilitation services should involve employment in integrated settings for minimum wage or above.
- Consumers should be placed in paid jobs as quickly as possible and according to their preferred pace.
- Ongoing vocational support should be available as needed and desired.
- Consumers should be helped to find jobs that match their career preferences.
- Vocational rehabilitation services should explicitly address financial planning and provider education/support around disability benefits and entitlements.
- Vocational and mental health services should be integrated and coordinated.
- Vocational service providers should work collaboratively with consumers to address issues of stigma and discrimination, and to help negotiate reasonable accommodations with employers.
- Vocational rehabilitation services should be made available to all mental health consumers.

Vocational services should involve family and friends in supporting consumers' efforts to work.

¹²⁸ Employment Intervention Demonstration Program, a 5-year, randomized study sponsored by SAMHSA's Center for Mental Health Services. The program had 1,400 participants and evaluated services designed to employ people with serious mental illnesses (SAMHSA, 2009b, p. 15).

9.8 A DETAILED DISCUSSION OF INTEGRATION PRINCIPLES AND ELEMENTS

9.8.1 Suter et al. Principles for Integrating Health Services

Suter et al. outline 10 principles for planning and development of “successfully integrated health care systems” (Suter et al., 2007, p. 5). Suter et al.’s research and principles were developed with a large provincial organization in mind; however, most can be adopted by a smaller organization.

1. *Comprehensive services across the continuum of care recognizing the importance of providing seamless health care despite the multiple points of access.*

While it is difficult or impossible for an individual homeless-serving organization to affect care beyond its sphere of influence, organizations can certainly work toward a seamless experience across partner agencies and their own services.

2. *Patient focus encouraging active participation by the patient and their family or informal caregivers while focusing on population-based needs assessment.*

The principle of patient-focus and active patient participation and family aligns with best practices generally. So, this principle should be part of treatment for any organization wishing to adopt best practices.

3. *Geographic coverage and rostering to maximize accessibility and minimize duplication.*

In a large province like Alberta, jurisdictions can be hundreds of kilometers apart, but that does not prevent the same principle from being applied by a single organization serving, say, two or more locations.

4. *Standardized care delivery through interprofessional [sic] teams and use of provider-developed, evidence-based clinical care guidelines and protocols.*

Depending on the structure and resources of the service delivery organization, this may be difficult to accomplish, as some organizations are small and do not administer inter-professional teams or are in a position to develop their own clinical care guidelines and protocols. However, this does not prevent an organization from attempting to coordinate such teams or use best practices developed outside.

5. *Performance management by evaluating the process of integration and measuring system, provider, and patient outcomes.*

While there are existing methods and measures to evaluate care for homeless clients, performance measures also have to be woven into the system of care, from high level policies to on-the-ground tasks and procedures. As a result, this may be a difficult task for organizations with existing processes and structure and may require process, structure, and culture changes to accomplish.

6. *Appropriate information technology and communication mechanisms such as electronic patient records and data collection systems to effectively track utilization and outcomes.*

Performance management and information technology go hand-in-hand. You cannot easily manage performance without corresponding measures and technology to track them. However,

it is also important to ensure ahead of time that technology used is well-suited to the task and able to properly track patients, outcomes, and performance measures. Inadequate or inappropriate technology may damage the organization and its efforts.

When used together, performance management and technology systems to track patient care and outcomes may also make financial management (principle 10) easier to accomplish. Together, they can highlight where funds are spent to good or ill effect.

7. *Cohesive, organizational culture with strong leadership and shared vision of an integrated health care delivery system.*

Cohesive organizational culture is a very difficult task where two independent organizations with different cultures merge. Examples of this challenge abound in business literature. Where smaller, independent organizations are part of a larger service-delivery whole, it may be difficult or impossible for such organizations to develop a culture extending beyond themselves. On the other hand, small organizations can lobby and work toward such a culture. Where they are in a lead position, they will have more influence to make change.

8. *Physician integration, particularly primary care physicians, by a variety of methods such as compensation mechanisms, financial incentives, and non-financial ways of improving quality of life.*

Coming from a province-wide perspective, this principle is beyond the scope of most homeless-serving organizations. In Canada, how physicians are compensated and incentivized is the purview of provincially legislated organizations. On the other hand, any organization can seek ways to improve quality of life.

9. *Strong governance structure that includes community and physician representatives.*

Almost any homeless-serving organization can develop a strong governance structure. “Community and physician representatives” in an organization serving homeless people translates to including homeless clients, care workers, physicians, and others in governance.

10. *Sound financial management.*

Sound financial management should be a key foundational piece for any organization—homeless-serving or not.

Suter et al. add two additional guiding thoughts. First, they offer that equal attention needs to be paid to the process of integration and that it will take time to accomplish, coming about only through a shared vision and strongly supported staff and strong management strategies (2007, pp. 5-6).

Second, they state that measuring the impact of integration on system, provider, and client levels crucial. However, they also note that few standardized tools exist for measuring integration and outcomes (2007, p. 6). Although the principles may be applied in other situations, Suter et al.’s research anticipates a much more ambitious integration than required at a program level. Their research anticipates integration of provincial organizations and systems.

9.8.2 Turner's Elements for Integrating Services

Drawing from “practical on-the-ground experience developing and implementing homeless system planning in Calgary (from 2008 to 2013), and through technical assistance provided to other communities,” Turner outlines seven “essential elements” for integrating services (Turner, 2014, p. 9).

1. *Planning and Strategy Development process follows a systems approach grounded in the Housing First philosophy.*

Turner places emphasis on a systems approach because she asserts program or operational models can lead to piecemeal programs without contributing to overall service transformation—the closing of “front-door emergency responses” that merely manage homelessness and the opening of the “back door into permanent housing” and infrastructure to support it (p. 10).

While this may be true where municipal, provincial, and federal efforts are concerned (as outlined in Figure 1 of the Introduction), it is more problematic at the operational level. Individual service organizations rarely have significant influence over higher-level programs and policies, thereby driving an operational approach. Without cooperation at higher levels, individual service organizations can do little except work as best they can on an integration continuum.

However, this does not preclude service organizations from organizing with other service providers and lobbying municipal, provincial, and federal entities.

2. *Organizational Infrastructure is in place to implement homelessness plan/strategy and coordinate the homeless-serving system to meet common goals.*

Turner outlines the importance of a *lead* organization in putting together required infrastructure—regardless of whether the organization is a funder or administrator. The lead organization acts as the “glue’ binding the various stakeholders together, coordinators play critical roles spanning organizations vertically and horizontally” (p. 11). This advice can be implemented by any organization seeking to better integrate services—either by being the lead or ensuring effort is directed by a strong lead entity.

In some respects, this element is related to Suter et al.’s seventh principle outlined earlier: cohesive organizational culture. Suter et al. emphasize the importance of having strong leadership in place to develop a common organizational culture.

3. *System Mapping to make sense of existing services and create order moving forward.*

While acknowledging system mapping can appear daunting, Turner points out how crucial it is for a lead organization to apprise itself of systems and services already in place. Not only does the exercise lead to a better understanding of how systems and services can be better integrated, it also will highlight service gaps, duplications, and other opportunities for improvement.

Again, any organization can use this advice. The complexity of heeding the advice will be driven by the number of actors and integration scope.

4. *Coordinated Service Delivery to facilitate access and flow-through for best client and system-level outcomes.*

Coordinated service delivery does not mean “diverse services collapse into one organization,” but instead stakeholders establish practices formalizing “service delivery coordination to enhance client outcomes and client perception of a seamless, effective system” (p. 13). Turner further adds that coordinated or centralized access is key, along with standardized needs assessment to match clients with treatment options, giving the system a common assessment language and a means to improve outcomes (pp. 13-14).

By virtue of their limited reach and resources, smaller organizations will be unable to present homeless people with a single entry point or a “no wrong door” approach. On the other hand, this doesn’t mean they are helpless. For example, smaller organizations can develop relationships with other organizations providing complimentary services.

5. *Integrated Information Management aligns data collection, reporting, intake, assessment, referrals to enable coordinated service delivery.*

These information systems, if implemented in a comprehensive manner across services, can effectively stitch together the homeless-serving system and provide real-time, service- participant-level longitudinal data to enable co-ordination. They are absolutely essential tools to enable system planning from a practical perspective. Such an approach can align funder mandates and leverage resources, reduce duplication and ultimately make measurable change visible using real-time data. Without such visibility of the homeless-serving system, the ending-homelessness efforts are severely hampered. (p. 14)

While resource constraints may restrict options available to smaller organizations, there are many homeless information management systems (HIMS) available to service providers.

6. *Performance Management and Quality Assurance at the program and system levels are aligned and monitored along common standards to achieve best outcomes.¹²⁹*

Turner breaks performance management and quality assurance into two categories as follows (p. 15).

Program-performance indicators vary depending on the target population, program purpose, services design, etc. They are useful for measuring program performance of individual programs and for comparing performance across similar programs.

If properly planned in advance, performance indicators can be built into almost any program, whether the organization is large or small. This will make performance measures available for tracking progress and client outcomes. Where possible, smaller organizations may wish to investigate and adopt performance measures used by similar organizations both horizontally

¹²⁹ To assist smaller organizations develop performance management programs, Alina Turner has published *Performance Management in a Housing First Context: A Guide for Community Entities* (2015).

and vertically in relation to their position in the service delivery chain. This will help internal and external performance management.

System-performance indicators reflect aggregate system performance and impact. They are used to measure achievement across the homeless-serving system towards high-level goals and can be used compare various communities.

Using system performance indicators will allow a participating organization to view its own performance relative to other organizations. Again where possible, smaller organizations may wish to investigate and adopt these measures.

7. *Systems Integration mechanisms between the homeless-serving system and other key public systems and services, including justice, child intervention, health, immigration/settlement, domestic violence and poverty reduction.*

Turner encourages horizontal and vertical integration between “emergency shelters, transitional- housing providers, and outreach services” and “public systems, such as correctional services and hospitals, mental health units, police and bylaw services” (pp. 16-17). Again, this is impossible for individual service providers to fully affect, as generally they have little influence on municipal, provincial, and federal policy and programs. On the other hand and as pointed out by one of the respondents to the survey, small organizations can always plan their programs and infrastructure to coordinate with higher level program systems, policies, practices, and so on. Turner’s chart, summarized in the table below, illustrates this point.

Table 18

Turner’s chart presenting an approach to service integration (p. 17)

Focus on Homeless-Serving System	Focus on Systems Integration
<p>Planning and Strategy Development Local/regional strategy follows a systems approach and the Housing First philosophy to end homelessness.</p>	<p>Development of shared planning approaches across systems, focused on common target population.</p>
<p>Organizational Infrastructure Organizational infrastructure is in place to implement homelessness plan/strategy and co-ordinate the homeless-serving system to meet common goals.</p>	<p>Co-ordinating infrastructure to lead integration efforts across systems is established.</p>
<p>System Mapping Making sense of existing services and creating order moving forward.</p>	<p>Extending service mapping to document populations experiencing homelessness and housing-instability touchpoints across systems.</p>
<p>Co-ordinated Service Delivery Ensuring key system-alignment processes are in place to facilitate access and flow-through services for best client and system-level outcomes.</p>	<p>Development of co-ordinated access, assessment and prioritization to determine service matching for clients across systems using shared processes, and facilitating integrated service delivery.</p>

Table 18

Turner’s chart presenting an approach to service integration (p. 17)

Focus on Homeless-Serving System	Focus on Systems Integration
<p>Integrated Information Management Shared information system aligns data collection, reporting, co-ordinated intake, assessment, referrals and service co-ordination in the homeless-serving system.</p>	<p>Extending the use of a shared information system, or developing data bridges among existing systems to enable information sharing for service co-ordination and planning purposes.</p>
<p>Performance Management and Quality Assurance Performance expectations at the program and system levels are articulated; these are aligned and monitored along set service standards to achieve best outcomes. Resources are in place to support uptake across organizational levels.</p>	<p>Common indicators are developed across similar service types and at system levels to articulate how components fit as part of a broader whole. Service quality standards are in place across systems providing similar function and reinforced through monitoring and capacity building.</p>

9.8.3 Principles and Elements Side-by-Side

Comparing the ten principles put forward by Suter et al. with the seven essential elements outlined by, Turner, Table 15 places principles and essential elements side-by-side.

Table 19

Suter et al’s principles and Turner’s essential elements

(Suter et al., 2007, p. 5)	(Turner, 2014, p. 9)
<p>a) Comprehensive services across the continuum of care recognizing the importance of providing seamless health care despite the multiple points of access.</p>	<p>b) Planning and Strategy Development process follows a systems approach grounded in the Housing First philosophy.</p>
<p>c) Patient focus encouraging active participation by the patient and their family or informal caregivers while focusing on population-based needs assessment.</p>	<p>d) Organizational Infrastructure is in place to implement homelessness plan/strategy and coordinate the homeless-serving system to meet common goals.</p>
<p>e) Geographic coverage and rostering to maximize accessibility and minimize duplication.</p>	<p>f) System Mapping to make sense of existing services and create order moving forward.</p>
<p>g) Standardized care delivery through inter-professional teams and use of provider-developed, evidence-based clinical care guidelines and protocols.</p>	<p>h) Coordinated Service Delivery to facilitate access and flow-through for best client and system-level outcomes.</p>

Table 19

Suter et al's principles and Turner's essential elements

(Suter et al., 2007, p. 5)		(Turner, 2014, p. 9)	
h)	Performance management by evaluating the process of integration and measuring system, provider, and patient outcomes.	i)	Integrated Information Management aligns data collection, reporting, intake, assessment, referrals to enable coordinated service delivery.
j)	Appropriate information technology and communication mechanisms such as electronic patient records and data collection systems to effectively track utilization and outcomes.	k)	Performance Management and Quality Assurance at the program and system levels are aligned and monitored along common standards to achieve best outcomes.
l)	Cohesive, organizational culture with strong leadership and shared vision of an integrated health care delivery system.	m)	Systems Integration mechanisms between the homeless-serving system and other key public systems and services, including justice, child intervention, health, immigration/settlement, domestic violence and poverty reduction.
n)	Physician integration, particularly primary care physicians, by a variety of methods such as compensation mechanisms, financial incentives, and non-financial ways of improving quality of life.		
o)	Strong governance structure that includes community and physician representatives.		
p)	Sound financial management.		

There is overlap in the two lists. For example, the principle in cell "c)" is redundant because of the reference to HF in cell "b)". Client-centred focus and inclusion of family members and care-givers is part of HF.

Also, the principles in cell "h)" and "k)" address performance management. And, the elements in cells "i)" and "j)" address information technology required to support integrated services.

When the two lists are amalgamated after eliminating duplication, 14 principles and elements for integrating homeless services remain. For the balance of this paper, the principles and elements will be referred to as Integration Principles or "IP."

15. Planning and Strategy Development process follows a systems approach grounded in the Housing First philosophy.

16. System Mapping to make sense of existing services and create order moving forward.

17. Comprehensive services across the continuum of care recognizing the importance of providing seamless health care despite the multiple points of access.
18. Geographic coverage and rostering to maximize accessibility and minimize duplication.
19. Standardized care delivery through inter-professional teams and use of provider-developed, evidence-based clinical care guidelines and protocols.
20. Performance Management and Quality Assurance at the program and system levels are aligned and monitored along common standards to achieve best outcomes.
21. Integrated Information Management aligns data collection, reporting, intake, assessment, referrals to enable coordinated service delivery.
22. Organizational Infrastructure is in place to implement homelessness plan/strategy and coordinate the homeless-serving system to meet common goals.
23. Cohesive, organizational culture with strong leadership and shared vision of an integrated health care delivery system.
24. Physician integration, particularly primary care physicians, by a variety of methods such as compensation mechanisms, financial incentives, and non-financial ways of improving quality of life.
25. Strong governance structure that includes community and physician representatives.
26. Sound financial management.
27. Coordinated Service Delivery to facilitate access and flow-through for best client and system-level outcomes.
28. Systems Integration mechanisms between the homeless-serving system and other key public systems and services, including justice, child intervention, health, immigration/settlement, domestic violence and poverty reduction.

IP above provide direction for developing an integrated program for serving homeless people. What IP does not do is outline why it is difficult to integrate services for the homeless. One of Leutz’s integration “laws” states “You can’t integrate a square peg and a round hole” (2005, p. 4). Leutz does a good job of explaining why. Table 19 below presents what Leutz calls “Square/Round Divisions.”

Table 12 (repeated from the body of the research)

Leutz’s Square/Round Divisions (2005, p. 5)

Aspect	Health Care	Social Care
Clinical orientation	Diagnose and cure disease	Access and mitigate functional status deficits, developmental delays
Financing	Universal entitlement	Multiple means-tested programmes
Administration	National and private insurance, or systems (e.g. NHS)	State-level or local authority bureaucracies
Provider organizations	Hospitals, physicians’ groups	Home care, day services, residential care
Provider staff	High and mid-level professionals: MDs, RNs	Mid-level professionals (MSWs) to paraprofessionals and family

Table 12 (repeated from the body of the research)

Leutz's Square/Round Divisions (2005, p. 5)

Aspect	Health Care	Social Care
Access	Relatively equitable: doctor's orders	Lumpy: caps, waits, exclusions, local systems
Benefits	Relatively uniform core	Geographic differences in coverage and availability

Although Leutz draws his examples from the United Kingdom and United States, similar characteristics can be found in other jurisdictions like Canada. Health care and social care are structured differently and as long as these differences persist, perhaps service integration for homeless people will remain more a patchwork of supports than an integrated whole. Still, this do-the-best-you-can-with-what-you-have situation does not warrant acceptance of the status quo, but rather it points to how organizations need to work with the systems they find themselves in.

9.9 SURVEY RESPONSES

Responses are presented below in their raw form, either as directly transcribed from recorded telephone calls or text cut and pasted into this section from completed surveys. Except where a portion of a question lends context, questions are not included.

RESPONSE #1

1 I am the lead residential case manager. So, I supervise another case manager and an intern.

2 Yes the employment piece and the housing piece are the cornerstones of what we do. We do have a separate career development department that specifically works on employment and educational or vocational goals, both short-term and long-term. And, housing is the main focus of the case management that we provide.

3 I would say providing a lot of the services under all one roof. 'Cause this is a residential building and clients can access their case manager, their mental health professional, a children's program specialist, their career development worker, and then they also of course attend programming, which has meals. Everything kind of happens in-house. So, I think that takes some of the difficulty out of it.

4 Skipped.

5 Perhaps engagement. You know engaging families in actually seeking services and attending to the services. I think a lot of time the primary needs: food, shelter clothing has maybe been difficult to access before and so now that those are taken care of kind of getting them to take that extra step to engage additional services can be one of the first challenges.

We deal with it every day, just in terms of speaking with our families, you know and having those meetings really encouraging participation, encouraging it on a team level and coming together and having team meetings really just kind of explaining and demonstrating how their case plan looks with all of these different team members coming together to offer them services and how one can't happen without the other and, just really harping on the importance.

6 I'm honestly not sure. I think here in our area we really struggle with the housing market, the cost of rentals, and the inaccessibility of affordable housing. So, I'm really not sure how to connect those dots but that is a huge issue in getting families housed and getting families to maintain their housing.

7 A program that integrates housing, healthcare, and employment? I think X Services sometimes has a public health nurse that comes onsite in office clinic hours. We don't do that but I do think that would take away that extra step. I would help remove a barrier if that was localized and centralized.

8 Skipped.

9 I mean maybe it would be something like a partnership with a public health clinic, cause I'm thinking although there are a lot of programs that would include two out of the three and then it's the medical piece that's usually not um not woven in. I mean, we certainly would offer education around health and wellness and, you know, that sort of thing, but actually having medical staff onsite, I mean that's considered specialized service, so, there's programs that specifically offer that around substance

abuse or detox or mental health, but unless a program's main focus is one of those areas then it doesn't usually include the medical aspect. But maybe an organization could foster more of a partnership with a local clinic and try to um you know smooth out the referral process and the access.

10 Like program administration-wise or direction... I think it's really important to know your population and really understand what it's like, as best as one can and not assume that we know what's best. We have to integrate the client's needs and experiences with that and not just impose what we they think they need to do.

11 I think it's really important to include the families served or the clients served in the program implementation model, like a board should include a client representative or a former client representative so that their voice can be a part of the planning procedure.

12 Skipped.

13 Ah, putting the clients first. Because we have to remember what we're doing here. You know. It can't be about pleasing your board of directors. It has to be about what are we trying to do, what are we trying to accomplish, and who are we trying to serve? Again, we're trying to serve our clients. We shouldn't be having to serve the board of directors.

14 I mean... Again, it's kind of hard to put myself in those shoes Kerry. I mean in my organization, those are two separate and unique aspects of the program that really have nothing to do with what I do with the clients and with the families. I think in terms of outcomes and, you know, it is important to understand what our goals are and to constantly refocus on the goals, and to have quarterly and mid-quarterly checkpoints to see how we are doing in the attainment of those goals. So you know my director is really good at keeping us organized and just making sure that we are always you know focusing on that, but in terms of who is setting the goals and who is planning them, like I don't have anything to do with that.

15 I think, again, it's a really good idea to involve the clients that are served in the feedback process and in the, you have to have a space to provide feedback and then also to include their feedback in the planning process. If we think something is working but it's really not, we need to hear that from, on the other side and then actually put that into action and do something about it. I think it's a really good idea to have, like in our case, like some sort of parent representative board or just a more organized and structured way to include that sort of feedback into the planning process. Because, again, it loops back to who are we trying to serve and how. And if we're not including their feedback then we're really missing an important piece.

RESPONSE #2

1 Executive

2 Housing, support & activation; Partnerships with Health, Employment, Counselling, Drug&Alcohol Services, Recreation support

Housing and Homelessness Services; Aged care services

- 3 Supported accommodation with an integrated and holistic approach
Individualised case management approach using the Outcomes Star and Results Based Accountability framework to track progress.
- 4 Affordable housing as an exit point from our supported accommodation.
Flexible support to maintain housing successfully (Housing First)
Outreach Support to better connect rough sleepers with services
- 5 Service Culture – internal approaches to our work being ‘program’ driven rather than consumer driven
Separate allocation of funding through different government agencies
Inability to gain integration of government agencies for common outcomes.
- 6 Consumer led approaches
Need to integrate service responses – map the current services and identify gaps
Ensure that there is a whole of government response to Homelessness and not allocated to one govt agency.
- 7 Foyer Model

Common Ground

These programs only succeed to the extent that they can provide a holistic and integrated service to clients.

- 8 Consumer Led Approach and developing shared goals with all partners.
Developing agreed measures of success or outcomes to drive developments and improvements.
- 9 Lack of funding arrangements that support integration and therefore I would seek to ensure there is a sustainable funding stream that ensures a range of flexible services can be provided.
Introduction of Social Impact Bonds as an alternative methodology to sustainable funding?
- 10 Collective Impact approach to ensure there is agreed measures of success/outcomes.
- 11 Data collection around shared goals
Consumer focused approaches integrated into staff interactions
Evidence informed practice
- 12 Staff and training – ensuring that all staff have the shared approach and practice framework.
Data collection processes – systems to record data and generate reports.

Evaluation – having the expertise to conduct ongoing research and evaluation.

13 Consumer focused practice.

Each person’s journey forward is individual and therefore no one approach is the right one. Each response should be tailored and specific to the person concerned.

14

	Integrated Services	Best Practices
Best Practices in Planning	Housing and Health Services	
	Housing and Employment Services	
	Housing, Health, and Employment Services	
Best Practices in Operations	Housing and Health Services	Street to Home Program – providing accommodation, support to maintain accommodation and clinical assistance for Mental Health. Boston Homeless healthcare – Dr Jim O’Connell. Housing First approach
	Housing and Employment Services	Foyer Model for young people – accommodation and training with the focus to gain employment.
	Housing, Health, and Employment Services	Common Ground Model – wrap around support for chronic homeless. Staff include nurses for health issues, social workers and case managers for wrap around support including linking to training and employment options. X in X used co-location with a social enterprise as a method of skills and training development for residents seeking employment, Unsure how successful this was.

15 Skipped

RESPONSE #3

1 Manager

2 Yes, our organization also provides anger management counselling, couples relationship sessions. Specialized and trained staff in DV response and support.

We have open door policy and therefore refer to all other agencies as required.

3 We provide support with crisis accommodation, transitional accommodation and assist in finding long term accommodation and then living skills to go with each.

4 Maybe looking at supporting a crisis counselor on staff as clients come into the service in a time of crisis and need on the ground immediate support.

5 Lack of community knowledge and the constant changes within the funding arrangements.

How best is this challenge dealt with?

Community engagement and education, however this takes finances and time of which both are limited.

6 Try and get an accurate figure on how many hidden homeless there actually are, to ensure we are targeting the right people and issues.

7 Open door policy requires enough staff to have separate intake/admin worker to effectively ensure all referrals are completed and followed up on.

8 Look at the local communities and evaluate services that would be required.

9 Reaction on all current workers to change.

How would you go about overcoming that challenge?

Education and information to the current sectors

Questions 10 – 15 Skipped

RESPONSE #4

1 I am the acting executive director of the organization and also a member of the board of directors (President). As the director I am responsible for fundraising, paying involves related to the programs and office, I manage the books and participate in audits with the CPA. I am the face of the organization and therefore I interview with people and upkeep a community presence.

2 Yes, we offer supported permanent housing for homelessness and at risk clients. Their housing includes case management services. Our case managers help clients make connections to other organizations for clinical services, financial issues, legal issues, and additional addiction services. Our staff is all volunteer.

3 Our most successful programs are Code: Red, White, and Blue and the Shared Permanent Housing Program. Code is an event where we give out needed items to clients in the community – including clothing, food, and hygiene products. The housing program is 6 client group homes housing 22 in a family oriented way.

4 If we had additional resources I would improve the living conditions with renovations. We would hire part-time counselors to host groups and provide more in-depth 1 on 1 counseling for clients.

5 The most difficult thing is that our clients need to have an income – when they cannot pay anymore for whatever reason we have to sponsor them, this means finding the donations in the community.

How best is this challenge dealt with?

Fundraising all the time. Trying to select clients with a fixed low income.

6 I would create a college type program on a farm type environment. The client would be able to choose their courses for their life recovery including recreational activities, mental health, addiction, and education classes like budgeting/banking/credit/home economics/job readiness – we would have internships available to the clients to get them back into the work force. We would have permanent and transitional housing all on one beautiful campus. There would be a health clinic on the campus and transportation as well. It would be called X and it would be heavily advertised to clients as they are discharging. Our exit camp program would be an 8 week course in transitioning yourself into the world.

7 None that I know of integrate healthcare – unless X is an example of a program that deals in all these areas. Impact service deals with employment and housing for veterans. Project home as resources for homeless as well.

If so, what program is it and how well is the program working?

I am not sure how well the employment program works at impact services, but when I was working there – it was evident that they had a hard time getting the clients jobs.

If the program is not working well, why is that?

I think the clients are hard to market – especially the older ones. A lot of them want to be disabled and collect a check for the rest of their lives. They need new training – many people have a desire to get high-paying jobs right away yet they are not marketable at that level.

8 Research

Why would it be important to do first?

You have to look at evidence based research to see what has been done and what is working already. I think CA has some interesting programs.

9 Funding because the clients would not be able to contribute to their program financially. We would also have to get out into multiple communities to work with employers to obtain jobs and internships for our clients. We would also have to build our own permanent housing since their isn't enough in the world – not only that most people who have been chronically mentally ill, addicted, and homeless are not employable and if you give them a house they will lose it without real accountability.

How would you go about overcoming that challenge?

They would have ongoing case management services and drug testing. Mandated compliance with mental health treatment plans.

10 There has to be a return on investment for investors which is the only way to get this place up and running. Government grants are too competitive and hard to get people to work for free to start the programs while waiting to get approved for funding.

Why would you consider it essential?

You can't do anything without money.

11 – 15 Skipped.

RESPONSE #5¹³⁰

1 I guess it would be executive.

2 I would say that we provide a very, a very diverse range of housing services to a very specific population. And, I would say that the harm reduction, we don't do counselling we don't have licensed counsellors. So, we would call it one-on-one support. The harm reduction I would say that we follow a fairly, we do, I mean our services have a harm reduction component to them. So, I wouldn't market McLaren as clearly providing these things per se in, you know, listed. They're all integrated within the variety of housing and housing support services we offer.

3 I would say that, what we actually focus on is homeless at risk. So, a lot of our services and programs are pitched and that's where we look for funding. Because we believe that you know if you work with the at risk population, then you decrease the homeless population. So, we try to, in our work, to prevent people becoming homeless. We actually probably only have I would say less than 20 percent of the people currently in our program that would actually have been homeless before they lived with us. And, it depends what you define as homeless.

I think we as an organization and the staff that we have working for us we've all, we've most of us have worked in the east side, we have a very long history of experience of working in the housing sector with those that are less fortunate, let's put it that way. And, I think we go about things a little differently with quite substantial success and I think we're pretty unique in how we deliver our services and how we certainly run our supportive housing at X and so, it's interesting to be involved in stuff like this, but I think we are, we are a little bit more creative or we have the opportunity to be, creative with some of what we do, and I think that the key for us, and I think the key in all of this is that we as organizations need to work together, but I think that what we require is our government funders to come together and, you know, health, housing and other government departments at municipal and federal and provincial level have to work more together rather than, in a sense, protecting their pot of money, you know because the integrated services is a great idea, but it's so hard to get it rolling because you've got so much resistance and everybody that's protecting their little pot of money or whatever it may be, you know. We've got to break down lots of barriers in order to do that. So, that would be my final comment on that.

4 We are always looking for money for portable subsidies, which is one of our housing programs. Portable subsidies, if we can find funds to supplement private rent, people paying rent with private landlords, then that is an instant remedy to ensuring that people don't become homeless. So, for me, portable subsidies are a fabulous way to go. I didn't actually believe in portable subsidies until I worked here, but they work really well, in that all it requires is money, and organizations like ours who have the connections with landlords in the private sector, and you know whereas X Street took 8 years to build and cost \$28 million. And people were on the waitlist and they passed away before they got into housing. Eight years is a long time to wait for a building to be built. I mean, it's just the nature of the beast, so I'm not complaining about that. But, if you give me \$50,000 today with that I can get people in, I can get 10 individuals or families into affordable housing within a week to 10 days. You know, and I mean it's a quick solution that has huge repercussions in terms of people's housing stability and

¹³⁰ Questions 1 through 13 were answered by telephone, while question 14 was submitted in writing following the telephone survey.

everything else. So, that would be my, I wish that more government funding and more foundations would see the value of portable subsidy rather than bricks and mortar. Because the challenge with bricks and mortar is while you know we're funded through X for our two buildings, X is very stretched financially and so we're all of us in the non-profit sector here under extreme budgetary constraints. So, it's becoming increasingly challenging to manage our physical sites with the funds that we have, and to maintain you know, good quality housing. So, your portable subsidies are a quick solution, let's put it that way.

And, I mean just to give you a bit of information if you don't already know it, we fundraise for our portable subsidies and we get some government money, but we get private funders as well and foundations and we provide about 70-odd a year in that, which is quite substantial given, you know and that's just under 500 a month per portable subsidy is what we give people, so that, you know we're, it's a substantial program. What is great about it is that some of our folks living with HIV are fine living here at X or at X, um, but when they live in these two buildings even though we don't publicize it widely, people know that they're living in an HIV-positive building. So, what portable subsidies do they allow people to live in anonymity in communities of their choice, and that's huge because there is stigma attached. But at the end of the day what needs to go up is welfare and disability rates. I mean that's the ultimate issue I mean those need to be doubled in my opinion in order to really make a positive impact. There you go.

5 I would say in my experience the most difficult aspect is that, I would suggest that to be homeless in, say, in our city today the individual has or is experiencing complex needs that may involve addictions, mental health, and other challenges. So, there's a huge complexity I feel in our city to being homeless today. If it's about losing your job and not being able to afford rent and losing your apartment or your home, which is your apartment of course, you may have some resources, you're going to be temporarily homeless, but if you're dealing with complex addiction and mental health issues, then that just exacerbates the issue. So, how this challenge is dealt with, it's really tricky, cause you have this core of people that are going around in circles. They come into a building, a subsidized housing building, they can't manage to live within that building, so then they're moved out of that building, they're back in the shelter system. There are people that are circling in and out of this system right now because they're needs are so complex. How is the challenge dealt with? I think there needs to be another level, and I've chatted with other EDs in other organizations where those folks that have the really complex needs floating them through buildings and then see-sawing them around doesn't help. I think there almost needs to be another layer of housing options which could be a smaller building. We've got a 110 units at X. People with complex challenges can really get lost in those buildings. So, big is not necessarily the answer. I think smaller with a high input of staffing that can help address the addictions and mental health. And, you've got to integrate with other, obviously other you know other government funders and other non-profits. It's got to be an integrated approach that I think is health, housing, for sure in that.

6 Well, you know, I'll go on record, 'cause I have done before. I don't think you'll ever end homelessness. I, you know, I think that's a great blanket phrase that we're going to end homelessness. It's never going to happen. Not everybody wants to live in a square box or whatever you want to call it. I think you got to be creative and if you want, if we're looking at ending homelessness then we cannot assume that what we feel is a home and housing is what everybody wants. So, if I look at it from the

perspective of ending homelessness, more creativity is needed in the housing environments that we're providing.

7 Well, I went through these questions a bit earlier when we chatted to try and get a handle on them and the only one that I have been in meetings with and heard about is I believe X have, I don't know which of their housing program does that but I believe X does a collaboration with housing and employment. And, I have a feeling that X might be doing a similar thing. Those to me would be the only two that spring to mind. In downtown south here, most of the employment programs are run through the gathering place, but I think one of the challenges is, is funding, because I think the programs and I know I'm not directly answering your questions, but I think I am, I was around in the 90s at X neighbourhood house running their housing there, and there was with the X government here in the 90s there was a stash of employment related programming that community based organizations could be a part of. That's changed a lot. So, I think the challenge is bringing together, as I alluded before, the government departments that fund housing, that fund employment, and healthcare, there's got to be more integration. So, that I would think is the overall challenge. But, I, all I know is that the X, we, I haven't had clients go to a housing and employment programs integrated. That would be my answer to that Kerry. I don't know a ton on it.

8 I think you have to start with the housing, you have to stabilize the housing, and, it's more about people, it's not about what you have in the size. It's very much about having an environment that people can call their home. I don't feel that you're going to work on people's health issues or healthcare or employment until you provide a home for someone to live in that they're comfortable, that they can shut the door, that they can cook food in, they can feel safe, and they can feel secure in that. And, we see that in our programs, particularly at X. The key is having that place to call home. Because then you have a physical address that you can then hopefully find a doctor if you're not connected to the healthcare system. You know the challenge of living in a shelter and working, you see that the numbers of people that are living in shelters and are working is on the rise. So it's got to be affordable housing. So, for me, housing is the key.

9 Well, in my notes I put against healthcare the complexities. And, you know, if I'm taking, if I'm looking at these three areas—housing, healthcare, and employment services—if I'm looking at healthcare in its highest complexity and making that assumption that people are homeless because they have complex healthcare needs, the healthcare is going to be the key here because you are not going to be able to successfully, be employable and manage to maintain a job unless you have your healthcare needs met, your health needs met. And, the other challenge I see with this is that a lot of our folks, if they were working, at this point do not have the self-esteem or the educational qualifications to do a job that would be not much more than minimum wage. So, I mean it's great to think if you provide housing and healthcare people can go out and get a job and then move on in their lives, but that's hard enough for people who have an education right now in this city. It's even harder if you don't have an education, you don't have self-esteem, you know you don't present well physically. You know, there's all these other factors in there. So, I would say the challenge would be that the healthcare aspect of this.

10 From a working perspective I'm not sure if I would know from my own personal philosophy and practice and the way we work here I would say the acceptance of diversity is huge. And, I mean that on every level. It can be gender, it can be... It's the whole, it's acceptance of diversity.

11 Looking at from a practical level in our programs, the folks that we work with that have previously been homeless, I would say the addiction and the mental health is the biggest issue. Yeah, that for me would be the key. And that's, I say that partly because I believe to be homeless in our city in 2015 when there are a fairly reasonable number of housing options (there may not be enough, but there's a variety), if you're homeless in this city in 2015, for the most part, I think you've got some pretty complex needs. And, I would say addiction and mental health is the key in there.

12 Well, you know I think if you're integrating, if you're operating a service, now you're saying a service but you're not saying a housing. So, it could be a program, a day program or something like that. I think the greatest challenge in working with the homeless population that we're working with is around structure and boundary setting. So, in order to successfully operate a service, because you want it to be successful, you've got to have, I mean the way that we run our housing, our residential housing programs is we have an expectation of all our residents, regardless of who they are. And, if they can't meet that expectation then we have to sit down and talk about whether we're going to continue or not and how we can help them to meet that expectation. So, I would say the one operational challenge is that framework and that expectation that you have with everybody in that program. Because there has to be, for me there has to be a commonality that everybody agrees to and, being in that program they understand what the framework is. If you don't have that and you're focusing on meeting individual needs of people in that program without a baseline or a framework, then it's challenging to maintain some kind of structure and continuum.

13 Okay, that one has stumped me, Kerry because I... yeah, again, for me it goes back to respect, working with people for who they are, and non-judgmental. It goes back to that practice philosophy, you know that working philosophy, which we work really hard to here because all our folks are HIV positive so they deal with the stigma of that, they deal with the stigma sometimes of how they physically look because of how the disease is impacting them and everything else. So, you know, you've got to work with people from where they're at. So, for me, one of the practices is essential is that you've got to, while you have that framework that I talked about before, you've also got to work with the people from where they're at. And, that for me would be something that if was doing this would be a key for me. And, I would need the staff working in that program to work with people from where they are, you can't take people, you can't move people along unless you go to where they are and you go with them.

14 I have spent some time this morning trying to figure out my response to this section. It's a tricky one so please bear with me.

My challenge with this research survey is the complex nature of housing, healthcare and employment.

From X's perspective and in talking with support staff,

Don't know if we can respond to question 14.

For this agency Housing is Health- As you may already know, providing housing for people living with HIV/AIDS is proven to significantly improve health and wellness by:

- Increasing adherence to anti-retroviral medications
- Increasing participation in the health care system
- Increasing lifespan and quality of life

- Decreasing substance use and sexual risk behaviours
- Decreasing transmission of the virus
- Reducing need for hospitalization and use of emergency services

For most of our folks who are able to maintain housing in our programs the next step is stabilizing their HIV health which in itself is a whole other ballgame. In addition if the client has a support worker there may be a whole gamut of other needs- ensuring eligibility for gov monies, obtaining current photos id, (see the CBC story regarding the homeless man who won the Keno¹³¹ but could not get the money without photo gov id) connecting with overall health and wellness supports, citizen and immigration issues, family law and other legal issues, safety planning (spousal abuse), clients children's needs) and the list goes on.

So once you have the housing in place and the health care you can go out and get a job?

Interesting thought if homelessness wasn't so complex. To be homeless in in our city in 2015.....it's not just about losing your job, not being able to pay your rent, being evicted, finding a job and then being able to pay rent again. For those who have a history of working, skills and a post-secondary education this is possible although vacancy rates are at zero this month.

For most who are homeless and are clients of X it's a very different story.

Barriers to maintaining housing, stabilizing health outcomes and finding employment include:

- Residential school experience¹³²
- No post-secondary or grade 12 education- factors here include foster care consumer, literacy and learning issues, childhood abuse, education system not meeting needs of children.

Add to the mix, mental health and addiction issues caused by the above, socio-economic factors, self-esteem, isolation and loneliness.....

So now to the employment part, in this city with the cost of rents unless you are well above minimum wage you cannot afford to rent very much or rent in the burbs. This increase travel time, causes undue stress etc. away from social service and health supports. Secondly private landlords as a matter of course now ask for a criminal record check, gov photo id and a credit reference check before even considering showing you what they have for rent.

This takes me full circle to the top of the page.

So given the complexity of the topic best practice could be:

- Ensuring safe spaces
- Harm reduction
- Meeting people where they are at
- Accepting diversity and the uniqueness of individuals with no judgement.

¹³¹ Keno is a game of chance operated through a provincial agency.

¹³² Residential schools were 19th and 20th century institutions set up in Canada to assimilate First Nations people (Aboriginal). They became known for abuse and degradation of First Nations people. The last residential school closed in 1996.

This is not a linear process and perhaps the employment piece is not just about working it could be about giving back- volunteering etc. For the HIV/AIDS community if it wasn't for volunteers this community would not be where it is today. The strength lies in the lived experiences of people living with HIV/AIDS for which we at X acknowledge as vital in our ability as an agency to deliver services and supports to this community which been traumatized by this "long term and continuous" episodic health issue to quote the BC Government.

RESPONSE #6

1 Executive

2 Due to recording difficulties, the first portion of this question was missed.

If you offer housing to people who are homeless you get 100% acceptance, or you know 99% and if you offer healthcare it's pretty much the same uptake. But employment is more complicated, I mean some people want employment, some people are ambivalent about it, they are afraid to let go their benefits, some people don't feel they can work, some people would like to work but they can't and so on. So, you can offer it, but offering it doesn't necessarily mean you will get the same uptake as housing and healthcare. So, yes, we offer it to everybody but the uptake is quite different for the employment piece.

3 I would say what our organization does best is listen to the needs of the people who are homeless and then provides the services they want in the sequence that they want them.

4 I would say that if I had only one service to pick from I would pick a modified supported employment program that included job development, so that we could increase the uptake and get people working. If we could actually provide jobs to all those that wanted a work a job, that would be huge.

5 The most difficult piece of operating this program is that the government entities that fund it are usually in different departments or ministries. For example, health is funded by a different entity than addiction. Addiction is funded by a different entity than mental health. Housing is funded by a separate entity altogether. Employment is funded by the Department of Labor. So, you have a very siloed system of potential funding availability, and it's difficult to obtain all of those grants in a coordinated fashion. You might get some of the grants but not all of them, or not at the same time and then it's difficult to integrate the services at the level of agency so the program you're running can provide an integrated service to the consumer.

6 I would start a new program, meaning... What does that mean exactly, develop a new program? (A: starting from scratch). I guess the program we have is actually quite effective and integrates all of the treatment services pretty well. I guess if I were starting from scratch I would want to be able to offer the supported employment piece as an integral service right from the start.

7 Well, you know like I said earlier, I think the program we do operate does a very good job of integrating housing and healthcare, while it also offers employment services we don't do well there. But in general, how well is the program working? The program is working very well – especially to end homelessness and provide healthcare. It's working well because we do it in a sequence consistent with the person's needs and it's very client driven and provides an integration of housing and healthcare.

Where the program's not working well is that there are insufficient opportunities to address people's poverty or employment needs more effectively.

8 Well, it's sort of the same as I answered before, in terms of I think we would do exactly the housing first program. But, you know that's a very specific type of program... what we haven't talked about, and I don't know if any of these questions get to it – is the issue of scale. It's like we're not really talking about ending homelessness here, we're talking about helping a few people among the homeless that are particularly vulnerable or we're testing a model, right, and so we have a very good model but you know if one way to interpret this question is to if you're going to develop a new program to end homelessness, like focusing on the *end* homelessness part, like for the entire let's say city of Victoria or New York or whatever we're talking about, and then the issue of scale has to be part of that consideration. Well, are we really going to invest in the rent supplements or the funding to build the affordable housing that we really need in order to end homelessness? That's the real question. So, if we were waving a magic wand here and you were going to develop a program to end homelessness then I would say let's stop tinkering around with housing 50 or 100 or 300 people. Let's really end homelessness. Let's bring this thing to scale.

9 Well, depends on, the interpretation of the, developing the new program. So, if we're going to stay with that issue of bringing it to scale, the challenge becomes one of a policy shift and an investment by federal governments. Because like in the US I do know that in Canada the federal government was directly responsible for the creation of homelessness because it had a policy shift that basically took the federal government out of the business of building affordable housing. Perhaps the federal government hoped that somehow either the municipality or the province or the state would take on that function. Those smaller governments couldn't and didn't and homelessness was a direct result of very poor federal policy. That is the root cause of homelessness not an individual's mental illness or addiction. So, to fix the root cause one of the things you would have to go about changing is the current federal position on the investment in the building of affordable housing.

10 Well, I think that one of the most significant challenges in providing services, you see here you define homelessness a just a group of people without housing that, but a significant number of the chronically homeless, a small percentage but highly visible and vulnerable, are people who also have mental health and addiction problems. Given that is the population Housing First is so focused on, that skews my view of homelessness. Because if you don't have the mental health and addictions issues, you're...you know the answers to these questions is simpler and much more about affordable housing, employment and poverty reduction. The minute you bring mental illness and addiction into it, then you're talking about integrated services and mental health and health and so-on. So, it's services to a particular segment of the homeless. But, I would say still the fundamental healing principle in our program and I would advocate for this to be essential in planning any service is to have the services provided in a way that's consistent with the directives of the consumer—totally client-centred and person-specific. You know, no particular sequence, the sequence is what each person determines. And, why do I consider it essential? We have lots of research that shows that client-directed services are not only more effective in terms of engaging people in treatment, but also more effective in terms of outcomes, greater sense of well-being, increased sense of mastery, and this sense of self-determination and mastery leads to symptom reduction and recovery.

11 Well, remember our organization goals are all about providing consumer-driven services so that one practice I would make sure to have as part of policy is to include people with lived-experience in every aspect of the organization, so that, um, you know from the direct service providers to supervisors to the board directors you'd want to have people with lived-experience informing the mission of that organization.

12 The greatest operational challenge is to sustain staff morale and ensure that the staff is communicating a hopeful and recovery-focused message to the people they are working with, both in good times and in times of crisis, and to remain respectful of their choice throughout both those good and bad times.

13 I think that if we look at it as a practice, I would say that housing has to be the cornerstone of any service for people who are homeless. It's their sort of the fundamental starting point.

14 For me, I don't really know exactly, cause I haven't seen for programs serving our population examples of really effective program that had housing and employment. Anything I've seen has housing and health, whether it's mental health or primary health care. The highly effective programs are not working with people diagnosed with severe mental illness. Most programs have mostly permanent supportive housing programs and health services. Very few that I've seen have housing and employment. But, there are some. I think best practices for me maybe more like, what is recovery-oriented services? What is the trauma-informed care? What is motivational interviewing? What is harm reduction? What is integrated dual-diagnosis, treatment? What is supported employment? Those are specific evidence based practices.

At the core of all this is the housing first approach. Housing First is like the platform and the all these other effective interventions are like the apps. What I just listed are the kinds of work that the housing first teams do. The program starts with immediate access, housing as a basic human right, and that gets a lot of emphasis. But the real work, long term, day in and day out is more accurately defined by the provision of these evidence based practices in the sequence and intensity that makes sense to the program participant.

15 Well, I would say what I just said about housing first. I think it's an evidence based practice, you know in that scattered site model that I just described for you.

RESPONSE 7

1 I'm part of the executive team, so, we'll underline that.

2 So, I would say the answer is yes, we do integrate services for homeless people. So, I guess primarily it's through our housing first program where we connect people to housing most often in the private market, provide them with funding so that they can access that housing, so first month's rent, security deposit, any kind of rental arrears, utility arrears, furniture, household supplies, and then once they're in that housing they're provided with a support worker, who's primary role actually is connect them to mainstream services including health, addiction and mental health, employment, et cetera, but really at the direction of the client. Oh, and I should say that the services are provided with a harm reduction approach, so they're within the housing first philosophy, not putting any preconditions on the housing or support element.

3 I would say that what we do best is act as a backbone organization for our community, and being that backbone we're involved in everything from system planning to funding to monitoring, training, technical assistance, performance measurement, and then also connecting the services that we fund with mainstream services like health, child and family services, income support, and others.

4 This one I was struggling with a little bit, I mean there's so many needs. I'd say that, I guess you're not really limiting me to one option here so I'll just go through the list. So, primarily additional resources are required for higher intensity clinical support models because most of our, housing first support program is, uses an intensive case management model that has non-clinical support workers. So, really the bulk of the people we've housed over the last six years has been a non-clinical approach, but we've had two assertive community treatment teams that of course apply a clinical approach, one of them based within the health authority and the other one based within a community health organization. The one in the community health organization applies the Pathways to Housing Model. The other one is your typical sort of community treatment program with a housing component. And so we need a lot more of that level of support. So, I would say that's our primary need.

Second to that, we do need more onsite supportive housing with onsite support. The extent, not the extent but the level of intensity of those onsite supports is variable, but if we had more clinical support models then we could integrate those with the supportive housing models that have fairly minimal onsite support, so just basically looking at you know tenancy management and sort of early identification of any kind of issues.

Last but certainly not least and arguably it's probably the most important thing is better employment supports. Because we have fairly good connections with the health authority in terms of addressing addictions, mental health, but as far as employment goes basically people are left to their own devices and relying on mainstream systems to help them access housing. So, a lot of them would go through Alberta Works, which is the primary income support program here in Alberta, and they do have employment resources related to that. But many of the people were working with have significant addictions and mental health issues, they may have other disabilities. So, having some kind of supportive employment opportunities built into the housing first program I think would be an official, so that it's not just a matter of people who are capable of being connected, of connecting themselves to employment, but, and I shouldn't say capable. People who are very high functioning, who are able to connect themselves, it would be great if we had resources for people who probably need a little bit more support, or a staged kind of approach to re-entering the labour market or entering the labour market for the first time.

I guess the last piece is around primary care. Many of our clients although it is a top priority for the support workers to connect them with a primary care physician, like a GP or a family doc, there are many limitations to that. A lot of primary care physicians, let me, number one, finding one that's taking on new patients is often an issue. But then finding someone who has the background and context to be able to care appropriately and respectfully for someone with a history of homelessness can be quite hard. I mean there's a fair bit of discrimination that happens there. And, so, they end up going to medical centres and not getting the sort of comprehensive approach. So, I think that's also a big missing piece for us.

5 The most difficult aspect of integrating services is the connection between community-based delivery and mainstream systems. I mean our experience has been that support workers who are

working with their clients and are trying to help them access services, particularly around addictions and mental health, but not limited to that. I mentioned the primary care challenge as well. There are others. They often hit brick walls. They're, many sort of attempts to refer that just don't make it through. In some cases the support workers don't have the sort nuanced, kind of, nuanced knowledge to be able to find the ways in. So they end up spending a lot of time with fairly unimpressive results, I'll say. And so in terms of how to best deal with this, it's integral that any kind of planning that happens around a program if there is goal of providing integrating service that mainstream systems are brought in at the beginning and there's clarity about what their expectations are and there's a clear pathway for escalation of any kind of systemic barriers, and essentially a table where cross-system kind of issues can be addressed collaboratively. So, if you want to think about it as a two-way street, that on one hand you have support workers who are on the client side helping them, supporting them to access services, but on the other side you have systems that have been primed to expect these clients to come in and are also supported themselves in providing the best service to these individuals.

6 Well, I would do basically exactly what I just said. I think it was kind of an afterthought for us. When we implemented our housing first program back in 20XX, the primary focus was on getting people housed. And, we did it quite well. I think in the first few months we had several hundred people housed, and then supported through that intensive case management model that I mentioned earlier. Now it has been our experience that support workers have been very good at working with the clients for the most part, but they can't be expected to be all things to all people, and so there is that expectation that clients will need to get services from mainstream systems, but because of the barriers to accessing the system that has been a significant challenge. So, if I could turn back the clock and go back to 20XX, I'd want all of the major systems to be around the table and clarifying how they would support this work, and make sure our clients are able to access their programs and services without any difficulty. I think now when we approach systems we can see this as much a benefit for them as it is for our clients and for our workers because in many respects these systems are missing the housing piece and the challenges they experience are because of housing instability and so we can ensure that facet of the clients' needs is met or addressed and their systems can operate more efficiently and they can provide better services to their clients. So, I would bring the systems to the table right from the start and make sure they're on board and supporting this initiative right from the beginning.

7 Yeah, so incorporating all three. One that comes to mind is the Foyer Model for addressing the needs of homeless youth and that does integrate housing, healthcare, and employment services basically it's a model, I think was developed in France, so in Europe, and then tried out in UK and I believe in the US as well. I don't know if it's been implemented in it's you know pure form here in X. I've heard that there are some similar programs in Toronto and Halifax, but the extent to which they fit that model, I'm not sure. But, there's plenty of literature around the Foyer Model, and so I suggest you have a look at that.

Another example would, actually this one I really like. I hope I'm getting the name right. I think it's called X, out of X. Basically, it's housing for people with severe mental illness and addiction and it's, what's really interesting about it is that primary support model is peer support. The tenants are basically members of a community and they're hired to perform all sorts of services, both in terms of supports as well as maintenance of the housing, and operational aspects too. I think that we haven't explored enough, or we haven't done enough exploration of models like this that really build on the strengths of the people that we're serving and give them an opportunity to take ownership over the

community in which they live and to support themselves in achieving health outcomes and to, and essentially to employ themselves and have it all in the context of the place that they live.

X, there was a study done recently by X. She looked at X as a potential model for supportive housing. So, it might be worth getting in touch with them.

8 I mean more or less it is the same as the last question, although from my perspective the case management approach is important, um, and so, and I'm not sure whether this would be considered, [unintelligible]. So, we adopted what's called intensive case management, which is a fairly loose kind of model for case management. It is strongly client driven, the one that we've used with the housing first program, which is definitely positive. Again I think that sometimes it helps for workers to have a little more structure to how they do that case management, basically how they prioritize their work with the clients and also planning from the very beginning the point when they will be disengaging from the client, unless we're talking about indefinitely, basically an indefinite period of support, of long term support, it's just not realistic to have a support worker enter their lives, support workers enter the lives of clients and then basically abandon them later on once the dependency has been created.

So, there's a model, and I'm not necessarily advocating for this model, but it is an approach that makes sense. It's called the critical time intervention. The best part of that critical time intervention is that it's structured in a way that, it basically sets the stage for disengagement of that worker as part of the case management process, and it focuses on you know some key priorities, and again those priorities can be client-driven, and, I just think that if you combine a focused model like that where there is the expectation that most of the supports will be, for the individual will be provided by mainstream systems as well as our natural networks. I think that's critical to long term sustainability. I've said this many times in different venues, and I'll say this again here, we often take a very backwards approach to supporting people with complex needs or with a history of homelessness. We tend to just sort of stack formal supports or formal workers, and then as an afterthought we talk about, we can think about, oh but then they don't have any friends. We need to connect them to a community or we need to connect them to a social support network for social support. But that's the exact opposite of how support you know actually works for most of us. First, we turn to our family members, we turn to our friends for support and when they're not capable of providing support, then we turn to formal supports or formal systems. And so our support models for homeless people and for people with complex needs. We actually need to take a page out of that book. And we should start by building the natural support. That could be through mutual support, peer support, helping them to build a network of friends, re-connect with family and then build in what whatever form of supports that can augment that or enhance that. So, I think you know as sort of an alternate answer to what we would do if we were to start our program again, I think I would put a lot more emphasis on building that natural support and I think combining that with you know the CTI approach of connecting to mainstream systems is a primary way of supporting someone as opposed to like someone like a support worker who carries that burden. I think it would result in, it would lead to better results.

9 Question 9 was skipped.

10 Well, I think, I mean the answer to that, well, I don't know one principle might be difficult. Applying a housing first philosophy is critical. And because without housing stability you can't really affect any other aspects of the person's life. You can offer all sorts of treatment and all sorts of counselling and services but if they don't have a safe place to go, a safe place to call home, where they

can feel more comfortable and so forth and you know feel like it's their own place, you're not going to get the outcomes. So, I think that in any kind of service planning for the homeless, unless you're addressing the underlying, the most important issue, namely that they're homeless, you're not going to achieve any of what you desire. And when I say housing, I mean like permanent housing, not shelter, not internal accommodation, not facility living, but actually their own home. And that's why I think it's essential.

11 Hmm... Operational goals, I, you know there are so many that I would think, but if I'm going to pick one for this, I'm going to say client driven. So, I think incorporating some structure so that the people receiving the services are also the ones providing input and guidance on operation. I think it's a very strong sort of model, again, X had some early succ...I shouldn't say early success because they've been operating for a while, but there's just something to be said about empowerment in that we could, people toss around that word all the time, but I think ensuring participants can have a say, and more than a say, they can take ownership over the operation, that can lead to some very, very good results and, sorry, there is another example that I forgot about, the X, they have a very cool model of housing where they basically provide some common space in their building for their tenants to just, I mean the tenants run it, they do whatever they want with it, and it turns into basically a community support centre that serves not only the people in the building but also outside the building, it's a place where they feel they have some sense of ownership over the building, they solve problems themselves, if there are tenants that aren't a good fit, well we'll put it that way, if there are tenants that aren't contributing positively to the community, they address that themselves. So, it's a great model. So, I think giving more sort of ownership to clients is an integral piece of that policy framework.

12 Money! LOL I'd say money. Basically, you have to expect that I mean, unless... Actually I won't even start there. You know when you're serving homeless people, particularly chronic homeless people or people with a long history of disengagement and trauma you have to expect that they're going to run into some challenges, and those challenges may result in damage or evictions, and re-housing, and, sorry, damages and evictions and just people not getting along and you need to find new places. But in applying the housing first philosophy you can't just kick 'em out and sort of leave them back on the streets, so having funds so that you can ensure that someone can be rehoused, so that they can have as many chances as they need. We've seen it in our own program that sometimes it's the third, the fourth rehousing before the client realizes that, you know, maybe I need to change my approach and having a supportive network around them to help them through that is critical. And we see that. If we had kicked them out of the program after getting evicted the first time or even the second time, they never would have got to that point. So, in the end it really is about money. Like you know having the resources to be able to rehouse someone, to pay the damages in a private unit and to, you know basically to resource that, those, all those extra chances.

13 I'd say that the most important practice is to, if you're offering an integrated service, you need to do integrated planning. And, when we talk about integration, it's about, it's kind of like, if you want to look at it kind of like a matrix. You need to integrate your formals or your institutional supports with your community-based supports, and then on the institutional side and the community side, you need to integrate sort of horizontally across different silos. So, having you know a way for health services to work with income supports, to work with employment supports, to work with addiction and mental health, to work with cultural supports, I mean it's getting them involved from the get-go in terms of the planning so that you don't end up with a situation where you have support workers doing counselling or

your support workers dabbling in work they're that not equipped to do, and I talked about this earlier, having them at the table at the beginning basically committing to providing supports for individuals in your housing program will ensure that the people that you're serving are getting the right kind of support in the right way from the right people.

14 For housing and health services I'd say that a best practice from a planning side is coordinating access to housing with the health authority, particularly supportive housing. So, when X has done this we partnered with X to have a single, sort of access point for people with addictions and mental health issues who are homeless to be connected to an appropriate supportive housing placement. So, there is coordinated review of referrals, coordinated assessment, and then assignment based on the best fit. So, I think that is a definitely a promising practice. So, in a nutshell really it's just involving the health authority in that intake process.

Housing and employment services? I can't really name anything in terms of planning. There are some models. Like I mentioned the Foyer. There is another one that could actually, you know it certainly is one. There's a project in Edmonton or actually it might be an organization now. It's called X, and it's for women who often have a history of homelessness but at the very least have a history of significant challenges. And, basically what it is is housing that's tied to skills training. So, and when I say skills, it's for the trades. And there's educational opportunities right within the building. They learn a trade like welding or electrical or whatnot and then they go off to very, actually very significant success. There's some ridiculous success rate of like 95% or something. They're easily found on the web and they'd be happy to talk about what they do. But it's a really great model and it started several years ago so, it's basically, you get that supportive housing environment and then you have the, like, a direct sort of path to very gainful employment through education and training, right, like right in that same building.

With regards to operations, there's a really interesting model in Edmonton called X. It's a partnership between X Health Services, which is the health authority, and the X Foundation, which provides, it's the, the public seniors' housing provider in X. And so, X had a building, like an old lodge that they wanted to use to serve addiction and mental health population. And so, they partnered with the X, and, basically to provide a, what I'd consider like a best practice in supportive housing for a fairly complex group of people. And, it has integrated supports from X addiction and mental health, ah, they provided incredible training to the staff at the facility, who, you know and their history had been working with seniors and so they had no clue about addictions and mental health issues, but they did a great job of training them. There's an excellent sort of relationship between X staff and X staff, so that you know issues are escalated like right away, like when early warning signs come up they can address them right away. They've also created just through the sort of atmosphere there it's, it's very respectful. The staff get along with the clients, tenants. They've created like a sense of community and like I said earlier a sort of sense of ownership over this place that's shared amongst the tenants and the client. So, I'd say that's a really great model for integrating basically affordable housing and health services.

So, just looking at this thing I think for housing and employment services looking at X I think would be a good idea. And, I'm personally very interested in their model of employing tenants to take on roles for the operations of the building and then, there more than operations in terms of supports for each other. So, I think that's something that needs to be expanded and tested in different contexts.

Yeah, and then in terms of operations for that trifecta there, the housing, health and employment services. I think, if, I don't know from an operational standpoint, I can't think of anything off the top of

my head, but, I suspect there probably are some examples from the application of the Foyer Model that might yield some evidence for you there.

Oh, and actually, I remembered another one, so, under housing and health services, ah, there is one for operations, there is an example. It's called X. And, basically the way it works is X acts as, so we've engaged a private landlord, like a rental company, and they basically rent the entire building to X and X acts as the sub-landlord. And then we contract a community agency to provide supports onsite. And, Alberta Health Services in-reaches, so what they do is they provide their own workers to augment or supplement the supports that are on the site. So, providing a fairly integrated approach there.

15 I think I've mentioned a lot. The main one that I'd say is a best practice because it seems to produce results is kind of that tenant driven, client owned ownership kind of model. Often you'll see this in cooperatives, it really is a cooperative model actually. So, I think that applying cooperative approaches to engaging tenants in everything from governance to operations and maintenance and things like that and supports. I think that's something that we need to be applying at a broader scale. It addresses a lot of the issues that I talked about in terms of building that sort of natural support network, empowering people, making them feel like they have a sense of ownership over the place that they live, and then also giving them meaningful employment opportunities.

You know what, I'll be honest, it's scary for us because we're not used to it. We're used to, as much as we talk the good talk in terms of client-driven principles and so forth, there are very few of us that actually operationalize that and, kind of, divest that sort of authority and accountability to the people that actually have, I mean they have the most to gain from the success of this project. And so, it is a little scary but the evidence there is building that you know when you do, do that in a supportive sort of well-thought out sort of way, the results speak for themselves.

RESPONSE 8

1 Due to problems with the recording, question one was missed, as well as the first part of the response to question 2 below.

2 fit. And I know that I can support them in that then I put their name forward. So, we don't really have as many sort of people directly walking in and accessing housing first. The reason we do this is because then instead of just having a follow up support worker, the person actually ends up with two support workers, because they keep their original worker. And, then they get assigned a follow up support worker.

So, to answer your question if somebody just walks in the door are all those things immediately available, kind of, other than the waiting period to get into housing first? We have a huge waiting list. So, but in theory yes, everything would be available right there and then.

3 What do we do best? Well, I think that actually having the range is part of it, having the range of services and sort of coordinating them. I think we do that really well. So, even if the person sort of gets referred into housing first and they get housed through housing first we do sit down as a team and do the case plans and figure out what else right, like it's not just about housing. It could be about accessing some pre-employment stuff. It could be about cultural stuff. It could be whatever. So, we sit down and we try and think holistically about what could increase this person's chance of success in their housing. So, I think we're pretty good at that and looking really creatively, 'cause it might, what might work for

one might not work for the other, right. So, I think we're good at sort of looking at a broad range of things to sort of you know really think about what does this person need, what could really help them to be successful and looking at a whole range of things. It's not super formulaic. We're pretty good and creative about that.

4 New housing program, related like to housing? (A: any kind of service to supplement you know programs you already have) We have so many. I'll talk about something that we in respect to housing actually that I've heard a number of other people talk about and I know that one of the things that's a challenge for us is that, we're in the inner city right and a lot of the people that come here are really connected to this community, the inner city community. And, so sometimes what happens when people get housed, because of the scattered sites model, they get housed in communities where they're not. They don't feel part of that community. And, sometimes there's discrimination and you know the story. I think we, we've talked about wouldn't it be cool if you could have like an actual program that helps people integrate into new communities. Now I know that follow up support workers are supposed to do some of that work. But, let's be honest, their time is really, you know they don't have a lot of time. We've talked about you know bringing people to community league events and helping people to, like where's the library, taking people to churches, or dinners, and just really working in an intentional way about helping people to integrate into the communities that they live in. So, that's something we've talked about around housing. We have so many services.

I think if anything else right now at this point in time I think like we do have one position that works with new Canadians but I think that's an emerging need as well, and I think that probably for us moving forward we'll start to look at how we can bolster that service, because we're starting to see an increase in the number of newer Canadians at the centre and one person to help them all isn't really very realistic. So, we'd probably start looking at those kind of things too.

5 When they're homeless or when they're housed? (A: when they're homeless). Well, I think finding them. LOL Finding them so, you know finding them and finding them consistently I guess, right. It's like any time you're trying to get somebody into a program you gotta go to an appointment at this time well if you can't find somebody, how are you going to get them to an appointment at that time? So, I mean we do a lot of assertive engagement style outreach here that we go and connect with people in the river valley, go and find them there. Sometimes we try and bring the appointments to them in their, wherever they're camped, ah, but sometimes it's just persistence. So, I think like actually finding them, following up with them is huge when people are homeless.

Once they are housed, what's the biggest challenge? I think we don't do a good enough job of acknowledging what a big shift that is for people. So, if someone has been living in the river valley for five years and then we put them in a house all of a sudden and expect them to just be fine I think that, I think it can be a really huge scary shift for people so I think sometimes we have to when we are thinking of what services to provide, I think we have to be a little bit careful not to overwhelm people. I mean we have guys that put in an apartment and then they sleep on the balcony, outside—even in wintertime. They just can't sleep with a ceiling, things like that, right. So, if you're then, you put them in this place and then you're throwing all these other things at them I think it could be pretty overwhelming for people. So, I think finding the right timing to introduce the right sort of services I guess.

6 Whoa! A new program to end homelessness! Am I reflecting my own opinions or the opinions of the agency as a whole? Well, okay, so my opinion is that I think that, I think that part of the issue for us about ending homelessness is that, I think sometimes we have to manage homelessness a little bit better, acknowledging that it's not ended yet, right. So, what I mean by that is that, at least in our city the shelter system could use a little tweaking at times like, they do their best, but I mean they're sort of underfunded and they're always full, there's no shelter for families. I think one of the things I would do first if I was queen of the world is I would acknowledge that sometimes people end up being homeless and so, if we could design shelters that were built in a, to accommodate families and to be like more like homes where people could like still work and still look for work and still, 'cause I mean we all know that people in, get into shelters it's really hard to do all of those other things and it seems like the longer they stay in shelters, the harder it gets, right. They just get further and further out of that, and it gets harder and harder to return to a more normal for a lack of a better word. So, I think I would, to end homelessness I would first acknowledge it and manage it better, 'cause let's say a family ends up being homeless so now what happens, their kids get probably apprehended and put into care unless they have family that they can put them with. And then the adults have to, they can't really stay together, and so, you're either staying on a mat program where you can stay together or you're staying in the river valley in a tent 'cause you can stay together or you're staying separate, and then you're open to violence and you're priority isn't going to be getting back to normal, you're priority is going to pretty quickly become survival. So, if people could just you know, oh shit we're homeless, pardon my language, go and, here's a nice shelter, it's sorta like a house, you can maintain some sort of semblance of normality and just get back on your feet really quickly. It could look a little bit brighter, right. That's one thing I would do.

I think [unintelligible] like though in our city, you're calling from Victoria right? Here we have a real shortage of housing options outside of the housing first range. Housing first does a great job for the people that are eligible, like fantastic job, but there's a lot of people that aren't going to be eligible, either they're too high needs or they're too low needs and we just don't have that much housing right now, period. Like we need way more housing. But we also need way more like different models of housing so permanent supportive housing and stuff like that.

7 Yeah and that's why I asked like when I talked to you the other day about integration, I asked you I believe whether that was formal or just in practice. Like we don't formally integrate those things. We just have all of those services available. And we just work as a team from program to program, right. So if somebody's in housing and we have our working together meeting and somebody's in housing saying, oh, this guy needs to do this, then we go oh well just lets' we can do this we can do this. So, we just work in a collective fashion. But that's not, there's not like a formal, like this program is for housing and employment. Do you know what I mean? And, there are other agencies like that here as well that have a range of programing. Like the X is another program that has a whole bunch of different programs. And so their participants can draw on any of those programs. So, is that formally integrated? Not really.

I think like the fact that we do service team meetings together I think that's sort of a level of integration, right. Because like if I'm somebody's key worker I'm going to sit down with them and with their housing worker and we're going to go through their plan and we're going to identify everything, not just housing-related stuff. We're going to identify everything that could contribute to the success of the housing placement. I guess that's sort of a formal integration 'cause that's' when we start pulling all that other stuff in.

Well, I will say it's a lot, we find we have a lot more success than we did before when the housing program sort of more worked in isolation. Yeah, and like I said we do tend to end up with people who are higher on the acuity scale like our community has a lot of challenges. And so, we're sort of more at the top end. I think some of those people probably wouldn't even be successful, they need that extra support. They need those extra things in place. So for sure, working in sort of a more collective or integrated way has seen some better outcomes for our community for sure.

And also like the range of options, right when you have more people working together the range of options is going to be a lot more comprehensive. So, I think that's probably another factor.

8 If I was going to start a program that had housing and healthcare and employment integrated? What would I do first? In like, I haven't done anything yet and I want to build this program?

Well, it's housing first, so I guess that should be the answer, right? I suppose I would get enough structure in place so that minimally we could start the process of housing people. I think a lot of issues are mitigated when people jump into housing, right. So, people might have all kinds of crazy behaviours and all kinds of crazy mental health or health issues while they're homeless, but then once you get them into housing people can really stabilize a lot, and I think like even when we SPDAT¹³³ for as an example of a person living in the river valley their SPDAT might be super high but then say we put them into transitional housing for a little while their SPDAT might go way down just because of the stabilization and so I think I would start with the housing piece so that we could really get an accurate sense of what were the health needs and what were the employment needs. I guess if that makes sense.

No, I think I would go with the principles of housing first and provide the housing first and then take a temperature, like what, 'cause like for us honestly sometimes a lot of the clients we have employment's not even going to be an option. So, you know going in to some certain environments perhaps with like a whole bunch of employment options, it might not be appropriate for you know a good chunk of the folks that you're serving. So, I think getting people into the housing, letting things settle down a little bit, and then really thinking like okay what really are the needs here. Because we also see with mental health people who are homeless tend to not take their medication and then when you can get them into a home and you can get them into a routine, they start to take their medication. And so, then all of a sudden they appear much better. And, so I would probably do something like that. And then, build the other services based on what I was finding, what would be useful to people. And, talking to people too, right, letting your participants guide that sort of stuff.

9 Hmm... Lack of housing is always a challenge. And lack of a range of housing, as well. And I guess I kind of answered that in saying when you first interact with a person you don't necessarily know what the other needs are. So, that assessment time, you know like I think if you did an assessment right at the beginning you might not move in the right direction.

What else could be a challenge? I think just, for us a lot of the challenges are appropriateness of services, sometimes, even with an employment style program. We have a pre-employment program and it's fantastic, but it really can be anything from resume help to you know like basic math to safety

¹³³ The Service Prioritization Decision Assistance Tool (SPDAT) is an evidence-informed approach to assessing an individual's or family's acuity. The tool, across multiple components, prioritizes who to serve next and why, while concurrently identifying the areas in the person/family's life where support is most likely necessary in order to avoid housing instability (OrgCode Consulting Inc., 2016).

tickets. So, it's very broad so that we can meet a very wide variety of needs. When we started, actually started out as sort of a GED prep thing that was doing high school level online virtual learning kind of stuff and you know we found out that wasn't realistic and people couldn't come every day for three hours a day. That didn't fit into their lifestyle and so it ended up being underutilized even though it was an amazing service it just wasn't appropriate to our population. So, fortunately we were able to evolve it and so now there's no attendance requirements. You can go whenever you want, whenever you feel up to it. And, yeah, there's a broader range of services. So, I think appropriateness is big.

10 One, only one? You're only going to let me pick one? I think it has to be, I'll use the term client-centred, or client-driven because I think that it captures a number of different things, like appropriateness and you know. So, I think we have to be like is this useful for this population, is this realistic for this population, you know, are they going to be able to access it, is it going to be meaningful and useful, those kinds of things.

11 Probably centralizing intake, and that first, that intake and then service team meeting plan. That has to be collaborative. So, that's two things, but they're kind of related in my mind. What I'm saying is that from the onset if we're going to truly integrate all this stuff, then from the onset from the very beginning we need to figure out a) all the things this person needs realistically and then b) have everybody in the room when we figure out what we're going to do, including the person themselves, obviously.

12 Operational challenge to doing that kind of work? I think the thing that jumped out at me when you asked me that, was is the funding for these different programs coming from different sources. And, the reason I say that is because, let's say, well I mean housing first funding is pretty much a given, right, and you know it's fairly stable it's fairly secure, you know we're not going to get any... But other services that we provide are more reliant on grants or pilot funding or annual funding that needs to be renewed year after year and isn't necessarily as stable and secure. So, I'd hate to like setup this really awesome thing and then have a whole chunk of it not get funded. And that's a reality our, in a not-for-profit in the inner city, right like some of our programming we have is stable but some of it and some of the best programming we have is like we gotta be schlepping all over it year after year trying to find people to give us money to provide these services so. So, that's huge, it would be great if you were going to do something like that, or if I was running a program. It would be great if this could all be funded equally, as a unit, right, like as one thing instead of patchwork funding. 'Cause then you can't, like yeah you get six steps down the road and then you're like oh, we're not going to get our funding, or the other thing that can happen if you've got a bunch of different funders is the funder can say we don't want you doing that. We want you to focus on this over here, right. So, yeah, that jumps out at me for sure.

13 I think it has to be a commitment to, because it will, like if we were, we're doing it now in a way right? But, it's different programs with different departments, different management, different funders, blah, blah, blah. I think there has to be a real commitment to working in that collaborative way. And sometimes working in a collaborative way can take more time, you know because you gotta go to that extra meeting with the team. And I think that sometimes people are so busy already that they see that and they kind of go oh just don't have time for one more flippin' meeting I need to be out working with my clients. And, I think there, you know if you've got management on board and everybody's on board with committing to this I think you could see real savings down the road, but when you're a front line worker and you're running off your feet all day every day it's hard to see that bigger picture, right. I

think it has to be a commitment at all levels, this is how we're going to work, we're going to work in a cooperative way in a collaborative fashion and that's what we're going to prioritize and then, and then support that, support your people to do that.

14 Well, I think I've talked about a couple. I think a big thing is figuring out really what people and not in a situational sort of way. Letting people stabilize a little bit and give their head a shake. It's almost like you consider even if you put a person in a home you almost give them a transitional time in the home, in a way. I think like doing, I mean and that's all around doing a good assessment, really being careful about that assessment. And so, some of those other principles I talked about like making sure it's client-centred and realistic and accessible and all that kind of stuff. I think for me that would be the big thing, like, okay so we've got this guy in this house and want to pile on all these other services, how are we going to do that and how are we going to do that in a way that's meaningful for that person, so that they're actually going to want to be engaged in those services. 'Cause we got lots of services here, we got lots of people here. Lots of the people don't pick, don't always, you can't force services on people. You're going to feel like I know you need this service. People have to want to be engaged in your services. None of them are like mandatory or you know court ordered or anything like that, well most of the time I guess, but you know it's all voluntary for us anyways. So, yeah, it would just be really thinking about, really thinking about that client being engaged in those services and what that looks like. And then also planning for sustainability at the same time. So, if you get something really good going and it's really going well, you know how are you going to keep it going? Which brings in evaluation and research and all that good stuff to prove that your practice works. Again, not one thing.

I think really this, really doing a good survey and a good assessment. And also like sometimes, if I was creating something new that didn't exist, I am always mindful that we don't re-invent the wheel, 'cause we like to do that. And, so, I mean, is it, do we have to build it in order for it to be integrated or does it exist in the community and could we collaborate with our partners and create integration? Does it have to all be in the same agency? Okay, so let's say we only had housing, I mean do I have to go create an employment program or am I going to my partners and finding somebody who already has an employment program that might be suitable that we could maybe create a link there that my clients could access that pre-existing services. And, maybe there would be tweaks in that pre-existing service so that was appropriate, but could we do that, you know—looking at all the options, looking at what already exists in the community and being mindful of who we're serving. Figuring out where you're going to get the money, that's a big thing, in planning, right? Who will fund us? And sometimes you know funding options out there that might impact your planning. Well, it happens all the time, right, especially around housing, 'cause people get sort of like, because it's always such a frustrate...and I don't know if it's the same where you are but like it's, the problem here is that there just isn't enough housing, but so then it becomes like well who's responsibility is that? Is it the city's responsibility? Or, is it the province's responsibility? Or, is it the fed's responsibility to build more housing in our city? And so, sometimes if you're being funded by these people who are supposed to be serving this segment of the population but you know then you partner with somebody and you know then you're not exclusively serving those people anymore then, oh, like oops, it can be a real significant issue. Or, if you change your practice a bit, right, start doing an activity that wasn't really a part of your mandate.

I think I would just underline that, the whole commitment in all sort of levels of your organization to committing to that collaborative kind of work and that integrated way of working. And it's tricky, right, because as much as you might say that, you still get silos. And it's largely because of funding sources

and stuff like that. But, it's also because of busy-ness and mandates that are different and all that kind of stuff. So, it's a major commitment, especially initially I think.

15 I think something I haven't talked about which seems to work kind of well in some of our services here is the involvement of the service user in the planning stages, well and actually in every stage actually. I mean, it's a challenging thing to do in a respectful meaningful way, but I think we're trying to come up with these services for these people, well why aren't they involved in the process? You know, okay we've got our professional wisdom and can certainly probably make educated guesses as to what people need, but why not ask people that need it? I think taking it a step further than that, like a best practice in planning could be to formally involve people in some way, the recipients, formally involve them, take your ideas to them and say what do you think? And in operations, let's have a check-in, how are we doing? What could we do differently, have an advisory board, or something like that? I don't know. So, I haven't talked about that yet. I've seen that work in some realms of our practice so, where things that affect people, when we have decisions, they're able to be part of the decision making.

RESPONSE 9

1 I'm the co-director, so I guess executive.

2 Let me just back up a quick sec, so we provide the property management services of supportive housing, but there are supports, there are case management sort of more clinical services provided by the department of public health in the building so, we just do the property management but the buildings do have an integrated service in them. Health and housing.

3 I think we do best at providing housing for people who have often struggled with being able to access housing either due to their acuity or being able to actually maintain their housing. Because the people that we serve all have pretty severe mental health and physical health issues.

4 I think for us, we've been wishing we had additional resources to do, you know I think it's kind of tricky because at its face I'd like to see more employment services, but that's not something that we provide as a property management company so what, as a property management company we are really looking at is building more resources to do more, I guess more holistic community building events like bringing in kind of non-traditional services, art or yoga or, you know we've been doing these photography projects to try to help people connect in a way that's not so related to their disability or their homeless status. And I think it's important just because it recognizes that folks who are formerly homeless you know case management is not all they need. They need also just to kind of re-connect to who they may have been or skills and talents that they have, even if they're perhaps unable to go back to work or don't have the resources to do kind of the, to get engaged in those things as anyone else would.

5 I think getting, one of the challenges is just ensuring that the different providers that are involved are on the same page and sharing the same mission. You know we'd like to see for example our service provider do more unemployment and food. They don't see themselves as an employment or food program, so, there's just some challenges around sharing the same vision in the same priority. And I think it's best dealt with just with ensuring that you have a solid MOU about what's important and solid communication channels you know we're going to be re-visiting some of these issues in the New Year and I think just being able to have frank and open communication is important.

6 I think I would try to get, I have a community advisory board that's made of tenants in my current buildings. I think I'd like to sit down with them and think about what are we doing now that's working, where do they see that we're falling short as formerly homeless people in the program, you know what works for them about getting in or staying in that kind of thing. 'Cause I think their perspective is the most valuable in trying to do this work and, I've been working in this field a long time and I know a lot about it but certainly don't know as much about as the people in our housing program. So, I think it would be best to get their perspective first.

7 There are many providers in our city that are, that have health care, employment services and housing. When you ask what's the program, you mean what's the name of the organization or what are you looking for?

You know I think X does a great job. You know they have significant housing stock, they have a pretty robust employment program, they have health-related care, they don't have, they're not affiliated exactly with a health clinic the way that we are but, they have case managers and mental health providers involved. I think they do a great job because they're very clear. They have it all in-house but they're very clear that their mission is to do more than housing. They want to help people regain some independence certainly financially and I think it seems to work well.

X is another organization locally that I think does great work. They have housing, they have healthcare, they have pretty robust employment services as well.

8 Well again, I think working with, after getting the perspective of the tenants, the potential tenants I think it's really important to get very clear on the goals of the program and get the organizations who would be providing the services clear on who we're serving and what kind of outcomes we'd like to see. I think it's important because I think there are differing beliefs about who's ready for employment services, who's ready for housing and I think getting all that out would be a good way to start—being clear on that.

9 Well am I assuming in this question that I have the resources I need? I think, that seems to be the biggest challenger for us at least in terms of getting all of the services in place to make sure that, you know, get them funded. I think aside from that again it's how do you ensure that people are on the same page? Are your employment providers interested in people who can demonstrate sobriety where that's not really what's required in the housing. That doesn't happen as much anymore. I think people are getting savvy around harm reduction, but, I would want to make sure people are sharing that same vision. And it's a lot of time to spend in planning and implementing programs. There's a lot of time that it takes to ensure you're on the same vision, build that trust to be able to have tough conversations so, and it can be hard to do 'cause everyone's pretty strapped and under-resourced in terms of their own time. I think being able to dedicate the time for planning is tough.

10 I think involving the folks you're going to be serving in the planning—in a meaningful way, I mean trying to figure out how to really get people at the table who can help figure out what the barriers are why are people unable to access traditional services, you know what's happening for people.

11 Ah, I'm trying to think about how you would talk about building in some method of accountability in your policy so if you're assuming these are provided maybe by different organizations or even different people within the same organization, how do you ensure that there's a real

commitment to holding each other accountable to having tough conversations to embracing conflict to make better decisions. I think that's really important in any work that you do but I think especially in serving a complex population with a complex number of, trying to entertain different services I think really being able to embrace that we're all going to be frank with each other and really embrace healthy communication I think is really important.

12 Well, I think I'd have to think about that for a second. I think just the coordination again and collaboration is very, can be very difficult and so I feel like I keep hitting on the same issue and I don't mean to be not helpful but it just, yeah, it feels like the challenge is collaborating. Certainly in supportive housing there's so much built-in inherent tension with property management staff and service staff and tenant demands and I think the challenge can be to kind of keep people on track and keep people on mission and have those kind of discussions before what are we doing here and what are we doing when stuff breaks down what do we do when things aren't working out, like having some agreement ahead of the game and having regular communication built into your system, I think is really helpful. It just seems the break down and difficulty in collaborating can be some of the hardest stuff to do.

13 I think really to have the basic philosophy, which I guess is mostly usually concerning harm reduction but to be able to meet the person where they're at so to be able to keep your judgement back and be able to see the person in front of you as being the driver in what your services are, you know what's valuable to offer to them. So, I think having that really client-driven practice is very, you need to have it because otherwise the tenants, if the service is voluntary but they're not relevant to what people need, they're not going to use them.

14 Can you give me an example of what you're looking for? Do you mean something specific? (A: Could be something as day-to-day as having regular staff meetings, ah, or you know planning them, or it could be something as high level as something as what you've already been talking about already and that is making sure everyone is on the same page from the very get-go.)

I think in planning around sort of all the services is really in looking at the design of the site, if we're talking about a permanent housing site, single site, I'm most familiar with single site design but you know ensuring that the services, presuming they're voluntary, which all of ours are, are well located, are accessible, are friendly, and I think those things make a difference. I've worked in a building where the health clinic was down in the basement and people did not want to go down there and I've worked in building where the nurse is right there as you come in and it's a very, very welcoming environment. I think it has a big change. So some of it around building design, where the services are, hiring the right staff who can engage with the people who maybe are not interested in the services. I think people give up, like oh like I've tried to engage that guy in services and he's not interested. I'm like, well, maybe you're not offering the right services yet, you know. Keep trying.

I think certainly the regular communication with us in-person meetings, having the right people in the room, so decision-makers are regularly seeing each other face-to-face and hearing about the challenges. I think also in terms of health services, debriefing deaths, debriefing evictions, debriefing crises in a timely way with decision-makers in the room to really be able to see are there things that were, we're missing, are there ways that we could, for example, we're looking at now you know we've had, not a lot but a handful of overdoses. Is there more we could be doing around providing Narcan or, you know are there more pro-active ways we could be trying to work with people who are actively using, and who we

know they're using but they're not coming to us for some life-saving things where there could be things we could be doing differently.

15 I think for us we've really been amazed at the impact of things like, as I was mentioning earlier like this photo-portrait project where we have someone coming in and they're doing these portraits of residents and the residents are getting a portrait to keep and there are these beautiful photographs where people are really at their most self-possessed and it's interesting to hear from people. It's the first photo they've had of themselves in years and some people are talking about sending it to a family member who probably hasn't seen them over twenty years. So, I think, some of those things around looking at people holistically at people. We all take pictures of ourselves all the time or we have pictures of our friends or our families, so trying to look beyond the immediate health needs or even the employment or even, once people are in housing and have a certain level of stability, are there ways to engage with people at a different level where you're not just looking at sort of what deficits they're bringing and more art, you know again we have some difficulty getting people into it but once we find people get engaged in art or yoga or whatever, we've had a lot of real successful experiences with residents feeling better about themselves. And I think those are really important to keep in mind when you're designing things.

RESPONSE 10

1 Executive.

2 Due to recording difficulties, the first part of the response to this question is missing.

And, that runs the full gamut from, we train peer workers that go out and do outreach in the community and in various community agencies. We provide education related to harm reduction, every week the peers come in and make up harm reduction kits that we make available in the drop-in 24 hours a day and we have an arrangement that, men don't come into X, but during the daytime hours they can pick up kits from baskets on the stairs and then after administrative hours they can go to the drop-in door and staff will give men kits as well. We have a psychotherapist that works here. It's a partnership arrangement with the Jane Tweed Centre. We have two psychiatrists. We have two GPs that come to us through a partnership with the inter-city health agency. We have a nurse that comes once a week. We have our own trained social workers who work as case managers and counsellors for people that come here. We have an employment program that provides employment-readiness, so how to write a resume, how to get prepared for an interview. We keep clothing here for, specifically for women that are going to job interviews. We have a range of social enterprise programs leading to employment, which includes pottery, sewing, weaving, and knitting and in January we're starting rug hooking. And, we do social recreation programs, and depending on what you think of social-rec, I think it's a, I consider it as a part of a healthy lifestyle, part of the healthcare provision. Other people wouldn't agree with that or would have a different perspective. I think that's pretty much it. There are quite a few programs actually.

3 I think the major piece is we provide a physically and emotionally safe environment for women and trans-women. And, we provide three full meals a day: A hot breakfast, a hot lunch, which has both meat and vegetarian options. We provide dinner at 8 o'clock at night, again meat and vegetarian. We have sandwiches and hot soup available overnight, and then we have two different during the day that we provide snacks for women. So, I think the food program is really important and I think the

environment that we provide is really, I mean at a really basic level and then all the other programs build on that. We have a clothing donation program. We have a houseware donation program. People can come here and launder their clothes for free.

4 Okay, on the health side, I think if we could provide a foot clinic. A lot of our women they're homeless, they're walking around outside and they have a lot of difficulty with their feet. We see a lot of elderly women and with diabetes. So, it's that kind of, again basic kind of service. Dental service is really an important part of healthcare. At one point earlier this year I thought I had an organization that does mission work in other countries. We almost got to the point of having a dental clinic here, but it fell through because they, of their lack of funding. So, those are the sort of health side. And then I think we could use additional resources to build on our counselling program, because we have so many women and we have, our staff have huge caseloads so you can't really do appropriate counselling. Each person has something like 50 women on their list. So, you're really just dealing with crisis you know. The program that we have with Jane Tweed however, women can sign up to that program and they get a 100 hours of counselling over a year, which is really, really helpful for people that really need and can benefit from the long term care.

5 I think that one of the major issues we see... Let me start, people just fall through the cracks. And, people, we have one woman here who has been in Canada for twenty years and she lives in a shelter. She has no documentation. She cleans our washrooms once a week for ten dollars. And, that's what she has. So, she comes here every day, has her meals and then goes back to the shelter. Oh, sorry, that makes me think, we have a settlement worker here as well, and that's in partnership with another community agency. The settlement worker helps with getting people integrated, and proper documentation et cetera. But this woman has not been able to be documented, has no family, has nothing. So large numbers of women fall through the cracks. It's, there's such a variety of services in the downtown core and there's been lots of different attempts by the provincial government to try to integrate reporting programs and things like that, you know, so that people can be followed, except, there's lots of drop-ins, like ours, and people may or may not want to be known. So, we ask people to sign in and they may or may not. They may use their right name, they may not. So, it's just really, really hard to follow people like that, street people. So, it's tough to really integrate service, and one way we're trying to do that is we're partnering up with two other local agencies, one another drop-in and one a multi-service agency. We have a shared peer program and these peers are available to take our clientele to doctor's appointments, or criminal justice appointments or whatever, and, between the three of us, the three organizations, we can, we get a fair bit of integration going. But, I think probably the most difficult part I guess is that it requires human resources just to do this. It's definitely not a paperwork kind of process. And, that all comes back to funding, and what you mentioned right at the beginning. It takes a lot of determination on the part of service providers and a willingness to really put your shoulder to the wheel to make this kind of thing happen.

6 Well, I guess not following a project management approach or not following process report of process initiative. I would just start building housing, and you know we just don't have it and in our city our shelter beds, we don't have enough shelter beds. They're full, and I've been pushing for a low-barrier shelter with the city because women that come here with the kinds of issues they have they can't stay in a shelter. Our women come and go and they use alcohol, they use drugs to the shelter system can't accommodate them. So, I would just be building houses, I'd be, not houses, but housing. I'd be building in the supports that people need. You may or may not be familiar with our city's Housing

Authority, years ago they had a large social component to their program so we had workers that provided support to people living in housing. And, over the years, due to budget et cetera all those supports have been taken away and it was expected that other agencies or the city, whatever, would provide those supports but they can't and they haven't. And so, people can't survive, a lot of people can't survive in housing without day-to-day support. So the system needs folks that can support homeless people in housing and we need housing. So, I guess I'd go at it from two prongs, Kerry: Building the housing and then building in the supports.

7 Okay, a couple of, one agency comes to mind. I don't know if you've spoken with them, it's the X. They're located in X, which is a traditionally a lower socio-economic area of our city. It has lots of homeless people. When the institutions turned out mental health clients onto the streets, that's when they ended up in X. So, this organization has been around for about XX years. They own their own building. They provide a range of programs like we do. And, they have, have had 10 units of housing in the building and about four or five years ago they were able to buy an adjacent boarding home and they now have 29 units of housing in there, with you know programs, assistance, etcetera. And, um, they've, they work on the advocacy site as well as the integrated people into housing. Um, it seems to be working well, and, um, you know the problem is again you need more housing. And the program works well I believe because it's integrated into the rest of the centre. They provide 24-hour support in their housing. They will prepare meals for people that are living there, um, people can prepare in their own units and they have communal kitchens on each of the floors. So, depending on the level of need, people can get their food needs met, as well. And, um, that's one of the integrated programs that I think really works well. And, the kind of program that we have that we've been talking about is similar, other than we work with other agencies that have the housing and we refer people to them.

8 Well, I think the, with something like that I think the first step would be, assuming you that had the funding etcetera, would be community involvement, community development process. We have, I don't know, I assume it's the same out west, we have the problem with communities not wanting these kind of facilities in their neighbourhood. We had one recently where a men's shelter, it was already in existence, but they were increasing the number of beds and the community uprising was incredible, and it was just down the street from where we are. I think the very first step would be to get the community on board, make sure that they understood what we were doing and why we were doing it and get the kind of support that you actually need to make the community successful.

9 (referring back to the previous question) I think definitely that would be a challenge. Then there would be a funding challenge.

I think, at least here in our city, there's an acceptance that this kind of model can work and there's been various attempts at different types of this model over the years. But, if I use the example of X, I think it demonstrates that it can be successful and that it can fit into the community. One of the things X did before they started their 29 unit of housing, is they trained clients of X to be, what they called ambassadors, and, they went through a training program and then they went out in the community and knocked on doors and explained to people what X did, what the plan was. People were invited to come and see X and to participate in community meetings. And, they actually sailed through. And, I think that just twigged something in my mind. I think the success of all the various programs work if we have our clients working on our behalf: So, in our case peers going out to appointments; in X's case, clients being ambassadors for the program. Both of our organizations train our clients to do work in various

capacities within our centres, so, from dishwashing, food preparation, cleaning, receptionist services, that kind of thing. And so, I think the more clients get involved in developing and running the programs I think that's a challenge getting that setup but if for long term success it really makes a difference.

10 One of the, aside from what I talked about with the community etcetera, planning in that regard, it's really critical to get all of the various players in the room at the same time and for a series of times. We just started 24-hour operation in November and, so we had a series of meetings with various service providers in the city, the police, the emergency folks, street nurses, outreach people, anyone that deals with our population from whatever perspective, the, downtown hostels, etcetera. All of us were in meetings over a period of months to make sure that we knew what services we could provide, how they could be shared, how they could be integrated, and, each agency has their own culture, and their own way of doing things so you have to work through all of those issues to make sure that everyone's on the same page moving forward in the same way. And, you do have to, in my view, put that front end work in if you want any chance of success.

11 I think the biggest thing there is agreement on how you wanted, how you would meet and treat your clientele. So, X operates from what we call a trauma-informed, anti-oppression, anti-discriminatory perspective to ensure that people coming here are safe and feel safe. And, we're just now because we've been open 24-hours and we are advertised as a safe space for women and trans-women we've had a big uptake in our trans-population. And that has really tested our vision of how we operate. We have a number of women who have been coming to X for years and years and years and we have a lot of elderly people. And for a number of them, having trans-women in the space has been really challenging, and it's raised a lot of questions for them, which a number of them are terrific, they'll stop me or stop staff and have a conversation about it, but, just yesterday one of our trans-women came into my office and was complaining bitterly about this one woman who continues to call her, he and refers to her as a him and asked what body parts she had and if she had the operation. And it gets complicated because this woman that was asking is 85. So, we've had those kinds of challenges so, it's so critical to have people understand the culture—both the participants and the staff—that you want to have. And then once you have that in place and it is a policy, it allows you to deliver on a safe environment. But it's not something, like it's required us to talk to the individual women to do additional training with staff and training with the women that come and ongoing monitoring and if people, we have this situation now, we've been open now almost two months that when people are saying transphobic comments, we are now asking them to leave. We figured there's enough time has gone by. And that's, it's very hard to do that, but you know we decided we have, if the place is going to be safe for everyone, we have to get everyone on board.

12 And, this is assuming the facility is there, right? It's a bit of a logistical challenge to be quite frank. When you're open 24 hours a day/365 days in a year, logistically you really have to be well-organized. Communications is really critical between the different shifts, and, we run 3 shifts a day and between each shift, people sit down, and, but you can't have the whole team sitting down because you need people on the floor, telling people what happened on that shift, who's in crisis, who's whatever. And then there's the written communication. And if the communication piece is not really clear, you can get into some really thorny situations. So, communication between the various pieces of the operation and communication between the people working the various shifts is, I think is really, a really critical issue. If you don't have that, all hell could break loose really. It's very difficult and if you, if

there's one little piece missed, you know, and you make a decision based on that, it can have ramifications.

13 Okay, again, I would come at it from the perspective of understanding that our clients come from a place of trauma. I would say it's safe to say that every one of them, and to me it's safe to say that for the whole population, general population, but, I think the trauma in their backgrounds has probably led to them being homeless and we as service providers in every interaction with the homeless have to understand that this is operating in the background of everything they do and every interaction they have. Even while people appear well and appear to be functioning smoothly, anything could just trigger a different kind of reaction. And, I think that people just have to have that in their core that understanding that trauma exists all the time for these people when you never know when it can be, when it can be activated. And, unless you can do that, I don't think you can be successful. So, I think it's just a real thorough under, that level of understanding of what conceivably could be in a homeless person's background, and then you provide your services based on that.

Questions 14 – 15 Skipped

RESPONSE 11

1 Manager

2. No, we provided a supported living service, visiting people in the community in their homes, temp homes, hospitals or hostels and then continue to work with them as they get allocated permanent homes.

3. Provides recovery focused support to assist them to reach their outcomes preventing them returning to homelessness situations

4. Crisis centre, self-harm centre, recovery college. To ensure that we are able to offer the individuals in the area other services which may suit their individuals needs more appropriately.

5. Making the service easily accessible to all individuals affected by homelessness

How best is this challenge dealt with?

Staffed 24hrs, limited remit to service, approachable and experienced staff, peer staff (paid)

6. Speak to homeless people, gather information in what service was missing in the city, too many services are commissioned without discussions with people that they are there to help.

7. No

8. Speak to homeless people

Why would it be important to do first?

Identify needs and what will work best for people who are living with homelessness.

9. Engaging with the hard to reach individuals who traditionally don't link in with services ie rough sleepers.

How would you go about overcoming that challenge?

Do some joint work with the individual services who are already working in this area.

10. Person centered service

Why would you consider it essential?

Puts the person in the center of the service and looks at what they need and not what the service can offer.

11. Service delivered by mainly paid peer workers,

12. Balancing the support to the workforce of paid peer workers and the people who the service is aimed at.

13. Flexibility, offer options to service users and keep trying to engage with them, keep the service open to them, no barring due to missed appointments.

Why is it essential?

People who are homeless can have chaotic lifestyles and may not always be able to keep planned appointments.

14 – 15 Skipped

RESPONSE 12

1 Executive

2 So all of the above, harm reduction, counselling, rehab, employment services. So, we've got XX different sites, our primary health clinic, free clinic for folks, and we've got a low-cost dental clinic, HIV services, harm reduction is practiced in all of the different sites, so, we're offering education and harm reduction materials. We've got nurses hired for two of our more precarious sites, that's 346 and the X. The X is a drop-in specifically for people with mental health concerns. We've got employment programs, we're doing an employment pilot, which is a research project with the feds, fed money, and X is leading the research and it's a partnership with the X group, and that's happening at three of our downtown facilities, that's the X, the X, and the X so, all housing programs. We're doing social enterprising out of the X on two different projects, a flooring company and a moving company, and they're being offered to the tenants upstairs in the transitional housing and our X, our sober housing. So, we've got two sober sites where we've actually been supported by the medical model for sobriety but also by the multiple-step groups, so we do some of that as well. We've got a lot of peer-to-peer stuff that serves, pre-employment and skill-building, as well as community socialization that kind of stuff, I guess. I don't how much more you need to know in terms of, I could talk a lot about, we've got VCC¹³⁴ on one of our sites doing grade 12s and that kind of thing, we've got the X Partnership and the X is our cook training program, so that runs on the North Shore and at the Sakura so in the downtown. So, we're actually training people with credentials for cooking.

We made this jump, I came on to our organization about a year and a half ago and we made this jump, the organization and myself and, ah, senior management proposed a little bit of a strategic plan, the

¹³⁴ A Community College

board did a bunch of work on that, and we've been working under this directive to build health and employment resources and new options and opportunities for people at all of our sites. So, that's been a real change in focus from historical work that we've done, cause we've really just provided shelter and housing, but over the last 18 months we've done incredible work at bringing in partnerships. We've got Work BC is on almost every one of our sites offering, you know, employment opportunities, resumes, cover letters, interviewing skills, yeah, so, it's been a great shift for us.

3 Um, I guess it provides, ah, well, I think we're really strong at rapport building and relationship building, kind of meeting folks in a non-judgmental, safe environment, where they can get offered different opportunities and they gravitate to the ones that most fit them. Um, but, I think the most important piece is certainly, that, the relationship building and that trust, fostering trust with folks, cause you know the people we work with have, you know, an inherent distrust for anybody with perceived power and that's I think something that we do best as an organization is present the options without leading them towards anything in particular allowing them to make those decisions but fostering the trust and the safety that's required for them to start thinking about what their life might be like with some different choices.

4 Hmm... That's a great question. Depends on the day you ask me this kind of stuff. There's always, I mean I've got probably 15 shovel-ready projects, ready, you know good-to-go. Like we just need the funding around that, so prioritizing them can be a little tricky at times. You know in some communities, case we serve 8 different communities across the lower mainland, right, so we're X all the way into X. The community need is very different from municipality to municipality, but I can tell you the common thread is, poverty reduction programs and housing programs. So, it would be a tossup between one of those and the different communities, certainly, I could prioritize if you were asking me about you know what do we need in one area more than anything, I'll tell you it's transitional housing, and if you asked me about X, what do we need, we need a shelter, right. So, it just depends on the municipality. But, certainly the common thread for the whole region in my opinion is the poverty and very extreme ostracize, nobody cares, nobody gives a shit about me kind of poverty, or the housing, which hopefully the new change in federal government we're going to some investment there.

5 I guess it's pure need. It's just this sheer number of people that need specialized services, you know I've been in the field a long time. Ten years, 15 years ago I don't think people were as harmed as they are today. The drugs are harder and more addictive than they were, you know the resources have never been in my opinion as saturated in terms of folks lining up every night and wanting to get into our beds or get into our, drop-ins, you know systemic challenges seem to be falling on deaf ears in terms of poverty reduction plan in the province or a national housing plan or a national health plan, particularly around mental health and addictions. You know the region has been absolutely inundated with mental health challenges, you know people that would have one time probably got service in institutions, and I'm certainly advocating for that model to come back, but right now they're coming into shelters and they're coming into drop-ins and, it's certainly plugging system up and plugging up the health system in terms of if you look at any hospital emergency room across I think the province you're going to find folks that have typically been served in institutions.

You know there are systemic challenges from the province and the feds that need to be addressed. What are we only the only G8 country in the world not to have a national housing strategy, what are we, the last province in Canada not to have a poverty reduction strategy? You know, you wonder why folks

are so incredibly fragile especially in a place like our city which is, you're on the street you've been in the shelter system in multiple provinces you know this is kinda the Mecca, the place to be in terms of sheltering because, it's even warm enough in the summertime you can sleep outside. In the wintertime you're not buried in snow. So, it's always going to be an attractive region for its natural beauty and its reputation. But to not address some of the ongoing issues around the lack of integrated health services in programs like these or to have legislation that seriously takes a run at addressing some big issues like poverty or housing. We're not working, we're not pulling the rope in the same direction and everybody is just trying to do what they think is right.

6 It would be development of those key plans, and the reason why I would is cause there are a lot of resources focused in on marginalized people that could be used so much better reducing duplication, helping the non-profit sector, which is far cheaper than the health or the criminal justice system or the, you know these, in terms of outputs per cost if you could focus current resources into the same kind of approach around ending poverty or ending homelessness or creation of social housing or, those kind of things, then I think that would be the first steps that I would take in terms of developing a new program.

It's interesting cause you look at something like a provincial entity like X non-profit housing and some of the work that they've done there and I'm a recent new addition to the board at X non-profit housing. You know they really want to kick-start the end homelessness campaign in the province but some of the challenges you inherently run into is the advocacy that could be done by local community organizations is threatened by funder relationships. If you say that that we're not doing a good enough job at housing then it's difficult not get under the skin of the housing providers, or your peers in terms of housing providers or X housing themselves in some cases. And, the system itself, the provincial direction and the federal direction isn't clear on what we want to do and the investment certainly at the federal level in the last couple of years just simply hasn't been there. And at the provincial level it's the shift to more rent subsidies and outreach supports and away from the traditional four walls and a roof and shelter opportunities. It's great and housing first is another kind of recent tool that's been thrown out there but it is only a tool and it doesn't work for everybody and it isn't the second coming in terms of this is our solution it's a piece of the puzzle that we certainly have to utilize but we don't want to forget the shelter sector is doing incredible work in place of sometimes criminal justice system or in places the health system. And, without kind of a detailed plan on who's going to take on what role, what happens is that people are pulling in different directions and the folks that suffer most are the most marginalized.

7 So I think this is a difficult question. I don't know how much time we have booked for this but I could go on and on and on and on about this. I guess what I'd like to talk about the most in terms of this question is the emergency shelter program offered by X Housing because like I said I think it's offering relief to other large systems in the province that seriously need it and that's the criminal justice and the Ministry of Health and certainly MSDSI¹³⁵ in connection to service and to you know, to help people to move out of that plight. I think that sheltering has got more and more complicated with the challenges amongst the vulnerable people in the community and, the move to housing more often than not I mean even with this effort to move to housing first and this extra outreach, shelters are nine times out of ten in my experience a part of that equation and kind of the hub out of which outreach teams are typically assigned out of shelters so they work out of shelters their offices tend to be within shelters, shelter guests connect to those outreach teams who then get them housing first opportunities or housing

¹³⁵ Provincial government ministry.

prevention program opportunities or homeless outreach program opportunities, the different streams of outreach being offered all having kind of specialized clientele and service recipient criteria. And, it seems to be that starting point, we've run a few drop-ins as well and that's great for rapport-building but the majority of people that come to our drop-ins have housing. They use this as more of a social and an ongoing support stop for them, where people only stay in shelters if they're homeless. So, when you really look at ending homelessness and people living on the streets, typically I think the shelter is an incredible vehicle to integrate that housing. You know at our X shelter, which is our flagship shelter, the largest one that we operate, XX – X beds or something in X Street in our city, we've literally partnered with X Housing and X,¹³⁶ the local health authority to bring in specialized health care. So, what happens is X identifies somebody who has no fixed address in X Hospital or the General, does a referral over to the shelter. We save five beds for those types of folks, discharged from hospital. And then, X Housing and we work together to expedite housing opportunities for these folks. But what it does is it reduces long lengths of stays in hospitals and it allows people to come out still getting the ongoing care. So, they send out LPNs¹³⁷ and nurses and those kind of things to service these folks within our shelter, and we can focus in the housing experts, our organization and X Housing can focus in on next steps for these folks and they're outside the healthcare system. And that allows you and me when we get hurt and in an emergency situation to get response, you know, rather than the system remaining convoluted. So, we're doing that at two of our shelters and we're looking at one in X.

I think we've taken, and two city shelters we've taken roughly 25 people that have been able to remain with four walls and a roof over their head through a very difficult transition and we understand that transition in or out of hospital is usually a point where folks, the risk of homelessness is very high. So, understanding that transition point and then working together at getting them out of hospital, which is, you know, incredibly expensive to the taxpayer and getting them into a much cheaper non-profit shelter situation, who, are experts in housing has been working incredibly well and relieves the bigger system, the more costlier systems so in terms of the bottom dollar, you're saving everybody time money and for the people themselves, they don't have to worry about being discharged onto the street, trying to find their next step and trying to make sure that they hit their next medical appointment so, that actual quality of care and the ongoing, we can coach around you know listen you just had a knee replacement surgery, you've got to do your exercises. We can do that as a non-profit, so that continuation of care, so from a health perspective it makes sense as well.

The shelters not only do they link folks obviously to the housing, and I also gave you a couple of strong examples of health care within the shelter system. But, you know spring boarding to employment services is another thing we do on an ongoing basis in terms of referrals, in terms of bringing that skillset in you know all of our shelters have an activity schedule where we'll have X coming in offering their services to the most disenfranchised folks as an ongoing kind of mechanism they'll tend to most of our programs that we offer right now.

8 I guess it would be to have the appropriate partners in place, right. Start with the dialogue this is our concept, common vision, hopefully based on, cause I've already done the national housing strategy and homeless poverty reduction, right. So, base it on senior leadership which direction, who do we need at the table, have those dialogues, what is it going to look like operationally. I guess that would

¹³⁶ Health Authority.

¹³⁷ Licensed Practical Nurses.

be, make sure you've got the gaps filled and the continuum, roles and responsibilities of the partners have all been basically surfaced and on the table. Everybody has a pretty clear understanding of the direction it's going in.

9 I think getting everybody at the table would be little bit of a challenge. Systems, the ministries involved don't have, there's privacy obstacles, there's responsibility, the municipalities hit it to the provincial government and the provincial government says it's the federal government. I don't think the responsibilities are clear and they're ever-changing. You can talk about getting a program going together but to actually have a tangible this is what the Ministry of Health is going to do, this is what, and then to keep that accountability after you've brokered that relationship. Different directions I mean these are all organic bureaucratic kind of systems that under different leadership tend to make different decisions.

10 There are lots of essential planning, principles and practices, from, including the demography you intend in the dialogue, front end, to staffing and making sure that you've got municipal support, in terms of offering that service within a municipality, making sure you understand and focus in on the funder deliverables, that can sometimes get lost in this, we've got to do good work and it's the right thing to do, but at the end of the day the contract could be pretty explicit on the direction you need to go in.

11 I guess for me, it would be role-definition around the operations. It's very complex when you've got homeless people that have a [unintelligible], it's not a finite definition, you can't give me a definition of a homeless person that fits a particular demography or socio-economical background or it's very difficult to define that phrase, because everybody as they come in you want to offer individualized one-to-one service. The person in front of you is going to be, you can't predict what they're going to come with you know and over the years we've had so many people come into the organization that, wow, we've never dealt with this before what do we do now, and we're scrambling to build partnerships and opportunities for folks that have been out of our mandate, right. So, anywhere from people being discharged from hospitals in hospital gowns to police taking the handcuffs off, the bracelets and dropping them at our centres to a dementia guy who didn't know anything about his history or past to the new inmate that's just been left from a correctional institution in their reds and that's all in one day. Or, you know a guy who's deaf and blind and only signs walks into the, what do we do? So, operational policy to address all of those things is an important part of understanding how to operating a homeless service, operate any type of service for homeless people. When you adding the elements of housing, health, and employment it just becomes more and more, policy and more and more, complex at the site. Again more policies are necessary but the defining of the roles in terms of the leadership at that site is very important. Who is your housing expert? Who is your health expert? Who is your employment expert? How can they work together to make sure the process is easy, because our folks don't navigate systems very well and it has to be easy for our folks to grab the pieces of whatever that portfolio looks like. Most people that will come in aren't going to need all three of those services, nine-tenths of them won't. There's a strong population that will need the housing, most of them in a shelter setting. There's a strong population that will need the health, a lot of them because the folks that we're seeing are older and ageing in place and more fragile and all that kind of stuff. Employment services, there's only a smaller population of people I would say that are employable. Some of them will never work. Some of them want to contribute in a different way, volunteerism, make only their \$800 a month, right, what they're allowed to make with their disability. Others will never be able to do any of that.

It's very complex, so having that definition, that role definition, this is what I want you to do and this is what you're going to be responsible for and this is what you have autonomy over and that role definition for the partners, for the leaders of the site is a very, very important process in terms of how it's going to run boots-on-the-ground for the people it's serving. And it needs to be flexible and it needs to be, you know, policy and guidelines are not black and white, they're not written in stone they're not, they're made to bend and they will change with different people coming through the door and pushing the envelope of what we thought had to be this way when you see some folks. Fluid [unintelligible] The nice thing about running tenancy, and we've got X00 units of housing as well, is that you build a relationship with people, they stay there longer. Shelters, you can get 65 or 70 percent of our people come see us once and they never see us again, and if they engage in one of our health or appointment practices or one of those kind of things, that could be the caveat to never seeing them again. And other ones, they'll stay in shelters an awful long time and typically their needs are much more complex and they spend a lot more time on the street and their adjustment to entering the housing or employment or even addressing their own personal health is a whole lot longer process. They have a lot more mistrust, they feel the systems have failed them a lot more and it's a lot more effort on our organization and staff members to create the opportunity for them to even contemplate or be pre-contemplative in terms of making change.

12 I do run these programs all the time. I would say the sheer need, the number of people that require these types of intervention, certainly shelter, I mean, we get, I mean this is a busy time for us, it's cold outside, it's pissing rain and we got, we're turning people away every day. So, I would say that's one of the operational challenges I wouldn't anticipate it. I would say that it is one of our greatest challenges, is how do you shorten stay and how do you move people through the spectrum of services a little faster so we can take more people off the streets.

How would I address it? By increasing options across the board for people. Because sometimes you know, Kerry, you possibly have different needs than I have and if we've got a banquet of services that you're able to choose, hey, this is important to me and I need to do this. You know I've had the heroin junkie come to me, into the shelter, needle sticking out of the arm all the rest of it. Hey, listen I'm fine with my heroin use, but I really want to quit smoking. You help them quit smoking, you foster that trust, they have some success. They've cut down from a full pack to half a pack in one day and then gone down to four a day and now not smoking at all. Celebrate that success, make them feel good about themselves, build that self-esteem. And then, all of a sudden, you know what, if I can do that then maybe I can quit the heroin. And that's, you know, it's, but all of that takes time depending on how disenfranchised people are and our system gets plugged. We need more housing, we need more options, we need more resources, Right now I'm trying to do a health program, a wellness program that involves a nutritional list, acupuncture, reiki, yoga, you know, just one more opportunity for the people that live in our systems to, you know, if you want to access it, it's here come, you're welcome, you're our client, let's help you take other steps forward and be incredibly helpful and pain management and those kind of things. For me, it's offering a more comprehensive menu of service to all of our sites. And, we've done a lot of work on that in the last year and a half, but we've got a ways to go.

13 Non-judgmental: People need to be welcomed no matter where they're at, and, you're going to find that people developmentally or self-esteem-wise are incredibly fragile and, quite often they're coming to our types of services, and speaking on our behalf, our types of services, cause they don't have anywhere else to go. And, if we turn them down, then where do they go next. So, I think that that

practice is incredibly important and something that I reinforce at all levels of the organization all the time.

14 Planning best practices, it's you know get the right people in the room, right people at the table, to achieve, this is our goal and the desired outcomes, ensure that role definition is incredibly well-understood at that table. This is what you're going to do. This is what the job looks like. Things can get a little bit challenging around money in a collaborative situation. So, I like to have all that really open, fair, transparent. Who is leading is an important piece and the true intentions of that leader can be a positive or a negative on the project. I think that obviously involving service population is an important piece. Involving front-line staff, the people that are actually going to do the work is an important piece. And the senior level planning should probably be cared for before you do some of that other stuff because they're going to have questions, what is it going to mean to my job, what is it going to mean, how do I do that on a day-to-day basis when I've already got 150 people in the room and, so, there's some really practical impacts, but they're going to want answers and you're going to increase anxiety if you don't have some kind of framework in my opinion.

I think that it's very important to have sustainability, and to be able to, cause I think it's really, reputational damage, but also further damage to vulnerable people when they buy into a program and then it can't continue any longer. I think that it's very important to have open grievance procedure. What if a client's not happy, what if a staff member isn't happy, what if a partner isn't happy, what if, right. I think that in terms of our clientele, literacy is a problem. It's important to have pictures of that kind of grievance procedure. If you're not happy here, talk to this one. We do that in some of our shelters, or in most of our shelters.

I think that being realistic is a big piece of, certainly around the employment side. Just cause if someone is homeless and has mental health and addictions concerns doesn't mean they are able to work and they won't be able to work so having 100% employment outcomes is ridiculous, but maybe 5% is achievable in a shelter population. Having some goalposts I think is important that they don't always have to be external or they don't always have to be presented to the staff to put that pressure on. But I think it's important to, that, is it working or isn't it working? I'm a fan of research in terms of what are other models out there, what does that look like, having that research and what's been tried, but also innovative thinking out of the box, what's different, why can this work when it's been tried before. Again, I think that it needs to be steeped on the direction of the players within whatever program you're trying to run. If there is a poverty reduction plan, how does that feed into it? Or, if there is that national housing strategy, how can we serve that. Because if you're working on these initiatives anyway, you'd better mirror the direction of senior levels, cause if it doesn't then you're really pulling in a different direction in my opinion. I think that it needs to be that non-judgmental welcoming rapport-building focus, because more than anything, our people need that relationship and need to feel that trust and need to break down the barrier of power and powerless.

Operations: Role definition is huge, who does what, who's responsible for what and then keeping that accountability and responsibility structure happening. So, hey listen you were supposed to deliver on that date, why not? You know, it helps everybody keep their socks pulled up I think.

A common approach: So, this is how somebody's welcomed in and all the staff is doing it the same way, this is what a referral looks like from one department to another, and, so, it becomes systemic and expected, all with dignity kind of understood and customer service. We've moved away from calling our

people clients to calling them guests. There's a little more dignity to that, and if we think about what we do in a customer service kind of environment, we're a lot more like a hotels than we are client-based clinical service, and that's a choice of our organization, but we think that it adds an opportunity for a little more dignity and a little more self-worth to the people that access our services. I think that we need to be, as we talked already, you need to be ready for absolutely anything. You can't predict who's going to come into these programs, you need to have backup plans. It needs to be a learning program, no matter what it is. So, that, okay we've noticed that two or three people, this has happened to them, why, how can we address this, how can it be better next time? Create policy or create opportunity or create direction that helps fix those issues but also create that same momentum towards what's working and what's happening well and what's going on, what's being, what are we seeing on the front line? So, I think that's a very important process in terms of running these things is that performance quality improvement making sure that, you know, the program is getting better and if there are risks or challenges whether it's staff or clientele or staff or management or partner, it's identified, it's on the table, it's talked about, it's not taboo, it's as many heads as possible putting their efforts into rectifying it in a quick fashion. These things shouldn't take a long time. I think any complaint escalated in terms of delivery to the guest is incredibly important to take a look at what's the motivation, what's happened here, why is this challenge, why are we able to dismiss this if that's the case, and have a justification around that. And, I think with the person that's put the complaint in deserves that remedy, deserves that answer. I think that ongoing meetings around the operations team, the stakeholders if it happens to be a bigger project involving community or municipality or other organizations, I think it's an important piece reflective of constructive feedback and feedforward. You should have done this different and in the future why don't we try this, that mechanism is really, really important and it's organic. So, you know what you create from the get-go may look great on paper but when it actually, you actually put it into practice it may work better in a different way, and that's, you've got to be willing to roll with that. I think the best non-profits are nimble non-profits that listen to the direction of their stakeholder groups, their funders, and certainly the people that they work with and their staff.

15 Skipped

9.10 CODED SURVEY RESULTS

9.10.1 Question 3

Regarding your organization, what does it do best to serve the homeless?

- At Risk of Homelessness -----1
- Backend Services-----1
- Creativity-----2
- Housing-----1
- Listen to Clients -----1
- Offer Svcs in Sequence Clients Want -----1
- Offering Multiple Services -----5
- One Door for All Services -----2
- Outcomes Star-----1
- Portable Subsidies -----1
- Rapport - Relationship Building -----1
- Recovery Focused Support -----1
- Results Based Accountability -----1
- Safe Environment with Supports -----1
- Shared Permanent Housing -----1

9.10.2 Question 4

If your organization were able to access additional resources to implement a new program or service, what would it be and why is that service important?

- Affordable Housing-----1
- Better Employment Supports-----3
- Better Primary Care -----2
- Client Enrichment Svcs -----1
- Connecting Clients to Community-----1
- Crisis Centre-----1
- Crisis Counselor -----1
- Depends on Area¹³⁸ of Service-----1
- Enhanced Clinical Services-----1
- Flexible Support (HF)-----1
- Improved Counseling -----2
- Improved Housing -----1
- Onsite Supports -----1
- Outreach Support-----1
- Recovery College-----1
- Self Harm Centre-----1

¹³⁸ Geographic

The coding repeating most often (three times) is “Better Employment Supports,” and echoes the need Streetohome seeks to fulfill. As outlined previously, employment supports are an important part of assisting clients. Employment prospects offer the hope and prospect of independence and normalcy.

Two other coded responses repeat twice each: “Better Primary Care” and “Improved Counselling.” A need for better primary care reflects the fact marginalized people generally do not receive the same level of care as the general population. Homeless people seek medical aid primarily when a condition becomes acute—then relying on emergency services. Given emergency rooms provide some of the most expensive medical care available, better primary care is an area where outcomes can be improved *and* costs can be cut significantly. It is a clear win-win point of contact.

“Enhanced Clinical Services” does not repeat, but does relate to primary care. Clinical care is a crucial part of good primary care.

On the face of it, “Improved Counseling” is not as clear-cut as better primary services. Yet, counselling can be viewed as a service supporting better primary care. One of the reasons homeless people continue taking medications, make and meet medical appointments, and receive improved primary care is ongoing counselling. Without it, primary care might not be as cost and outcome-effective for homeless people, particularly those with multiple issues—the most prone to using emergency services.

Other coded responses do not repeat, though some are closely related. For example, “Affordable Housing” and “Improved Housing” are obviously related. The former indicates a need for more financially accessible housing and the latter relates to a need for better quality housing. Both are important, though the need for better quality housing is less obviously so. Without giving any thought to the subject, it is easy to speak out how someone ought to be grateful for housing, period. Health and safety issues aside, the reality is homeless people do not want poorly maintained, sub-standard housing any more than anyone else.

“Crisis Centre” and “Crisis Counselor” are closely related responses, indicating a need for acute support. For homeless people addressing multiple issues it is a needed ongoing support.

9.10.3 Question 5

In your experience, what is the most difficult aspect of integrating services to serve the homeless?

This question has two parts. The list below addresses the first part of the question, the list following it addresses the second part. It should be noted that not all participants responded to this question and not all who did responded to both parts of the question.

- Changing Funding Arrangements----- 1
- Client Engagement ----- 1
- Clients Falling Between the Cracks ----- 1
- Community Ignorance ----- 1
- Complexity of Homeless Needs ----- 1
- Connecting with Homeless - Finding Them----- 2
- Difficulty in Aligning with Mainstream Svcs----- 3
- Fragmented Funding----- 2
- Inability to Align Gov't Svcs----- 4

- Lack of Federal & Provincial Focus -----1
- Magnitude of the Need -----1
- Service instead of Client-Centred Culture -----1
- Transition from Homeless to Housed-----1

Four coded responses leap out: “Inability to Align Gov’t Svcs” (four responses), “Difficulty Aligning with Mainstream Svcs” (three), “Fragmented Funding”¹³⁹ (two) and “Lack of Federal & Provincial Focus” (one response). All are related. The top two most repeated responses are very closely related and when combined result in seven repeats, far ahead of any other grouping. The first three responses are not surprising, given the information revealed through the literature review. Existing municipal, provincial, and federal government organizations still work in silos, though there has been some effort to align aspects of various programs. Arguably, “Lack of Federal & Provincial Focus” is reason participants brought up the first three issues.

Together, the first three themes give a good idea of where planning efforts are best directed. Although it may be impossible for a single organization to align various agencies generally, planning and logistical effort can be directed at aligning agencies and funding for a particular program.

A lack of government focus suggests there is a need for advocacy and lobbying of governments to support an integrated homeless response.

Although the remaining responses do not repeat, they are excellent examples of how each one of the challenges mentioned is important and should not be overlooked: “Changing Funding Arrangements,” “Client Engagement,” “Clients Falling Between the Cracks,” “Community Ignorance,” “Complexity of Homeless Needs,” “Connecting with Homeless - Finding Them,” “Magnitude of the Need,” “Service instead of Client-Centred Culture,” and “Transition from Homeless to Housed.”

How best is this challenge dealt with?

- 24-7-365 Svcs -----1
- Collaboration with Mainstream Svcs -----1
- Community Engagement-----1
- Experienced Staff -----1
- Fundraising-----1
- Good Memorandum of Understanding -----1
- Higher Intensity Care -----1
- Peer Staff -----1
- Selection of Clients with Income¹⁴⁰-----1

Coded responses do not repeat here, but two challenge responses are closely related: “24-7-365 Svcs” and “Higher Intensity Care.” Both respond to the three challenges: “Client Engagement,” the “Complexity of Homeless Needs,” and the “Magnitude of Need.”

There also are responses useful for planning purposes: “Collaboration with Mainstream Svcs,” “Community Engagement,” “Experienced Staff,” “Good Memorandum of Understanding,” and “Peer

¹³⁹ “Changing Funding Arrangements” is also one of the coded responses.

¹⁴⁰ Intended to ensure sustainability of the service organization.

Staff.” Both “Collaboration with Mainstream Svcs” and “Good Memorandum of Understanding” address the three of the four responses discussed above: “Inability to Align Gov’t Svcs,” “Difficulty Aligning with Mainstream Svcs,” and “Fragmented Funding.”

9.10.4 Question 6

If you were to begin developing a new program to end homelessness, what would you do first and why would it be the first thing you did?

- Address Housing Affordability-----2
- Align Gov't Svcs -----2
- Client-Centred Approach -----5
- Clients to Inform Practice-----2
- Collaboration at Program Planning and Beyond -----1
- Develop Federal - Provincial Housing - Homelessness Strategy-----1
- Employment Svcs Earlier-----1
- Holistic Life Skills - Education Program -----1
- Map Existing Svcs-----1
- More Home-like Shelters -----2
- Obtain Accurate Homeless Data -----1

“Client-Centred Approach” repeats the most (five times), indicating a respondent preference for building programs around a client-centred philosophy. “Clients to Inform Practice” is closely related and is repeated twice. Between these two coded responses, coding is repeated seven times, far more than others.

“Addressing Housing Affordability” is repeated twice, as is “Align Gov’t Svcs.” From a high level, addressing housing affordability and alignment of government services are not within the capability of most homeless-serving organizations to address. This points, again, to the importance of connecting with government and advocating for affordable housing strategies. Alignment of government services also alludes to a need for pressing government, as does a non-repeating related response “Develop Federal – Provincial Homelessness Strategy.”

Another closely related coded response, “Collaboration at Program Planning and Beyond” (repeated once), also points to the need for service alignment. Although government supports are not aligned, organizations need to coordinate and collaborate to mitigate the impact of service fragmentation.

“More Home-like Shelters” repeats twice and addresses a different part of the housing picture. The respondent who brings up the idea say they think shelters should be setup to provide people with a sense of normalcy while they deal with being homeless. If setup differently and with different policies, shelters could become a short-term solution. People could use the shelter while they look for work. Families would not have to be split where accommodation is configured for family units.

Again, remaining, non-repeating responses are solid. “Employment Svcs Sooner,” Holistic Life Skills – Education Program,” Map Existing Svcs,”and “Obtain Accurate Homeless Data” should not be ignored.

9.10.5 Question 7

Are you aware of any programs for ending homelessness that integrate housing, health care, and employment services? If so, what program is it and how well is the program working?

- 500 Lives - 500 Homes-----1
- Common Ground -----1
- Community Housing Partnership -----1
- Episcopal Community Svcs -----1
- Foyer Model-----2
- Hamilton Family Services -----1
- Houselink -----1
- MPA -----1
- Parkdale Activity Recreational Centre (PARC) -----1
- Pathways to Housing-----1
- The Bissell Centre-----1
- The Kettle-----1

If the program is working well, why is that?

- Sufficient Resources-----1
- Svcs in Sequence Client Wants - Needs Them -----1
- Svcs Well-integrated with Facility -----1
- Working Collaboratively - Integrated -----1

If the program is not working well, why is that?

- Clients do not Wish to Work-----1
- Funding Withdrawn -----1
- Veterans are Hard to Market (employment) -----1

9.10.6 Question 8

If you were to begin developing a new program to end homelessness and that program integrated housing, health care, and employment services, what would you do first?

While there were 10 responses to the first part of the question, only one respondent answered the second part.

- Agreed Measures of Success-----1
- Agreed Roles and Responsibilities-----1
- Community Involvement - Education-----1
- Critical Time Intervention (CTI)-----1
- Evaluate Local Requirement -----1
- Get Appropriate Partners in Place-----1
- Increase the Program - Service Scale -----1
- Research -----1
- Service Mapping -----2

There were 10 responses to the first part of the question. The only repeated coding is “Service Mapping.” Mapping of services is a topic raised in a survey response to question 6, outlined earlier. “Evaluate Local Requirement” is a closely related response. As well, system mapping was mentioned in the lessons learned, earlier in this research. In order to adequately build an integrated system, mapping of systems and services appears to be a crucial piece.

Once again, the other coded responses are worthy of attention: “Agreed Measures of Success,” “Agreed Roles and Responsibilities,” Community Involvement – Education,” “Get Appropriate Partners in Place,” “Increase the Program - Service Scale,” and “Research.”

Why would it be important to do first?

Regarding the second part, the only coded response was “Discover Evidence-based Practices.” This answer corresponds to the coded response “Research,” outlined in the first part above.

9.10.7 Question 9

If you were to begin developing a new program to end homelessness and that program integrated housing, health care, and employment services, what do you anticipate would be the greatest challenge?

- Appropriateness of Svcs-----1
- Changing Municipal - Provincial - Federal Policy-----2
- Educating Homeless People-----1
- Engaging the Hard-to-Reach -----1
- Getting Everyone to the Table-----1
- Homeless Hard to Employ-----1
- Integrating Health Svcs-----2
- Lack of Funding-----3
- Lack of Housing-----3
- Reaction of Existing Staff -----1
- Sufficient Time for Planning - Collaboration -----1
- Up-front Assessment -----1

Coding repeating most is “Lack of Funding” and “Lack of Housing,” appearing three times each. Lack of funding of course is a common issue for non-profit organizations, who generally shoulder the majority of work of addressing homelessness. Lack of Housing is also a common problem in many (if not most) urban centres. It may be useful to point out here how both issues relate to one of the second-most repeated codes: “Changing Municipal-Provincial-Federal Policy” (repeated twice). In fact, all four of the top most repeated codes (including “Integrating Health Svcs;” repeated twice) relate to municipal, provincial, and federal policy. Yet again, this result points to the importance of homeless-serving organizations advocating to and lobbying all three levels of government—and in the meantime also connecting with them to integrate services as best as can be done.

Other coded responses include the following: “Appropriateness of Svcs,” “Changing Municipal - Provincial - Federal Policy,” “Educating Homeless People,” “Engaging the Hard-to-Reach,” “Getting Everyone to the Table,” “Homeless Hard to Employ,” Integrating Health Svcs” (repeated twice), “Reaction of Existing Staff,” “Sufficient Time for Planning – Collaboration,” and “Up-front Assessment.”

How would you go about overcoming that challenge?

- Collaborate with Appropriate Svcs -----1
- Education for Staff & Sectors -----1
- Lobby Community using Peer Ambassadors -----1
- Mandatory Compliance with Mental Health Treatment -----1
- Mandatory Drug Testing -----1
- More Permanent Housing -----1
- Social Impact Bonds -----1

There was no repetition. Note: the two coded responses “Mandatory Compliance with Mental Health Treatment” and “Mandatory Drug Testing” relate to the respondent’s opinion that homeless people are hard to house, due to drug abuse.

In short, it is much too soon to know whether SIBs are a funding best practice.

Three responses deserve attention here. “Mandatory Compliance with Mental Health Treatment,” “Mandatory Drug Testing,” and “Selection of Clients with Income” do not align with best practices discovered in the literature review section. These three responses are also not in agreement with the majority of survey feedback. Overall, best practices dictate acceptance of clients as-is, with an emphasis on harm reduction and recovery over the long term.

However, these responses are completely understandable given the difficulty of operating a homeless-serving organization. As mentioned in a previous section, funding is an existential issue and often dictates what services are offered. In an environment where funders look for results like recovery and low recidivism, having clients agree to mandatory drug testing and medical treatment beforehand is an attractive option. Likewise, accepting clients with an existing income addresses funding, thereby addressing service viability. By implementing these policies, operators are addressing funders who want results (i.e. “bang for the buck”). In fact, the BPG discussed earlier in this research recommends just such an approach (Kessler-Beck et al., 1997, p. 2-1).

9.10.8 Question 10

What one planning principle or practice do you know to be essential in planning an integrated service for the homeless?

- Acceptance of Diversity -----2
- Collaborate with All Stakeholders - Related Svcs -----1
- Collective Impact Approach -----1
- Municipal Support -----1
- Return on Investment -----1
- Staffing -----1
- Understanding Funder Deliverables -----1
- Understanding of Client Population -----3

There are 11 responses to the first part of the question, but only one response to the second part.

“Understanding of Client Population” was most repeated (three times), with “Acceptance of Diversity” the second-most repeated (two times). Understanding of Client Population and Acceptance of Diversity

are related, indicating a need to plan with homeless clients in mind. These concepts are also related to some of the responses given for question 3, where participants indicated their organizations are good at developing relationships with clients, listening to them, and offering the services clients want when they want them.

It can be argued that understanding a population is not the same as acceptance of their diversity. Strictly speaking, perhaps it is true. For example, you could understand part of your population has HIV and, based on that piece of information, refuse treatment to them. But, in the context of best practices as outlined in the literature review and serving homeless people, it means adapting treatments to better suit their needs.

Other coded responses include the following: “Collaborate with All Stakeholders - Related Svcs,” “Collective Impact Approach,” “Municipal Support,” “Return on Investment,” “Staffing,” and “Understanding Funder Deliverables.”

Why would you consider it essential?

In answer to the second part, the coded response was “Money Funds Everything,” indicating donors’ need to see a “Return on Investment” when they look to invest in social causes.

9.10.9 Question 11

Assume you are operating a service for homeless people that integrates housing, health, and employment services. (Applies to questions 11 through 13)

What one practice would you ensure is part of operational policy in order to most effectively deliver services and achieve your organizational goals?

- Addressing Addiction & Mental Health -----1
- Agreement How Clients are Treated-----1
- Calgary Urban Project Society (CUPS) -----1
- Centralize Intake -----1
- Client Control Over Their Space-----1
- Client-Centred Approach for Staff-----2
- Collaborative Approach -----2
- Data Collection Around Shared Goals -----1
- Evidence-Based Practices -----2
- Include Clients in Implementation -----3
- Include Clients in Planning -----4
- Peer-delivered Svcs -----1
- Role Definition-----1

The coding repeated most often (four times) is “Include Clients in Planning,” with “Including Clients in Implementation” following next (repeated three times each). These first two are closely related to “Client Control Over Their Space” (repeated once), “Client-Centred Approach for Staff” (repeated twice), and “Peer delivered Svcs” (repeated once). All relate to the importance of ensuring services are client-centric.

Other responses are as follow: “Addressing Addiction & Mental Health,” “Agreement How Clients are Treated,” “Centralize Intake,” “Data Collection Around Shared Goals,” “Evidence-Based Practices,” “Peer-delivered Svcs,” and “Role Definition.”

9.10.10 Question 12

What one operational challenge do you anticipate would be the greatest?

- Balancing Support for Paid Peer Workers vs Clients -----1
- Collaboration -----1
- Communication Between Staff on the Floor-----1
- Data Gathering Systems-----1
- Framework for Clients in Program-----1
- Funding-----3
- Program Evaluation -----1
- Sheer Need-----1
- Staff and Training - Shared Approach-----1
- Sustain Staff Morale - Hopeful & Recovery-based Message -----1

The only repeated coding for the first part of the question is “Funding” (repeated three times). As mentioned earlier, funding is a common theme for non-profits.

The remaining coded responses are as follow: “Balancing Support for Paid Peer Workers vs Clients,” “Collaboration,” “Communication Between Staff on the Floor,” “Data Gathering Systems,” “Framework for Clients in Program,” “Program Evaluation,” “Sheer Need,” “Staff and Training - Shared Approach,” and “Sustain Staff Morale - Hopeful & Recovery-based Message.”

Perhaps one response deserve an explanation. “Framework for Clients in Program” refers to maintaining an effective, respectful, and accepting program while at the same time having standards clients need to meet. This is a tough balance to make, given the alternative for clients is the street.

Why would it be the greatest challenge and how would you address it?

There was only one response to the second part of the question: “Greater Range of Options,” which answered the coded response of “Sheer Need” in the first part of the question.

9.10.11 Question 13

What one operational principle or practice is essential in operating an integrated service for the homeless? Why is it essential?

- Acceptance of Clients' State -----3
- Client-Centred Focus-----7
- Commitment to Collaborative Approach -----1
- Individualized Programs-----2
- Integrated Planning -----1
- Trauma-informed Practice -----1

9.10.12 Question 14

When considering homelessness and best practices, assume that “best practices” means methods or actions having a two pronged effect. First, best practices affects process in such a way that those involved can do their jobs to the best of their abilities—without undue hindrance from poorly planned process or other administrative impediments. Second, best practices lead to desired outcomes such as permanent housing, good health, low or no relapses, independence, and so on.

In the table below, in right-hand columns (labeled “Best Practices”) please provide what best practices you have observed relating to the sets of integrated services specified in the left-hand columns (labeled “Integrated Services”). Please provide answers for only those sets and types (Planning and/or Operational) of services you are familiar with. The table will expand as needed to accept more input.

To simplify coded responses, this section is split into two sections: The first addressing best practices in planning and the second, operation. Coded responses to planning best practices are as follow:

- Align Planning with Higher Level Plans (e.g. Nat. Housing Strat) -----1
- Ensuring Facilities are Well-designed - Appropriate -----1
- Involve Clients in Planning-----1
- Involve Gov't Health Authority -----2
- Open, Transparent Understanding of Funds Between Partners -----1
- Plan for Sustainability-----1
- Plan Grievance Process-----1
- Set Realistic Goals -----1
- Set Standards -----1
- Sketch Overall Plan Before Involving Others-----1
- Who Leads the Program -----1
- Women Building Futures -----1

The only repeating coded response is “Involve Gov’t Health Authority,” indicating a need to include government health authorities in planning homeless services.

Coded responses for best practices in operating a homeless service follow:

- Adapt as Necessary-----1
- Boston Homeless Healthcare -----1
- Common Ground Model -----1
- Common Understanding Amongst Staff -----1
- Continuous Focus on Goals -----1
- Dignity in Service to Clients -----1
- Engaging Clients-----1
- Excellent Communications -----2
- Harm Reduction-----2
- Housing First -----5
- Integrated Dual-diagnosis Treatment -----1
- Learning Organization (flexibility) -----1
- Motivational Interviewing -----1

- Ottewell Manor -----1
- Performance Measurement-----1
- Private Sublet of Facility to Homeless Org-----1
- Recovery-oriented Svcs -----1
- Staff Training-----1
- Street to Home Program-----1
- Supported Employment-----1
- Sustainability Planning -----1
- Trauma-informed Care -----1

Although the survey did not lead participants to answer with best practices like HF, “Housing “First” was mentioned most frequently (five times), while “Excellent Communication” and Harm Reduction” were mentioned twice each.

Other responses are as follow: “Adapt as Necessary,”¹⁴¹ “Boston Homeless Healthcare,” “Common Ground Model,” “Common Understanding Amongst Staff,” “Continuous Focus on Goals,” “Dignity in Service to Clients,” “Engaging Clients,” “Excellent Communications,” “Harm Reduction,” “Integrated Dual-diagnosis Treatment,” “Learning Organization (flexibility),” “Motivational Interviewing,” “Ottewell Manor,” “Performance Measurement,” “Private Sublet of Facility to Homeless Org,” “Recovery-oriented Svcs,” “Staff Training,” “Street to Home Program,” “Supported Employment,” “Sustainability Planning,” and “Trauma-informed Care.”

It should be noted that “Adapt as Necessary” and “Learning Organization” (flexibility) are closely related.

“Private Sublet of Facility to Homeless Org” is a method of providing housing used by one of the participating organizations. The organization (the “Lessor”) engaged a private landlord (the “Lessee”) to lease an entire building. The Lessor then contracted a community provider to provide services to the building, with the Lessor acting as the landlord to the building’s clients/tenants.

The “Common Ground” model was mentioned again, as was the “Street to Home Program,”¹⁴² a program related to Common Ground, already discussed.

Two other programs are mentioned: “Boston Homeless Healthcare” and “Oettwell Manor.” The treatments, Harm Reduction, Integrated Dual Diagnosis Treatment, and Recovery-oriented Services are also mentioned. All are discussed briefly below.

9.10.13 Question 15

If you have observed best practices that do not fit into the table above (question 14), what was it? Why is it a best practice? What were the impacts of the best practices?

- Cooperative Operation of Facility -----2

¹⁴¹ The participant who gave this response also mentioned the need to plan an organization so it can adapt quickly (i.e. plan flexibility into its program).

¹⁴² Founded on the premise that housing is the essential first step to addressing the complex issues faced by chronically homeless individuals, Street to Home is a systematic method of identifying and prioritizing for housing those who have been outdoors the longest and who have the highest risk of premature death on the streets. (Breaking Ground HDFC, 2016c)

- Cooperative Planning of Facility -----2
- Ensure Client Feedback is Built-in -----1

Both “Cooperative Operation of Facility” and “Cooperative Planning of Facility” (repeating twice each) relate to how clients are integrated into the life of programs, from definition and design to implementation, operation, monitoring, and evaluating.

Of course, “Ensure Client Feedback is Built-in” is part of ensuring clients are integral to the life of the program. It also relates to building effective performance measures into programs.

9.10.14 Best Operating Practices

- **Client-Centred**
 - Acceptance of Clients' States -----3
 - Client-Centred Focus-----7
 - Cooperative Operation of Facility -----2
 - Dignity in Service to Clients -----1
 - Engaging Clients-----1
 - Ensure Client Feedback is Built-in -----1
 - Individualized Programs -----2
- **Flexibility**
 - Adapt as Necessary -----1
 - Learning Organization (flexibility) -----1
- **Programs-Practices**
 - Practices (Practices such as HF are not repeated here, though they appear in responses.)
 - Commitment to Collaborative Approach -----1
 - Excellent Communications -----2
 - Harm Reduction-----2
 - Integrated Dual-diagnosis Treatment -----1
 - Performance Measurement -----1
 - Private Sublet of Facility to Homeless Org -----1
 - Recovery-oriented Svcs -----1
 - Trauma-informed Practice -----2
- **Programs**
 - Programs were covered in a previous section and are not covered here.
- **Training**
 - Common Understanding Amongst Staff -----1
 - Continuous Focus on Goals -----1
 - Staff Training-----1

Overwhelmingly, “Client-Centred Focus” is the most frequently repeated coded response (seven times). “Acceptance of Clients’ State” (repeated three times), “Individualized Programs” (repeated twice), and “Trauma-informed Practice” (repeated once) are related to Client-Centred Focus. Once again, this indicates how thoroughly homeless services need to accept and involve clients, as well as serve them.

Related to each other, “Commitment to Collaborative Approach” and “Integrated Planning” also are responses. These concepts came up previously and come up again.

9.10.15 Best Planning Practices

- **Collaboration**
 - Align Planning with Higher Level Plans (e.g. Nat. Housing Strat) -----1
 - Cooperative Planning of Facility -----2
 - Ensuring Facilities are Well-designed - Appropriate -----1
 - Integrated Planning -----1
 - Involve Clients in Planning-----1
 - Involve Gov't Health Authority -----2
 - Open, Transparent Understanding of Funds Between Partners -----1
- Plan for Sustainability-----2
- Plan Grievance Process-----1
- Set Realistic Goals -----1
- Set Standards -----1
- Sketch Overall Plan Before Involving Others-----1
- Who Leads the Program -----1

9.10.16 Challenges

- **Client Challenges**
 - Appropriateness of Svcs -----1
 - Client Engagement -----1
 - Clients do not Wish to Work-----1
 - Clients Falling Between the Cracks-----1
 - Complexity of Homeless Needs -----1
 - Connecting with Homeless - Finding Them -----2
 - Educating Homeless People-----1
 - Engaging the Hard-to-Reach -----1
 - Homeless Hard to Employ-----1
 - Transition from Homeless to Housed-----1
 - Veterans are Hard to Market (employment) -----1
 - Community Ignorance-----1
- **Funds**
 - Changing Funding Arrangements-----1
 - Fragmented Funding-----2
 - Funding-----3
 - Funding Withdrawn-----1
 - Lack of Funding-----3
- **Measurement**
 - Data Gathering Systems -----1
 - Program Evaluation -----1
 - Up-front Assessment -----1
- **Need**
 - Lack of Housing-----3
 - Magnitude of the Need -----1
 - Sheer Need-----1

- **Staff**
 - Balancing Support for Paid Peer Wkrs vs Clients -----1
 - Communication Between Staff on the Floor-----1
 - Reaction of Existing Staff -----1
 - Service instead of Client-Centred Culture -----1
 - Staff and Training - Shared Approach -----1
 - Sustain Staff Morale - Hopeful & Recovery-based Message -----1
- **Svc Alignment**
 - Changing Municipal - Provincial - Federal Policy-----2
 - Collaboration -----1
 - Difficulty in Aligning with Mainstream Svcs-----3
 - Framework for Clients in Program -----1
 - Getting Everyone to the Table -----1
 - Inability to Align Gov't Services -----4
 - Integrating Health Svcs-----2
 - Lack of Federal & Provincial Focus -----1
 - Sufficient Time for Planning - Collaboration -----1

9.10.17 Responses to Challenges

Ten responses fall under four coding categories: Collaboration, Connecting with Community, Intensity of Service, and Staff. The remaining six responses are not categorized.

- **Collaboration**
 - Collaborate with Appropriate Svcs -----1
 - Collaboration with Mainstream Svcs -----1
 - Good Memorandum of Understanding -----1
- **Connecting with Community**
 - Community Engagement -----1
 - Lobby Community using Peer Ambassadors -----1
- **Intensity of Service**
 - 24-7-365 Service -----1
 - Higher Intensity Care -----1
- **Staff**
 - Education for Staff & Sectors -----1
 - Experienced Staff -----1
 - Peer Staff -----1
- Fundraising -----1
- Greater Range of Options -----1
- Mandatory Compliance with Mental Health Treatment -----1
- Mandatory Drug Testing -----1
- More Permanent Housing -----1
- Selection of Clients with Income -----1

9.11 ORGANIZATIONS CONTACTED

AUSTRALIAN INVITATIONS

Byamee Proclaimed Place INC

City:	Moree NSW
Web:	http://www.byamee.com.au/

Common Ground Queensland

City:	South Brisbane, QLD
Web:	http://www.commongroundqld.org.au/

Council to Homeless Persons

City:	Collingwood Victoria
Web:	http://chp.org.au/

Hanover

City:	South Melbourne, Victoria
Web:	http://www.hanover.org.au/

The Haymarket Foundation

City:	East Sydney NSW
Web:	http://www.haymarket.org.au/

Haven Home Safe

City:	Bendigo VIC
Web:	http://www.havenhomesafe.org.au/

Homeground Services

City:	Christies Beach SA
Web:	http://www.homeground.org.au/

Junction Australia

City:	Christies Beach SA
Web:	http://www.junctionaustralia.org.au/

Mercy Foundation

City:	North Sydney, AU
Web:	https://www.mercyfoundation.com.au/

Merri Outreach Support Services

City:	Broadmeadow, AU
Web:	http://merri.org.au/

Mission Australia

City:	Sydney, AU
Web:	https://www.missionaustralia.com.au/

North and West Homelessness Networks

City:	Collingwood Vic
Web:	http://www.nwhn.net.au/

Parramatta Mission

City:	Parramatta NSW
Web:	http://www.parramattamission.org.au/

St Bartholomew's House

City:	East Perth WA
Web:	http://stbarts.org.au/

Streetsmart Australia

City:	Middle Camberwell VIC
Web:	http://streetsmartaustralia.org/

Supported Accommodation and Homelessness Services Shoalhaven Illawarra

City:	Wollongong NSW
Web:	http://www.sahssi.org.au/

Under 1 Roof

City:	North Melbourne, AU
Web:	http://www.wombat.org.au/

VincentCare Victoria

City:	Melbourne, AU
Web:	http://www.vincentcare.org.au/

Wintringham

City:	Kensington VIC
Web:	http://www.wintringham.org.au/

Wombat Housing and Support Services

City:	North Melbourne, AU
Web:	http://www.wombat.org.au/

CANADIAN INVITATIONS

Accueil Bonneau

City:	Montreal, QC
Web:	http://www.accueilbonneau.com/english/

The Alex - Pathways to Housing

City:	Calgary, AB
Web:	www.thealex.ca

Alpha House Calgary

City:	Calgary, AB
Web:	http://alphahousecalgary.com/

Bissell Centre

City:	Edmonton, AB
Web:	http://www.Bissellcentre.org/

Blankets for Moncton

City:	Moncton, NB
Web:	http://blanketsformoncton.com

Boyle Street

City:	Edmonton, AB
Web:	http://boylestreet.org/

Calgary Homeless Foundation

City:	Calgary, AB
Web:	www.calgaryhomeless.com

Community Perspective in Mental Health

City:	Montreal, QC
Web:	http://pcsm-cpmh.org/en/

CUPS Calgary

City:	Calgary, AB
Web:	http://cupscalgary.com/

Dixon Transition Society

City:	Vancouver, BC
Web:	http://dixonsociety.ca/

Edmonton Homeless Commission

City:	Edmonton, AB
Web:	http://homelesscommission.org/

Elizabeth Fry Society of Greater Vancouver

City:	Vancouver, BC
Web:	http://www.elizabethfry.com/

Fred Victor

City:	Toronto, ON
Web:	http://www.fredvictor.org/

Greater Moncton Homelessness Steering Committee

City:	Moncton, NB
Web:	http://monctonhomelessness.org/

Herstreet

City:	Montreal, QC
Web:	http://www.laruedesfemmes.org/en/

Homeward Trust Edmonton

City:	Edmonton, AB
Web:	http://www.homewardtrust.ca/

House Link

City:	Toronto, ON
Web:	http://www.houselink.on.ca/

The Hope Centre

City:	Welland, ON
Web:	http://www.thehopecentre.net/

Inn From the Cold

City:	Calgary, AB
Web:	www.innfromthecold.org

John Howard Society of Southeastern New Brunswick, Inc.

City:	Moncton, NB
Web:	www.johnhowardsenb.com

Logifem

City:	Montreal, QC
Web:	http://logifem.org/

Lookout

City:	Vancouver, BC
Web:	http://lookoutsociety.ca/

McLaren Housing Society of BC

City:	Vancouver, BC
Web:	http://mclarenhousing.com/

Metro Community Housing Association

City:	Halifax, NS
Web:	http://www.mcha.ns.ca/

More than a Roof

City:	Vancouver, BC
Web:	http://www.morethanaroom.org/

Multifaith Housing

City:	Ottawa, ON
Web:	http://www.multifaithhousing.ca/

Newfoundland and Labrador Housing & Homelessness Network

City:	St. John's, NL
Web:	http://www.nlhhn.org/

Progressive Housing Society

City:	Burnaby, BC
Web:	http://www.progressivehousing.net/

Rain City Housing

City:	Vancouver, BC
Web:	www.raincityhousing.org

Salvus Clinic

City:	Moncton, NB
Web:	http://www.salvusclinic.com/

Siloam Mission

City:	Winnipeg, MB
Web:	https://www.siloam.ca/

Sistering

City:	Toronto, ON
Web:	http://www.sistering.org/

Victoria Cool-Aid Society

City:	Victoria, BC
Web:	https://coolaid.org/

Welcome Hall Mission

City:	Montreal, QC
Web:	http://www.welcomehallmission.com/en/

NEW ZEALAND INVITATIONS

Atareira

City:	Wellington, NZ
Web:	http://atareira.org.nz/

Lifewise

City:	Auckland, NZ
Web:	http://www.lifewise.org.nz/

UNITED KINGDOM INVITATIONS

Action Homeless

City:	Leicester, UK
Web:	http://actionhomeless.org.uk/

BCHA

City:	Bournemouth, UK
Web:	http://www.bcha.org.uk/

BetelUK

City:	Birmingham, UK
Web:	http://www.betel.org.uk/

The Big Issue Foundation

City:	London, UK
Web:	https://www.bigissue.org.uk/

The Big Life Group

City:	Liverpool, UK
Web:	https://www.thebiglifegroup.com/

Bosco House

City:	Liverpool, UK
Web:	http://boscohouse.org.uk/

The Bridge

City:	Leicestershire, UK
Web:	http://www.thebridge-eastmidlands.org.uk/

Brighton Housing Trust

City:	Brighton, East Sussex, UK
Web:	http://www.bht.org.uk/

Byker Bridge Housing & Support

City:	Newcastle Upon Tynel, UK
Web:	http://www.bykerbridge.org.uk/

Centrepoint

City:	London, UK
Web:	http://centrepoint.org.uk/

Changing Lives

City:	Gateshead, UK
Web:	http://www.changing-lives.org.uk/

Chapter 1

City:	Liverpool, UK
Web:	http://www.chapter1.org.uk/

Community Help and Advice Initiative

City:	Edinburgh, UK
Web:	https://www.bigissue.org.uk/

Crime Reduction Initiatives

City:	London, UK
Web:	http://www.cri.org.uk/

Crisis

City:	London, UK
Web:	http://www.crisis.org.uk/

Crossreach

City:	Edinburgh, UK
Web:	www.crossreach.org.uk/

Depaul International

City:	London, UK
Web:	http://www.depaulinternational.org/

Knightstone

City:	Weston-super-Mare, UK
Web:	http://www.knightstone.co.uk/

Emmaus

City:	London, UK
Web:	http://www.homeless.org.uk/

Latch

City:	Leeds, UK
Web:	http://www.latch.org.uk/

Erimus Housing

City:	Middlesbrough, UK
Web:	http://www.erimushousing.co.uk/

Local Solutions

City:	Liverpool, UK
Web:	http://www.localsolutions.org.uk/

Framework

City:	Leicester, UK
Web:	http://www.frameworkha.org/

Leeds Federated Housing Association

City:	Leeds, UK
Web:	http://www.lfha.co.uk/

Glasgow Homeless Network

City:	Glasgow, UK
Web:	http://www.ghn.org.uk/

Leeds Housing Concern

City:	Leeds, UK
Web:	http://www.leedshc.org.uk/

Golden Key

City:	Bristol, UK
Web:	http://www.goldenkeybristol.org.uk/

Mainstay

City:	Liverpool, UK
Web:	http://www.mainstayliverpool.org.uk/

Homeless Link

City:	London, UK
Web:	http://www.homeless.org.uk/

Nacro

City:	London, UK
Web:	https://www.nacro.org.uk/

Horton Housing

City:	West Yorkshire, UK
Web:	http://www.hortonhousing.co.uk/

The Marie Trust

City:	Glasgow, UK
Web:	http://www.themarietrust.org/

The Julian House

City:	Bath, UK
Web:	http://www.julianhouse.org.uk/

Midland Heart

City:	Birmingham, UK
Web:	http://www.midlandheart.org.uk/

Penumbra

City:	Edinburgh, UK
Web:	http://www.penumbra.org.uk/

The Roberts Centre

City:	Portsmouth, UK
Web:	http://www.robertscentre.org.uk/

Rethink

City:	London, UK
Web:	http://www.rethink.org/

Shelter Housing Aid and Research Project

City:	Leicester, UK
Web:	http://www.leicestershelter.org.uk/

Shelter Scotland

City:	Edinburgh, UK
Web:	http://scotland.shelter.org.uk/

Shelter U.K.

City:	London, UK
Web:	http://england.shelter.org.uk/

SHAP

City:	Merseysidel, UK
Web:	http://www.shap.org.uk/

SHP

City:	London, UK
Web:	http://www.shp.org.uk/

Simon Community Scotland

City:	Glasgow, UK
Web:	http://www.simonscotland.org/

Support Solutions

City:	Penryn, UK
Web:	http://www.supportsolutions.co.uk/

St Mungo's Broadway

City:	London, UK
Web:	http://www.mungosbroadway.org.uk/

Target

City:	Sheffield, UK
Web:	http://www.targethousing.org.uk/

Thames Reach

City:	London, UK
Web:	http://www.homeless.org.uk/

The Whitechapel Centre

City:	Liverpool, UK
Web:	http://www.newstarhomes.org.uk/

UNITED STATES INVITATIONS

211 LA County

City:	San Gabriel, CA
Web:	https://www.211la.org/

Access to Housing, Inc. DC

City:	Washington, DC
Web:	http://www.accesshousingincdc.org/

Action Ministries

City:	Atlanta, GA
Web:	http://actionministries.net/

Alexian Brothers

City:	Chicago, IL
Web:	http://www.alexianbrothershousing.org/

All Home

City:	Seattle, WA
Web:	http://allhomekc.org/

Alliance to End Homelessness in Suburban Cook County

City:	Hillside, IL
Web:	http://www.suburbancook.org/

Ascencia

City:	Glendale, CA
Web:	http://www.ascenciaca.org/

Atlanta Center for Self Sufficiency

City:	Atlanta, GA
Web:	http://www.atlantacss.org/

A Safe Haven

City:	Chicago, IL
Web:	http://www.asafehaven.org/

A Wider Circle

City:	Washington, DC
Web:	http://awidercircle.org/

Bay Area Homeless Services, Inc.

City:	Baytown, TX
Web:	http://bahs-shelter.org/

The Beacon

City:	Houston, TX
Web:	http://www.beaconhomeless.org/

Beds Plus Care

City:	LaGrange, IL
Web:	http://www.beds-plus.org/

Bethesda Project

City:	Philadelphia, PA
Web:	http://www.bethesdaproject.org/

Better Way Miami

City:	Miami, FL
Web:	http://www.betterwaymiami.org/

The Bowery Mission

City:	New York, NY
Web:	https://www.bowery.org/

Breaking Ground

City:	New York, NY
Web:	http://www.breakingground.org/

The Bridge North Texas

City:	Dallas, TX
Web:	http://www.bridgenorthtexas.org/

Bridges to Independence

City:	Washington, DC
Web:	https://bridges2.org/

Brooklyn Community Housing and Services

City:	Brooklyn, NY
Web:	http://www.bchands.org/

Broward Partnership

City:	Ft. Lauderdale, FL
Web:	http://www.bphi.org/

Camillus House

City:	Miami, FL
Web:	http://www.camillus.org/

Carrfour Supportive Housing

City:	Miami, FL
Web:	http://www.miamihomeless.org/

Coalition for the Homeless - Leading Houston Home

City:	Houston, TX
Web:	http://www.homelesshouston.org/

Casa Central

City:	Chicago, IL
Web:	http://www.casacentral.org/

Coalition for Homeless Youth

City:	New York, NY
Web:	http://www.nychy.org/

Care for the Homeless

City:	New York, NY
Web:	http://www.careforthehomeless.org/

Community Housing Partnership

City:	San Francisco, CA
Web:	http://www.chp-sf.org/

Center for Urban Community Services

City:	New York, NY
Web:	http://www.bchands.org/

Community of Hope

City:	Washington, DC
Web:	https://www.communityofhopedc.org/

Change Happens

City:	Houston, TX
Web:	http://www.changehappenstx.org/

Compass Housing Alliance

City:	Seattle, WA
Web:	http://www.compasshousingalliance.org/

Chapman Partnership

City:	Miami, FL
Web:	https://www.chapmanpartnership.org/

Connections Housing

City:	San Diego, CA
Web:	http://www.sdconnections.org/

Charlie's Place

City:	Washington, DC
Web:	http://charliesplacedc.org/

Corporation for Supportive Housing

City:	New York, NY
Web:	http://www.csh.org/

Christian Community Health Center

City:	Chicago, IL
Web:	http://www.cchc-online.org/

Deborah's Place

City:	Chicago, IL
Web:	https://www.deborahsplace.org/

Coalition for the Homeless

City:	New York, NY
Web:	www.coalitionforthehomeless.org/

DESC

City:	Seattle, WA
Web:	http://www.desc.org/

Detroit Central City

City:	Detroit, MI
Web:	http://www.dccmh.org/

Family Aid Boston

City:	Boston, MA
Web:	www.familyaidboston.org/

Detroit Rescue Mission Ministries

City:	Detroit, MI
Web:	http://drmm.org/

Featherfist

City:	Chicago, IL
Web:	http://www.featherfist.org/

Dignity Housing

City:	Philadelphia, PA
Web:	http://dignityhousing.org/

Franciscan Outreach

City:	Chicago, IL
Web:	https://www.franoutreach.org/

Directions Home

City:	Fort Worth, TX
Web:	http://www.directionshome.org/

The Fresh Start Foundation

City:	Philadelphia, PA
Web:	http://www.endveteranhomelessness.org/

DISH San Francisco

City:	San Francisco, CA
Web:	http://dishsf.org/

Friends of Boston's Homeless

City:	Boston, MA
Web:	http://www.fobh.org/

DuPage Pads

City:	Chicago, IL
Web:	http://dupagepads.org/

Gateway Center

City:	Atlanta, GA
Web:	http://www.gatewayctr.org/

Dolores Street Community Services

City:	San Francisco, CA
Web:	http://www.dscs.org/

Gettlove

City:	Los Angeles, CA
Web:	http://www.gettlove.org/

End Homelessness Among Veterans

City:	Philadelphia, PA
Web:	http://www.endveteranhomelessness.org/

Goddard Riverside Community Center

City:	New York, NY
Web:	http://www.goddard.org/

Episcopal Community Services

City:	San Francisco, CA
Web:	http://www.ecs-sf.org/

Grace

City:	Grapevine, TX
Web:	http://www.hccdallas.org/

Halifax Urban Ministries

City:	Daytona Beach, FL
Web:	http://www.halifaxurbanministries.org/

Haymarket Center

City:	Chicago, IL
Web:	http://www.hcenter.org/

Heading Home, Inc.

City:	Boston, MA
Web:	http://www.headinghomeinc.org/

Henry Street Settlement

City:	New York, NY
Web:	http://www.henrystreet.org/

Hesed House

City:	Aurora, IL
Web:	http://www.hesedhouse.org/

HomeAid Houston

City:	Houston, TX
Web:	http://www.homeaidhouston.org/

HOPE Atlanta

City:	Atlanta, GA
Web:	http://www.hopeatlanta.org/

Horizon House

City:	Philadelphia, PA
Web:	http://www.hhinc.org/

House of Ruth

City:	Washington, DC
Web:	http://www.houseofruth.org/

Housing and Services, Inc.

City:	New York, NY
Web:	http://www.hsi-ny.org/

Housing and Homeless Coalition of Syracuse and Onondaga County

City:	Syracuse, NY
Web:	http://www.hhccny.org/

Housing Crisis Center

City:	Dallas, TX
Web:	http://www.hccdallas.org/

Initiative for Affordable Housing

City:	Decatur, GA
Web:	http://www.affordablehousingatl.org/

Inspiration Corporation

City:	Chicago, IL
Web:	http://www.inspirationcorp.org/

The Impact Group

City:	Norcross, GA
Web:	http://www.theimpactgroup.org/

Jars of Clay Outreach

City:	Atlanta, GA
Web:	http://www.jocatlanta.org/

La Casa Norte

City:	Chicago, IL
Web:	http://www.alexianbrothershousing.org/

Lamp Community

City:	Los Angeles, CA
Web:	http://www.lampcommunity.org/

Lazarus House

City:	St. Charles, IL
Web:	http://www.lazarushouseonline.com/

Lifenet Texas

City:	Dallas, TX
Web:	http://www.lifenettexas.org/

Lincoln Park Community Shelter

City:	Chicago, IL
Web:	http://www.lpcsonline.org/

Lutheran Services Florida

City:	Tampa, FL
Web:	http://www.lsfnet.org/

Lutheran Social Services of Northern California

City:	Concord, CA
Web:	http://www.lssnorcal.org/

Massachusetts Coalition for the Homeless

City:	Lynn, MA
Web:	http://www.mahomeless.org/

Massachusetts Housing & Shelter Alliance

City:	Boston, MA
Web:	www.mhsa.net/

Matthew House Chicago

City:	Chicago, IL
Web:	http://www.matthewhousechicago.org/

Mercy Housing

City:	San Francisco, CA
Web:	https://www.mercyhousing.org/

Metrocare Services

City:	Dallas, TX
Web:	https://www.metrocareservices.org/

MHMR of Tarrant County

City:	Fort Worth, TX
Web:	http://www.mhmrtc.org/

Miami Coalition for the Homeless

City:	Miami, FL
Web:	http://www.miamihomeless.org/

Miami-Dade County Homeless Trust

City:	Miami, FL
Web:	http://www.homelesstrust.org/

The Midnight Mission

City:	Los Angeles, CA
Web:	http://www.midnightmission.org/

Must Ministries

City:	Marietta, GA
Web:	http://www.mustministries.org/

New Directions for Veterans

City:	Los Angeles, CA
Web:	http://www.newdirectionsinc.org/

N Street Village

City:	Washington, DC
Web:	http://www.nstreetvillage.org/

Pacific Clinics

City:	Arcadia, CA
Web:	http://www.pacificclinics.org/

Pathways National

City:	New York, NY
Web:	https://pathwaystohousing.org/

Revive Center for Housing and Healing

City:	Chicago, IL
Web:	https://revivecenter.org/

Partnership for the Homeless

City:	New York, NY
Web:	http://partnershipforthehomeless.org/

Sadowski Housing Coalition

City:	Tallahassee, FL
Web:	http://www.sadowskicoalition.org/

Pioneer Human Services

City:	Seattle, WA
Web:	http://pioneerhumanservices.org/

Samaritan House

City:	Fort Worth, TX
Web:	http://samaritanhouse.org/

Project HOME

City:	Philadelphia, PA
Web:	https://projecthome.org/

Seattle's Union Gospel Mission

City:	Seattle, WA
Web:	http://www.ugm.org/

Project Hospitality

City:	Staten Island, NY
Web:	http://www.projecthospitality.org/

Services for the UnderServed

City:	New York, NY
Web:	http://www.hsi-ny.org/

Project Renewal

City:	New York, NY
Web:	http://www.projectrenewal.org/

Shields for Families

City:	Los Angeles, CA
Web:	https://www.shieldsforfamilies.org/

Raphael House

City:	San Francisco, CA
Web:	http://www.raphaelhouse.org/

The Single Room Housing Assistance Corporation

City:	Chicago, IL
Web:	http://www.srhac.org/

The Renaissance Collaborative

City:	Chicago, IL
Web:	http://www.trcwabash.org/

Solid Ground

City:	Seattle, WA
Web:	http://www.solid-ground.org/

Renaissance Social Services

City:	Chicago, IL
Web:	http://www.rssichicago.org/

Southwest Solutions

City:	Detroit, MI
Web:	http://www.swsol.org/

SRO Housing Corporation

City:	Los Angeles, CA
Web:	http://www.srohousing.org/

Star of Hope

City:	Houston, TX
Web:	http://www.sohmission.org/

St. Francis House

City:	Boston, MA
Web:	http://www.stfranchishouse.org/

St Leonard's Ministries

City:	Chicago, IL
Web:	http://slministries.org/

Support Homeless Veterans, Inc.

City:	Glenside, PA
Web:	http://www.supporthomelessveterans.org/

Tarrant County Homeless Coalition

City:	Fort Worth, TX
Web:	http://www.ahomewithhope.org/

Thresholds

City:	Chicago, IL
Web:	http://www.thresholds.org/

Upward Bound House

City:	Santa Monica, CA
Web:	http://www.upwardboundhouse.org/

Urban Pathways

City:	New York, NY
Web:	http://www.urbanpathways.org/

Veterans Multi-Service Center

City:	Philadelphia, PA
Web:	http://www.vmcenter.org/

Wayne Metropolitan Community Action Agency

City:	Wyandotte, MI
Web:	https://www.waynemetro.org/

The Way to Win

City:	New York, NY
Web:	http://winnyc.org/

Weingart

City:	Los Angeles, CA
Web:	http://weingart.org/

9.12 CATEGORIZATION OF BEST PRACTICE CORE PRINCIPLES

Support	Principle	Theme	Repeats	Focus
ACT	Team members directly provide individualized, flexible, and comprehensive treatment, support and rehabilitation services	Individualized Support	5	Client
ACT	Individual supportive therapy	Individualized Support	5	Client
CCISC2	All people with co-occurring conditions are not the same, so different parts of the system have responsibility to provide co-occurring-capable services for different populations	Individualized Support	5	Program
CCISC2	Recovery plans, interventions, and outcomes must be individualized. Consequently, there is no one correct dual-diagnosis program or intervention for everyone	Individualized Support	5	Program
HF	Individualized, recovery-oriented, & client-driven supports	Individualized Support	5	Client
ACT	Small staff to consumer ratio (approximately 1 to 10)	Intensive Support	5	Program
ACT	Mobile crisis interventions	Intensive Support	5	Program
CTI	Small caseloads	Intensive Support	5	Program
ACT	Services are available on a 24/7 basis	Intensive Support	5	Client
CTI	Weekly team supervision	Intensive Support	5	Client
ACT	No arbitrary time limits on receiving services	Long Term Support	5	Client
HF	Commitment to rehouse	Long Term Support	5	Client
IPS	The client receives unlimited support to accomplish his/her goal of gaining competitive employment	Long Term Support	5	Client
IPS	Continuous assessment through trying competitive jobs, meaning each competitive job placement is considered to be an opportunity to assess the client's fit	Long Term Support	5	Client
CTI	No early discharge	Long Term Support	5	Client
ACT	Assistance with natural support networks	Socialization	5	Client
ACT	Majority of contacts are in community settings	Socialization	5	Client
CTI	Community-based	Socialization	5	Client
HF	Social & community integration	Socialization	5	Client
ACT	Peer supports	Socialization	5	Client
ACT	Illness management and recovery skills	Client Independence	4	Client
ACT	Skills teaching and assistance with daily living activities	Client Independence	4	Client
CCISC2	Progress occurs through adequately supported, adequately rewarded skill-based learning for each co-occurring condition or issue	Client Independence	4	Client
CTI	Time-limited	Client Independence	4	Client
ACT	Substance abuse treatment	Harm Reduction	4	Client
CTI	Harm reduction approach	Harm Reduction	4	Client
HF	Harm reduction	Harm Reduction	4	Client
ACT	Medication prescribing, administration and monitoring	Harm Reduction	4	Client

Support	Principle	Theme	Repeats	Focus
IPS	Rapid job search, meaning job-finding activities happen as soon as possible—within a month of entry into the program	Client Control	3	Client
HF	Consumer choice and self-determination	Client Control	3	Client
IPS	Attention to client preferences, meaning that clients are assessed regarding their unique aspirations and skills	Client Control	3	Client
HF	Standard tenant agreement	Normalization	3	Client
HF	Immediate access to permanent housing with no housing readiness requirements	Normalization	3	Client
IPS	Competitive employment is the primary goal	Normalization	3	Client
CCISC2	Recovery involves moving through stages of change and phases of recovery for each co-occurring condition or issue	Phased Support	3	Client
CTI	Decreasing intensity over time	Phased Support	3	Client
CTI	Phased approach	Phased Support	3	Client
ACT	Services are targeted to a specific group of individuals with severe mental illness	Targeted Support	3	Client
CTI	Addresses a period of transition	Targeted Support	3	Client
CCISC2	CCISC is designed so that all policies, procedures, practices, programs, and clinicians become welcoming, recovery- or resiliency-oriented, and co-occurring-capable	Targeted Support	3	Program
ACT	Supported housing and supports in accessing benefits, transportation, medical care, etc.	Affordable Housing	2	Client
HF	Clients should not pay more than 30% of their income towards rent	Affordable Housing	2	Program
CCISC2	When co-occurring issues and conditions are present, each issue or condition is considered to be primary	All Conditions Primary	1	Program
CCISC2	Co-occurring issues and conditions are an expectation, not an exception	Dual Diagnosis Oriented	1	Program
CTI	Focused	Focused Support	1	Client
IPS	Integration of rehabilitation with mental health services	Integrated Supports	1	Program
CCISC2	The foundation of a recovery partnership is an empathic, hopeful, integrated, strength-based relationship	Trust Building	1	Program
CTI	Regular full caseload review	Support Reviews	1	Program
ACT	Team members share responsibility for consumers served by the team	Team Support	1	Program

9.13 CATEGORIZATION OF LESSONS LEARNED

Guide, Handbook, or Research Advice	Lesson Learned	Category	High Level Category	Hi Cat Repeats
ETAH - Best Practices Guide	Provide Basic Skills and Work Readiness Skills Training.	Basic & Work Readiness Skills	Client Centred	14
ETAH - Best Practices Guide	Provide Thorough Assessment and Ongoing Case Management.	Client Assessment	Client Centred	14
US Dept of Health and Human Services (2003)	The programs with the best employment outcomes focused on rapid placement into jobs of the participant's choice	Client Choice	Client Centred	14
US Dept of Health and Human Services (2003)	Most participants changed jobs at least once (with an average of 2.3 jobs per person) during the study.	Client Choice	Client Centred	14
US Dept of Health and Human Services (2003)	For those participants who did change jobs, most were not fired but left jobs for various other reasons.	Client Choice	Client Centred	14
ECH - Employment and Housing	The best approach to work with participants is consumer focused. This requires listening to the participant and understanding the stages of change.	Client-Centred Approach	Client Centred	14
Serge et al. (2006)	The approach should be client-centred	Client-Centred Approach	Client Centred	14
Opportunity Chicago	Consider "hooks" and incentives to increase program participation.	Create Incentives to Participate	Client Centred	14
Serge et al. (2006)	Holistic approaches work best	Holistic Approach	Client Centred	14
ECH - Employment and Housing	Planning an integrated supportive housing and employment services program requires careful consideration of shifting programs and practices from traditional linear approaches to a more customized foundation, in which services are responsive to the interests, preferences, and capabilities of chronically homeless individuals.	Individualized Support	Client Centred	14
ECH - Employment and Housing	It is important for staff to assist participants identify, understand, and potential issues and behaviors that will impact their ability to pursue and attain employment goals. In order to do this staff should take the time to work with participants to develop a Person-Centered or Individual Service Plan, which not only uncovers the participant's personal skills, interests, talents and gifts, but also highlight the specific steps, activities, and supports needed in order to pursue these goals.	Individualized Support	Client Centred	14
ETAH - Best Practices Guide	Arrange for Short-term Job Search Assistance.	Job Search Assistance	Client Centred	14
ECH - Employment and Housing	Establish a no wrong door program orientation that not only allows access to services from almost any point but to do so regardless of how well prepared people are for competitive employment. Follow a zero exclusion policy: everyone who expresses the desire to work can access employment services.	No Wrong Door	Client Centred	14
Serge et al. (2006)	The quality of work is important	Work Quality	Client Centred	14
Opportunity Chicago	Case management and wrap-around supports are essential program elements.	Case Management	Integrated Support	9

Guide, Handbook, or Research Advice	Lesson Learned	Category	High Level Category	Hi Cat Repeats
ECH - Employment and Housing	In this approach, employment and housing services are offered concurrently, not sequentially.	Concurrent Supports	Integrated Support	9
Serge et al. (2006)	Housing and employment services need to be integrated	Concurrent Supports	Integrated Support	9
US Dept of Health and Human Services (2003)	The programs with the best employment outcomes integrated mental health and vocational supports	Concurrent Supports	Integrated Support	9
US Dept of Health and Human Services (2003)	Jobs alone do not ensure economic stability for consumers.	Concurrent Supports	Integrated Support	9
ECH - Employment and Housing	Federal housing programs for homeless people with disabilities, especially those funded by the McKinney-Vento Act, can do more to promote employment of tenants.	Housing Programs Can Do More to Help the Homeless Gain Employment	Integrated Support	9
ECH - Employment and Housing	It is possible to effectively combine employment services with permanent housing assistance to improve the well-being of individuals who are chronically homeless.	Housing Support	Integrated Support	9
ECH - Employment and Housing	No single agency can meet all of the needs of the chronically homeless population.	Multiple Supports	Integrated Support	9
ECH - Employment and Housing	Mental health care and substance abuse treatment are essential to move people from unemployed street dwellers to permanently housed wage earners.	Multiple Supports	Integrated Support	9
ECH - Employment and Housing	Staff needs to be cross-trained to understand each other's functions and support each other. This cost and time needs to be built in up front.	Build Inter-organizational understanding	Inter-organizational Relationships	9
ETAH - Best Practices Guide	Establish Linkages with Homeless-serving Agencies.	Link to Employment Services	Inter-organizational Relationships	9
ECH - Employment and Housing	Better linkages with the mainstream workforce investment programs are essential for developing a long-term, sustainable employment services.	Link to Mainstream Services	Inter-organizational Relationships	9
ECH - Employment and Housing	It is important to start your program with looking at the other agencies and groups that serve the same population. Building partnerships at the beginning of a program allows for better integration and problem solving.	Involve Other Organizations	Inter-organizational Relationships	9
Opportunity Chicago	Build a strong collaborative with relationships across stakeholders.	Build Collaborative Relationships	Inter-organizational Relationships	9
ECH - Employment and Housing	The goal of ending chronic homelessness through employment and housing will only be realized through collaborations across multiple systems.	Inter-organizational Collaboration	Inter-organizational Relationships	9
Opportunity Chicago	Abandon individual silos and agendas and work together on a single goal and collective approach.	Collective Approach	Inter-organizational Relationships	9

Guide, Handbook, or Research Advice	Lesson Learned	Category	High Level Category	Hi Cat Repeats
ECH - Employment and Housing	Take the time to learn about other systems, how to best work together, and eventually integrate the services to reach the project goals.	Build Inter-organizational understanding	Inter-organizational Relationships	9
ECH - Employment and Housing	The most important tool that program planners and the community have to address impacts is a survey of all partners involved at the beginning of the project. Ask each to honestly define important issues, such as: program and organizational policies, cultural histories and philosophies, hiring practices, overall skill and experience of current staff, and other organizational issues that will ultimately impact this type of project. Once this survey is complete, it is an incredibly important foundation to use for discussions that will ultimately define the centralized, unified vision, mission, goals, and overall culture of the integrated employment and supportive housing project.	Build Inter-organizational understanding	Inter-organizational Relationships	9
US Dept of Health and Human Services (2003)	Collaboration between support providers and the businesses who employed participants was associated with improved work outcomes. This result illustrates the importance of engaging employers	Engage Employers	Focus on Employment Market	5
Serge et al. (2006)	Employers need to be integrated into the process	Engage Employers	Focus on Employment Market	5
ECH - Employment and Housing	Community leadership from Workforce Investment Boards (WIBs) is a key element of improving employment services and outcomes for the chronic homeless population.	Leverage Relationships with Employment Agencies	Focus on Employment Market	5
ECH - Employment and Housing	Marketing job seekers to employers requires building a professional working relationship with businesses in the community that acknowledges the needs of the employers, and also provide new information and resources to the employers.	Engage Employers	Focus on Employment Market	5
ECH - Employment and Housing	Helping participants maintain employment is influenced by a number of factors beyond the individual features of the worker. You can, and should, design program strategies for job retention, labor market attachment, and career advancement.	Strategize Labour Market Attachment	Focus on Employment Market	5
Marshall, Rapp, Becker, and Bond (2008)	Before initiating the supported employment implementation, ensure top-level administrators are committed to the initiative and are willing to carry out the range of actions included in this report.	Committed Leadership	Leadership Quality	5
Opportunity Chicago	Recruit leadership with the ability to shift (sometimes ineffective) public funds.	Influential Leadership	Leadership Quality	5
Opportunity Chicago	Secure a reputable convener and facilitator.	Reputable Leadership	Leadership Quality	5
Opportunity Chicago	Secure commitments of leadership.	Committed Leadership	Leadership Quality	5

Guide, Handbook, or Research Advice	Lesson Learned	Category	High Level Category	Hi Cat Repeats
Marshall, Rapp, Becker, and Bond (2008)	Designate a full-time staff person to lead the supported employment program who has administrative authority. Give preference to candidates with strong skills in business and clinical supervision.	Strong Leadership	Leadership Quality	5
ECH - Employment and Housing	Integration of all services begins at the beginning. It is crucial to ensure that different system policies, philosophies, and practices have been fully discussed, examined, and coordinated prior to implementing the project. Without this preliminary work, it is impossible for direct services staff to operate a truly integrated employment and housing project.	Integrate Initially	Planning	5
ECH - Employment and Housing	Access to training services and intensive services for chronically homeless job seekers through the Workforce Investment Act (WIA) funded One Stop Career Centers is limited because of a combination of competing priorities, limited funding, and high performance measures that create a disincentive to serving the chronically homeless.	Competing Priorities, Limited Funding, and High Performance Measures Create Disincentives to Serve the Homeless	Planning	5
ECH - Employment and Housing	Take the time to make sure all systems fully understand the target population of the project and their service needs. Examine these needs in the context of the different service funding available to the project. Map potential funding to each need, to determine where the gaps are and what a comprehensive, fully funded, system will look like.	Map Systems, Services, & Funding	Planning	5
ECH - Employment and Housing	Create a project governing structure that can handle issues at every level, from service delivery to individual participants to changes in agency operating procedures that affect many participants to policy development and long-range planning.	Strategic to Operational Governing Structure	Planning	5
ECH - Employment and Housing	Give planning the time, attention, and respect it deserves. You will pay the price if you don't.	Up-front Planning	Planning	5
Marshall, Rapp, Becker, and Bond (2008)	Set clear performance standards based on the evidence-based model and be prepared to remove staff who do not meet them.	Clear Program Standards	Performance Measures	4
Opportunity Chicago	Agree at the outset on how data will be collected, stored, and analyzed.	Data Collection	Performance Measures	4
ECH - Employment and Housing	Service coordination in and of itself is not enough. Coordination efforts must achieve the goal of helping participants—particularly those who may face significant barriers to working—receive the services they need to obtain and keep employment.	Focus on Outcomes	Performance Measures	4
ECH - Employment and Housing	A formal program evaluation may not required but may be in the best interests of program planners, funders, program participants, and others.	Program Evaluation	Performance Measures	4
ECH - Employment and Housing	Be sure to include in planning people who are fully aware of the challenges posed by the target population and existing agency priorities and constraints, yet who are committed to the ultimate	Knowledgeable, Committed People	Staff Quality	4

Guide, Handbook, or Research Advice	Lesson Learned	Category	High Level Category	Hi Cat Repeats
	project goals and open-minded as to how they may be accomplished.			
ECH - Employment and Housing	Create a training plan for the staff from different service systems. Include trainings for managers and policy-makers that address the complex cultural and philosophical differences that exist between the systems.	Properly Train Staff	Staff Quality	4
ETAH - Best Practices Guide	Provide Staff Training on Serving Homeless Persons.	Properly Trained Staff	Staff Quality	4
Marshall, Rapp, Becker, and Bond (2008)	Hire employment specialists with strong clinical skills for working with people with mental illness who believe in recovery and supported employment principles.	Properly Trained Staff	Staff Quality	4
Opportunity Chicago	Integrate and align restricted and flexible funds to support innovative program models.	Flexible Funding	Flexibility	3
Opportunity Chicago	Learn from mistakes and make corrections.	Learning Organization	Flexibility	3
Opportunity Chicago	An ability to leverage and align resources is critical to maximize impact.	Leverage Resources	Flexibility	3
ETAH - Best Practices Guide	Provide Follow-up and Support.	Long Term Support	Ongoing Support	3
US Dept of Health and Human Services (2003)	The programs with the best employment outcomes provided ongoing support	Long Term Support	Ongoing Support	3
US Dept of Health and Human Services (2003)	On average, it took six months for participants in the study to obtain work; thus programs should not be overly focused on short-term attempts at placement.	Long Term Support	Ongoing Support	3
Serge et al. (2006)	Remedial programs are successful	Remedial Programs	Client Training	1
Marshall, Rapp, Becker, and Bond (2008)	Dismantle programs that contradict or interfere with supported employment (for example, prevocational, enclave, or agency-based employment programs).	Remove Barriers	Commitment	1

10.0 REFERENCES

- 500 Lives 500 Homes. (n.d.-a). 500 Lives 500 Homes: Background to the Campaign. Retrieved from <http://www.500lives500homes.org.au/activities--projects/background-to-the-campaign>
- 500 Lives 500 Homes. (n.d.-b). 500 Lives 500 Homes: Home. Retrieved from <http://www.500lives500homes.org.au/>
- Acuña, J., & Erlenbusch, B. (2009). National Coalition for the Homeless | HOMELESS EMPLOYMENT REPORT: Findings and Recommendations. Retrieved from <http://www.nationalhomeless.org/publications/homelessemploymentreport/>
- AHRQ. (2013). A Framework for Measuring Integration of Behavioral Health and Primary Care. Retrieved from <https://integrationacademy.ahrq.gov/atlas/frameworkIBHC>
- Arena, M., Bengo, I., Calderini, M., & Chiodo, V. (2016). Social Impact Bonds: Blockbuster or Flash in a Pan? *International Journal of Public Administration*, 1-13. doi:10.1080/01900692.2015.1057852
- Armstrong, N. P., & Steffen, J. J. (2008). The Recovery Promotion Fidelity Scale: Assessing The Organizational Promotion of Recovery. *Community Mental Health Journal*, 45(3), 163-170. doi:10.1007/s10597-008-9176-1
- ASCHA. (2014). Ottewell Manor (pp. 23): Alberta Seniors Communities & Housing Association.
- Aubry, T., Nelson, G., & Tsemberis, S. (2015). Housing First for People With Severe Mental Illness Who Are Homeless: A Review of the Research and Findings From the At Home/Chez soi Demonstration Project. *The Canadian Journal of Psychiatry*, 60(11), 467-474.
- Aubry, T., Tsemberis, S., Adair, C. E., Veldhuizen, S., Streiner, D., Latimer, E., . . . Goering, P. (2015). One-Year Outcomes of a Randomized Controlled Trial of Housing First With ACT in Five Canadian Cities. *Psychiatric Services*, 66(5), 463-469. doi:10.1176/appi.ps.201400167
- Batterham, R., Southern, D., Appleby, N., Elsworth, G., Fabris, S., Dunt, D., & Young, D. (2002). Construction of a GP integration model. *Social Science & Medicine*, 54(8), 1225-1241. doi:10.1016/S0277-9536(01)00092-2
- Beer, M., & Nohria, N. (2000, 2000). *Breaking the code of change*, Boston, Mass.
- Bejerholm, U., Areberg, C., HofGren, C., Sandlund, M., & Rinaldi, M. (2015). Individual Placement and Support in Sweden—A randomized controlled trial. *Nordic Journal of Psychiatry*, 69(1), 57-66. doi:10.3109/08039488.2014.929739
- BHCHP. (2014). Press Kit | Boston HealthCare for the Homeless Program. Retrieved from <https://www.bhchp.org/press-kit>
- Bond, G. R. (2004). Supported Employment: Evidence for an Evidence-Based Practice. *Psychiatric Rehabilitation Journal*, 27(4), 345-359.
- Bond, G. R., Becker, D. R., & Drake, R. E. (2011). Measurement of Fidelity of Implementation of Evidence-Based Practices: Case Example of the IPS Fidelity Scale. *Clinical Psychology Science and Practice*, 18(2), 126-141. doi:10.1111/j.1468-2850.2011.01244.x
- Bond, G. R., Becker, D. R., Drake, R. E., Rapp, C. A., Meisler, N., Lehman, A. F., . . . Blyler, C. R. (2001). Implementing Supported Employment as an Evidence-Based Practice. *Psychiatric Services*, 52(3), 313-322.
- Bond, G. R., & Drake, R. E. (2015). The critical ingredients of assertive community treatment. *World Psychiatry*, 14(2), 240-242. doi:10.1002/wps.20234
- Bond, G. R., Drake, R. E., & Becker, D. R. (2012). Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US. *World Psychiatry*, 11(1), 32-39.
- Bond, G. R., Drake, R. E., McHugo, G. J., Rapp, C. A., & Whitley, R. (2009). Strategies for Improving Fidelity in the National Evidence-Based Practices Project. *Research on Social Work Practice*, 19(5), 569-581. doi:10.1177/1049731509335531

- Bond, G. R., Peterson, A. E., Becker, D. R., & Drake, R. E. (2012). Validation of the Revised Individual Placement and Support Fidelity Scale (IPS-25). *Psychiatric Services, 63*(8), 758-763. doi:10.1176/appi.ps.201100476
- Bond, G. R., Vogler, K. M., Resnick, S. A., Evans, L. J., Drake, R. E., & Becker, D. R. (2001). Dimensions of supported employment: Factor structure of the IPS fidelity scale. *Journal of Mental Health, 10*(4), 383-393.
- Boon, H., Verhoef, M., O'Hara, D., & Findlay, B. (2004). From parallel practice to integrative health care: a conceptual framework. *BioMed Central Health Services Research, 2004*, 1-5. doi:10.1186/1472-6963-4-1
- Bradley Ruder, D. (2016). Street Doctor. *The Harvard Magazine*. Retrieved from <http://harvardmagazine.com/2016/01/street-doctor>
- Breaking Ground HDFC. (2016a). Mission & Model. Retrieved from <http://www.breakingground.org/mission-model#.Vr-6YXnouic>
- Breaking Ground HDFC. (2016b). News. Retrieved from <http://www.breakingground.org/news-and-events>
- Breaking Ground HDFC. (2016c). Street to Home. Retrieved from http://www.breakingground.org/our-programs/street-to-home#.Vr_Gjnnouic
- Buckner, J. C. (2014). The Why and the Who of Family Homelessness. In M. E. Haskett, B. A. Cowan, & S. Perlman (Eds.), *Supporting Families Experiencing Homelessness: Current Practices and Future Directions* (pp. 3-21). New York, NY: Springer.
- Burke, W. W., & Litwin, G. H. (1992). A Causal Model of Organizational Performance and Change. *Journal of Management, 18*(3), 523-545. doi: 10.1177/014920639201800306
- Burt, M. R., The Urban Institute, Pearson, C. L., Montgomery, A. E., & Walter R. McDonald & Associates, I. (2005). *Strategies for Preventing Homelessness*. U.S. Department of Housing and Urban Development Retrieved from https://www.huduser.gov/Publications/pdf/Strategies_for_preventing_Homelessness.pdf.
- Busch-Geertsema, V. (2013). *Housing First Europe: Final Report*. Retrieved from Bremen/Brussels: <http://homelesshub.ca/resource/final-reports-and-contributions-final-housing-first-europe-conference-amsterdam-june-2013>
- Byrnes, J. J. (1998). Do Integrated Healthcare Strategies Enhance Quality? *Integrated Healthcare Report*(July), 6-10.
- Canadian Council on Health Services Accreditation. (2006). Inside Our Health System: Canadian Council on Health Services Accreditation.
- Canadian Observatory on Homelessness. (2012a). *Canadian Definition of Homelessness*. Retrieved from <http://homelesshub.ca/homelessdefinition>
- Canadian Observatory on Homelessness. (2012b). *Foyer Toolkit #1: What is a Foyer?* Retrieved from Toronto, ON: <http://homelesshub.ca/resource/foyer-toolkit>
- CEBP. (2011a). Best of SAMHSA Resources for IDDT. Retrieved from <http://www.centerforebp.case.edu/resources/tools/best-of-samhsa-resources-for-iddt>
- CEBP. (2011b). *IDDT Fidelity Scale, Rating Sheet & Definitions*. Retrieved from Cleveland, OH: <http://www.centerforebp.case.edu/client-files/pdf/iddtfidelityscale-ratingsheet-definitions.pdf>
- CEBP. (2011c). Integrated Dual Disorder Treatment. Retrieved from <https://www.centerforebp.case.edu/practices/sami/iddt>
- Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. (SMA) 07-427). Retrieved from Rockville, MD: http://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/Summit_Rpt_1.pdf
- Chandler, D. (2008). *Supported Housing: Review of Evidence*. Retrieved from Sacramento, CA: <http://www.cibhs.org/sites/main/files/file-attachments/cimh-iddt-supported-housing.pdf>

- Coldwell, C. M., & Bender, W. S. (2007). The Effectiveness of Assertive Community Treatment for Homeless Populations With Severe Mental Illness: A Meta-Analysis. *American Journal of Psychiatry*, 164(3), 393-399.
- Collaborative Community Health Research Centre. (2002). *Research Review of Best Practices for Provision of Youth Services*. Retrieved from Victoria, BC: https://www.mcf.gov.bc.ca/youth/pdf/best_practices_provision_of_youth_services.pdf
- Collins, S. E., Clifasefi, S. L., Andrasik, M. P., Dana, E. A., Stahl, N., Kirouac, M., . . . Malone, D. K. (2012). Exploring Transitions Within a Project-based Housing First Setting: Qualitative Evaluation and Practice Implications. *Journal of Health Care for the Poor and Underserved*, 23(4), 1678-1697. doi:10.1353/hpu.2012.0187
- Community Housing Partnership. (2015). *Community Housing Partnership: At a Glance*. Retrieved from San Francisco, CA: <http://www.chp-sf.org/wp-content/uploads/2015/06/2015-Snapshot.pdf>
- Community Housing Partnership. (n.d.-a). Community Housing Partnership: History. Retrieved from <http://www.chp-sf.org/about/history/>
- Community Housing Partnership. (n.d.-b). Community Housing Partnership: Housing Portfolio. Retrieved from <http://www.chp-sf.org/housing-services/housingproperties/>
- Community Housing Partnership. (n.d.-c). Employment Pathway. Retrieved from <http://www.chp-sf.org/housing-services/training-programs/>
- Community Housing Partnership. (n.d.-d). What We Do. Retrieved from <http://www.chp-sf.org/about/>
- Conrad, D. A., & Shortell, S. M. (1996). Integrated health systems: promise and performance. *Frontiers in Health Service Management*, 13(1), 57-58.
- Cooper, R. L., Seiters, J., Davidson, D. L., MacMaster, S. A., Rasch, R. F. R., Adams, S., & Darby, K. (2010). Outcomes of Integrated Assertive Community Treatment for Homeless Consumers With Co-occurring Disorders. *Journal of Dual Diagnosis*, 6(2), 152-170. doi:10.1080/15504261003766471
- Cotter, D. M. (2009). Recovery-oriented systems of care, the culture of recovery, and recovery support services. *North Carolina Medical Journal*, 70(1), 43-45. Retrieved from <http://ezproxy.library.uvic.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=mnh&AN=19534055&site=ehost-live&scope=site>
- Cronley, C., Petrovich, J., Spance-Almaguer, E., & Preble, K. (2013). Do Official Hospitalizations Predict Medical Vulnerability among the Homeless?: Postdictive Validity Study of the Vulnerability Index. *Journal of Health Care for the Poor and Underserved*, 24(2), 469-486. doi:DOI: 10.1353/hpu.2013.0083
- Cuddeback, G. S., Morrissey, J. P., Domino, M. E., Monroe-DeVita, M., Teague, G. B., & Moser, L. L. (2013). Fidelity to Recovery-Oriented ACT Practices and Consumer Outcomes. *Psychiatric Services*, 64(4), 318-323. doi:10.1176/appi.ps.201200097
- CUPS. (2015). *Community Impact Report V1.0 July 24, 2015*. Retrieved from <http://cupscalgary.com/wp-content/uploads/2015/07/CUPS-Community-Impact-Report-July-242015.pdf>
- CUPS. (n.d.-a). About - CUPS. Retrieved from <http://cupscalgary.com/about/>
- CUPS. (n.d.-b). Community Development. Retrieved from <http://cupscalgary.com/community-development/>
- CUPS. (n.d.-c). Education Services. Retrieved from <http://cupscalgary.com/education-services/>
- CUPS. (n.d.-d). Family Development Centre. Retrieved from <http://cupscalgary.com/family-development-centre/>
- CUPS. (n.d.-e). Health Services. Retrieved from <http://cupscalgary.com/health-services/>
- CUPS. (n.d.-f). Housing and Support Services. Retrieved from <http://cupscalgary.com/housing-services/>
- CUPS. (n.d.-g). Housing Programs. Retrieved from <http://cupscalgary.com/housing-programs/>
- CUPS. (n.d.-h). Key Case Management & GRSP. Retrieved from <http://cupscalgary.com/key-case-management/>

- CUPS. (n.d.-i). One World Child Development Centre. Retrieved from <http://cupscalgary.com/one-world-child-development-centre/>
- CUPS. (n.d.-j). Parent Education. Retrieved from <http://cupscalgary.com/parent-education/>
- CUPS. (n.d.-k). Pre-Natal to Three Child Development Centre & Parent Education. Retrieved from <http://cupscalgary.com/pre-natal-to-three-child-development-centre/>
- CUPS. (n.d.-l). Supports. Retrieved from <http://cupscalgary.com/supports/>
- Currie, L. B., Moniruzzaman, A., Patterson, M. L., & Somers, J. M. (2014). *At Home/Chez Soi Project: Vancouver Site Final Report*. Retrieved from Calgary, AB: <http://www.mentalhealthcommission.ca/English/system/files/private/document/At%20Home%20Report%20Vancouver%20ENG.pdf>
- Dates, B., Young, M. S., Bennett-Clark, F., Broner, N., Neumiller, S., Jong, F. D., . . . Richards, S. (2009). Assertive Community Treatment Fidelity in Programs Serving Persons Who Are Homeless With Co-Occurring Mental and Addictive Disorders. *Journal of Dual Diagnosis, 5*(3-4), 264-286. doi:10.1080/15504260903288826
- de Vet, R., van Luijelaar, M. J. A., Brilleslijper-Kater, S. N., Vanderplasschen, W., Beijersbergen, M. D., & Wolf, J. R. (2013). Effectiveness of Case Management for Homeless Persons: A Systematic Review. *American Journal Of Public Health, 103*(10), 13-26. doi:10.2105/AJPH.2013.301491
- DeCandia, C. J., Murphy, C. M., & Coupe, N. (2014). Needs of Special Populations of Families Without Homes. In M. E. Haskett, S. Perlman, & B. A. Cowan (Eds.), *Supporting Families Experiencing Homelessness: Current Practices and Future Directions* (pp. 253). New York, NY: Springer.
- Department of Housing and Public Works. (2013). *Homelessness-to-Housing Strategy 2020*. Brisbane, AU: Queensland Government Retrieved from <http://girlstimeout.com.au/wp-content/uploads/2014/05/Homelessness-to-Housing-Strategy2020.pdf>.
- Dolbeare, C. N. (1996). Housing Policy: A General Consideration. In J. Baumohl (Ed.), *Homelessness in America*. Phoenix, AZ: Oryx Press.
- Drake, R. E., Becker, D. R., Clark, R. E., & Mueser, K. T. (1999). Research on the Individual Placement and Support Model of Supported Employment. *Psychiatric Quarterly, 70*(4), 289-301. doi:10.1023/A:1022086131916
- Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., . . . Rickards, L. (2001). Implementing Dual Diagnosis Services for Clients With Severe Mental Illness. *Psychiatric Services, 52*(4), 469-476. doi:doi:10.1176/appi.ps.52.4.469
- Engelhardt, M. A., Hills, H., & Monroe, M. (2009). Comprehensive, Continuous, Integrated System of Care Development: Tampa-Hillsborough County, Florida. *Journal of Dual Diagnosis, 5*(1), 110-116. doi:10.1080/15504260802619493
- Episcopal Community Services. (n.d.-a). CHEFS: Conquering Homelessness through Employment in Food Services. Retrieved from <http://ecs-sf.org/programs/chefs.html>
- Episcopal Community Services. (n.d.-b). Episcopal Community Services of San Francisco. Retrieved from <http://www.ecs-sf.org/>
- Episcopal Community Services. (n.d.-c). History of ECH. Retrieved from <http://www.ecs-sf.org/aboutus/history.html>
- Episcopal Community Services. (n.d.-d). Supportive Housing in San Francisco. Retrieved from <http://ecs-sf.org/programs/housing.html>
- Erlenbusch, B., Stevens, S., Towson, K., & Watts, M. (2010). *2010 HOMELESS EMPLOYMENT REPORT: Findings and Recommendations*. Retrieved from Sacramento, CA: <http://www.nationalhomeless.org/advocacy/economic/sacemployment2010.pdf>
- Ferguson, K. M., Xie, B., & Glynn, S. (2012). Adapting the Individual Placement and Support Model with Homeless Young Adults. *Child Youth Care Forum, 41*(3), 277-294. doi:10.1007/s10566-011-9163-5

- Finnerty, M. T., Manuel, J. I., Tochtermann, A. Z., Stellato, C., Fraser, L. H., Reber, C. A. S., . . . Miracle, A. D. (2014). Clinicians' Perceptions of Challenges and Strategies of Transition from Assertive Community Treatment to Less Intensive Services. *Community Mental Health Journal, 51*(1), 85-95. doi:10.1007/s10597-014-9706-y
- Fioritti, A., Burns, T., Hilarion, P., Weeghel, J. v., Cappa, C., Suñol, R., & Otto, E. (2014). Individual Placement and Support in Europe. *Psychiatric Rehabilitation Journal, 37*(2), 123-128. doi:10.1037/prj0000065
- Flatau, P., Conroy, E., Thielking, M., Clear, A., Hall, S., Bauskis, A., . . . Burns, L. (2013). *How integrated are homelessness, mental health and drug and alcohol services in Australia?* Retrieved from Melbourne, AU: http://www.ahuri.edu.au/publications/download.asp?ContentID=ahuri_82013_fr&redirect=true
- Fleury, M.-J. (2006). Integrated service networks: the Quebec case. *Health Services Management Research, 2006*(19), 153-165. doi:10.1258/095148406777888080
- Fleury, M.-J., Grenier, G., & Vallée, C. (2014). Evaluation of the implementation of the Montreal at home/chez soi project. *BMC Health Services Research, 14*(1), 1-14. doi:10.1186/s12913-014-0557-6
- G8 Social Impact Investment Taskforce. (2014). *Impact Investment: The Invisible Heart of Markets - Harnessing the power of entrepreneurship, innovation and capital for public good.* Retrieved from <http://www.socialimpactinvestment.org/reports/Impact%20Investment%20Report%20FINAL%5B3%5D.pdf>
- Gaetz, S. (2012). Substance Use & Addiction: Harm Reduction. Retrieved from <http://homeless.samhsa.gov/channel/harm-reduction-273.aspx>
- Gaetz, S., Donaldson, J., Richter, T., & Gulliver, T. (2013). *The State of Homelessness in Canada: 2013.* Retrieved from Toronto, ON: <http://homelesshub.ca/resource/state-homelessness-canada-2013>
- Gaetz, S., Gulliver, T., & Richter, T. (2014). *The State of Homelessness in Canada: 2014.* Retrieved from Toronto, ON: <http://homelesshub.ca/resource/state-homelessness-canada-2014>
- Gaetz, S., & Scott, F. (2012). *Live, Learn Grow: Supporting Transitions to Adulthood for Homeless Youth - A Framework for The Foyer in Canada.* Retrieved from Toronto, ON: http://homelesshub.ca/sites/default/files/foyer_report23112012.pdf
- Gillies, R. R., Chenok, K. E., Shortell, S. M., Pawlson, G., & Wimbush, J. J. (2006). The Impact of Health Plan Delivery System Organization on Clinical Quality and Patient Satisfaction. *Health Services Research, 41*(4), 1181-1199. doi:10.1111/j.1475-6773.2006.00529.x
- Gilmer, T. P., Stefancic, A., Sklar, M., & Tsemberis, S. (2013a). Development and Validation of a Housing First Fidelity Survey *Psychiatric Services, 64*(9), 911-914. doi:10.1176/appi.ps.201200500
- Gilmer, T. P., Stefancic, A., Sklar, M., & Tsemberis, S. (2013b). *Housing & Services Program Self-Assessment Survey.* Retrieved from http://housingfirsttoolkit.ca/sites/default/files/Revised_HF_Self-Assessment_Survey_12-23-13.pdf
- Goering, P., Veldhuizen, S., Watson, A., Adair, C., Kopp, B., Latimer, E., . . . Aubry, T. (2014). *National Final Report: Cross-site At Home/Chez Soi Project.* Retrieved from Calgary, AB: https://www.mentalhealthcommission.ca/English/system/files/private/document/mhcc_at_home_report_national_cross-site_eng_2.pdf
- Goering, P. N., & Streiner, D. L. (2015). Putting Housing First: The Evidence and Impact. *The Canadian Journal of Psychiatry, 60*(11), 465-466.
- Goscha, R. J., Rapp, C. A., Bond, G. R., & Drake, R. E. (2012). Case Management and Assertive Community Treatment. In H. L. McQuiston, W. E. Sowers, J. M. Ranz, & J. M. Feldman (Eds.), *Handbook of Community Psychiatry* (pp. 293-308). New York NY: Springer.

- Government of Alberta. (2008). *A Plan for Alberta: Ending Homelessness in 10 Years*. Edmonton, Alberta: Government of Alberta Retrieved from http://humanservices.alberta.ca/documents/PlanForAB_Secretariat_final.pdf.
- Government of Alberta. (2016a). *Aboriginal Programs*. Edmonton, AB: Government of Alberta, Human Services Retrieved from <http://humanservices.alberta.ca/documents/Edmonton-etcs-aboriginal.pdf>.
- Government of Alberta. (2016b). *Career and Employment Services/Job Search*. Edmonton, AB: Government of Alberta, Human Services Retrieved from <http://www.humanservices.alberta.ca/documents/Edmonton-etcs-career-and-employment.pdf>.
- Government of Alberta. (2016c). *Services for Low Income Women*. Retrieved from <http://www.humanservices.alberta.ca/documents/Edmonton-etcs-low-income-women.pdf>
- Greenberg, G. A., & Rosenheck, R. A. (2010). An Evaluation of an Initiative to Improve Coordination and Service Delivery of Homeless Services Networks. *The Journal of Behavioral Health Services & Research*, 37(2), 184-196.
- Greenwood, R. M., Stefancic, A., Tsemberis, S., & Busch-Geertsema, V. (2013). Implementations of Housing First in Europe: Successes and Challenges in Maintaining Model Fidelity. *American Journal of Psychiatric Rehabilitation*, 16(4), 290-312. doi:10.1080/15487768.2013.847764
- Groton, D. (2013). Are Housing First Programs Effective? A Research Note. *The Journal of Sociology and Social Welfare*, 40(1), 51-63. Retrieved from <http://scholarworks.wmich.edu/cgi/viewcontent.cgi?article=3714&context=jssw>
- Gubits, D., Shinn, M., Bell, S., Wood, M., Dastrup, S., Solari, C. D., . . . Spellman, B. E. (2015). *Family Options Study: Short-Term Impacts of Housing and Services Interventions for Homeless Families*. U.S. Department of Housing and Urban Development Retrieved from http://www.huduser.gov/portal/portal/sites/default/files/pdf/FamilyOptionsStudy_final.pdf.
- Haas, E., & Mattson, M. (2014). Harm Reduction Theory. In T. L. Thompson (Ed.), *Encyclopedia of Health Communication*. Thousand Oaks, CA: Sage Publications, Inc.
- Habibi, Z., Sobhi-Gharamaleki, N., & Bermas, H. (2011). Effectiveness of Harm Reduction Program on Addicts' Attitudes. *Procedia - Social and Behavioral Sciences*, 30, 1545-1548. doi:<http://dx.doi.org/10.1016/j.sbspro.2011.10.300>
- Hambrick, R. S., & Rog, D. J. (2000). The Pursuit of Coordination: The organizational Dimension in the Response to Homelessness. *Policy Studies Journal*, 28(2), 353-364. doi:10.1111/j.1541-0072.2000.tb02035.x
- Hamilton Family Center. (n.d.-a). Our Mission and Core Values. Retrieved from <https://hamiltonfamilycenter.org/about-us/our-mission-and-core-values/>
- Hamilton Family Center. (n.d.-b). Transitional Housing. Retrieved from <https://hamiltonfamilycenter.org/what-we-do/transitional-housing/>
- Hamilton Family Center. (n.d.-c). What We Do. Retrieved from <https://hamiltonfamilycenter.org/what-we-do/>
- Harrison, M. L., Moore, K. A., Young, M. S., Flink, D., & Ochshorn, E. (2008). Implementing the Comprehensive, Continuous, Integrated System of Care Model for Individuals with Co-Occurring Disorders: Preliminary Findings from a Residential Facility Serving Homeless Individuals. *Journal of Dual Diagnosis*, 4(3), 238-259. doi:10.1080/15504260802072305
- Health Canada. (2002). *Best Practices: Concurrent Mental Health and Substance Use Disorders*. Ottawa, ON: Minister of Public Works and Government Services Canada Retrieved from http://www.hc-sc.gc.ca/hc-ps/alt_formats/hecs-sesc/pdf/pubs/adp-apd/bp_disorder-mp_concomitants/bp_concurrent_mental_health-eng.pdf.

- Herman, D. B., Conover, S., Felix, A., Nakagawa, A., & Mills, D. (2007). Critical Time Intervention: An Empirically Supported Model for Preventing Homelessness in High Risk Groups *The Journal of Primary Prevention*, 28(3-4), 295-312. doi:10.1007/s10935-007-0099-3
- Herman, D. B., Conover, S., Gorroochurn, P., Hinterland, K., Hoepner, L., & Susser, E. S. (2011). Randomized Trial of Critical Time Intervention to Prevent Homelessness After Hospital Discharge. *Psychiatric Services*, 62(7), 713-719.
- Herman, D. B., & Mandiberg, J. M. (2010). Critical Time Intervention: Model Description and Implications for the Significance of Timing in Social Work Interventions. *Research on Social Work Practice*, 20(5), 502-508. doi:10.1177/1049731509360667
- Homeless Hub. (2015). Stephen Gaetz | The Homeless Hub. Retrieved from <http://homelesshub.ca/users/stephengaetz>
- Hopper, K., & Barrow, S. M. (2003). Two Genealogies of Supported Housing and Their Implications for Outcome Assessment *Psychiatric Services*, 54(1), 50-54. doi:10.1176/appi.ps.54.1.50
- Howard, L. M., Heslin, M., Leese, M., McCrone, P., Rice, C., Jarrett, M., . . . Thornicroft, G. (2010). Supported employment: randomised controlled trial. *British Journal of Psychiatry*, 196(5), 404-411. doi:10.1192/bjp.bp.108.061465
- HUD. (2009). *Continuum of Care 101*. Washington, DC: Office of Community Planning and Development Retrieved from <https://www.hudexchange.info/resources/documents/coc101.pdf>.
- Hughes, J. (2012). *Homelessness - Closing the gap between capacity and performance*. Retrieved from Toronto, ON: <http://mowatcentre.ca/homelessness-closing-gap/>
- Hulchanski, D., Campsie, P., Chau, S. B. Y., Hwang, S. W., & Paradis, E. (2009). *Finding Home: Policy Options for Addressing Homelessness in Canada*. Toronto, ON: Homeless Hub and the Canadian Homelessness Research Network
- Humphreys, K., & Lembke, A. (2014). Recovery-oriented policy and care systems in the UK and USA. *Drug and Alcohol Review*, 33(1), 13-18. doi:10.1111/dar.12092
- ICF International. (2009). *Creating Community Employment Pathways*. U.S. Department of Housing and Urban Development Office of Special Needs Assistance Programs Retrieved from <https://www.hudexchange.info/resources/documents/CEPGuidebook.pdf>.
- Johnsen, S., & Teixeira, L. (2010). *Staircases, Elevators and Cycles of Change: 'Housing First' and Other Housing Models for Homeless People with Complex Support Needs*. Retrieved from London, UK: <http://www.crisis.org.uk/data/files/publications/Housing%20Models%20Report.pdf>
- Keast, R., Brown, K., & Mandell, M. (2007). Getting The Right Mix: Unpacking Integration Meanings and Strategies. *International Public Management Journal*, 10(1), 9-33. doi:10.1080/10967490601185716
- Kessler-Beck, S., Trutko, J. W., Isabell, K., Rothstein, F., & Barnow, B. S. (1997). *Employment and Training for America's Homeless: Best Practices Guide*. Washington, DC: Employment and Training Administration Retrieved from https://wdr.doleta.gov/opr/FULLTEXT/1997_09b.pdf.
- Killaspy, H., White, S., Taylor, T. L., & King, M. (2012). Psychometric properties of the Mental Health Recovery Star. *The British Journal of Psychiatry*, 201(1), 65-70. doi:10.1192/bjp.bp.111.107946
- King, G., & Meyer, K. (2006). Service integration and co-ordination: a framework of approaches for the delivery of co-ordinated care to children with disabilities and their families. *Child: Care, Health and Development*, 32(4), 477-492. doi:10.1111/j.1365-2214.2006.00610.x
- Kirsh, B., & Cockburn, L. (2007). Employment Outcomes Associated with ACT: A Review of ACT Literature. *American Journal of Psychiatric Rehabilitation*, 10(1), 31-51. doi:10.1080/15487760601166340
- Kirsta, M., Zergera, S., Misira, V., Hwang, S., & Stergiopoulos, V. (2015). The impact of a Housing First randomized controlled trial on substance use problems among homeless individuals with mental illness. *Drug and Alcohol Dependence*, 1(January), 24-29. doi:10.1016/j.drugalcdep.2014.10.019

- Konrad, E. L. (1996). A multidimensional framework for conceptualizing human services integration initiatives. *New Directions for Evaluation*, 69(Spring), 5-19. doi:10.1002/ev.1024
- Koutsenok, I. (2012). Motivational Interviewing. In H. L. McQuiston, W. E. Sowers, J. M. Ranz, & J. M. Feldman (Eds.), *Handbook of Community Psychiatry* (pp. 201-210). New York, NY: Springer.
- Latimer, E., Rabouin, D., Méthot, C., McAll, C., Ly, A., Dorvil, H., . . . Braithwaite, E. (2014). *At Home/Chez Soi Project: Montréal Site Final Report*. Retrieved from Calgary AB: <http://www.mentalhealthcommission.ca/English/document/32101/montreal-final-report-homechez-soi-project>
- Latimer, E. A., Lecomte, T., Becker, D. R., Drake, R. E., Duclos, I., Piat, M., . . . Xie, H. (2006). Generalizability of the individual placement and support model of supported employment: results of a Canadian randomised controlled trial. *British Journal of Psychiatry*, 189(1), 65-73. doi:10.1192/bjp.bp.105.012641
- Lauzon, C. (2015, October 7). [Inquiry regarding Critical Time Intervention and the Public Health Agency of Canada Canadian Best Practices Portal].
- Leutz, W. N. (1999). Five Laws for Integrating Medical and Social Services: Lessons from the United States and the United Kingdom *The Millbank Quarterly*, 77(1), 77-110.
- Leutz, W. N. (2005). Reflections on Integrating Medical and Social Care: Five Laws Revisited. *Journal of Integrated Care*, 13(5), 3-12. doi:10.1108/14769018200500034
- Liebman, J. B. (2011). *Social Impact Bonds: A promising new financing model to accelerate social innovation and improve government performance*. Retrieved from https://cdn.americanprogress.org/wp-content/uploads/issues/2011/02/pdf/social_impact_bonds.pdf
- Lloyd, C., Williams, P. L., Machingura, T., & Tse, S. (2015). A focus on recovery: using the Mental Health Recovery Star as an outcome measure. *Advances in Mental Health*, 1-8. doi:10.1080/18387357.2015.1064341
- Loxley, J., & Puzyreva, M. (2015). *Social Impact Bonds: An Update*. Retrieved from Winnipeg, MB, CAN: <https://www.policyalternatives.ca/sites/default/files/uploads/publications/Manitoba%20Office/2015/01/Social%20Impact%20Bond%202015%20FINAL.pdf>
- Lucca, A. M., Henry, A. D., Banks, S., Simon, L., & Page, S. (2004). Evaluation of an Individual Placement and Support Model (IPS) Program. *Psychiatric Rehabilitation Journal*, 27(3), 251-257.
- Lukas, C. V., Meterko, M., Lowcock, S., Donaldson-Parlier, R., Blakely, M., Davies, M., & Petzel, R. (2002). Monitoring the Progress of System Integration. *Quality Management in Health Care*, 10(2), 1-11.
- Ly, A., & Latimer, E. (2015). Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature. *The Canadian Journal of Psychiatry*, 60(11), 475-487.
- Macnaughton, E., Stefancic, A., Nelson, G., Caplan, R., Townley, G., Aubry, T., . . . Goering, P. (2015). Implementing Housing First Across Sites and Over Time: Later Fidelity and Implementation Evaluation of a Pan-Canadian Multi-site Housing First Program for Homeless People with Mental Illness. *American Journal of Community Psychology*, 55(3-4), 279-291. doi:10.1007/s10464-015-9709-z
- Malcolmson, J. D. (2014). *Social Impact Bonds: Cleared for Landing in British Columbia*. Retrieved from Burnaby, BC, CAN: http://cupe.ca/sites/cupe/files/Research_note-SIBs_come_to_BC.pdf
- Mangrum, L. F., Spence, R. T., & Lopez, M. (2006). Integrated versus parallel treatment of co-occurring psychiatric and substance use disorders. *Journal of Substance Abuse Treatment*, 30(1), 79-84. doi:<http://dx.doi.org/10.1016/j.jsat.2005.10.004>
- Markoff, L. S., Finkelstein, N., Kammerer, N., Kreiner, P., & Prost, C. A. (2005). Relational Systems Change: Implementing a Model of Change in Integrating Services for Women With Substance Abuse and Mental Health Disorders and Histories of Trauma *Journal of Behavioral Health Services & Research*, 32(2), 227-240.

- Marrone, J. (2005). Creating Hope Through Employment for People Who are Homeless or in Transitional Housing. *American Journal of Psychiatric Rehabilitation*, 8(1), 13-35.
doi:10.1080/15487760590953939
- Marshall, T., Goldberg, R. W., Braude, L., Dougherty, R. H., Daniels, A. S., Ghose, S. S., . . . Delphin-Rittmon, M. E. (2014). Supported Employment: Assessing the Evidence. *Psychiatric Services*, 65(1), 16-23. doi:10.1176/appi.ps.201300262
- Marshall, T., Rapp, C. A., Becker, D. R., & Bond, G. R. (2008). Key Factors for Implementing Supported Employment. *Psychiatric Services*, 59(8), 886-892.
- McCoy, T. (2015a). Meet the outsider who accidentally solved chronic homelessness. *The Washington Post - Inspired Life*. Retrieved from https://www.washingtonpost.com/news/inspired-life/wp/2015/05/06/meet-the-outsider-who-accidentally-solved-chronic-homelessness/?tid=a_inl
- McCoy, T. (2015b). The surprisingly simple way Utah solved chronic homelessness and saved millions. *The Washington Post - Inspired Life*. Retrieved from https://www.washingtonpost.com/news/inspired-life/wp/2015/04/17/the-surprisingly-simple-way-utah-solved-chronic-homelessness-and-saved-millions/?tid=a_inl
- McGovern, M. P., & Carroll, K. M. (2003). Evidence-based practices for substance use disorders. *Psychiatric Clinics of North America*, 26(2003), 991-1010. doi:10.1016/S0193-953X(03)00073-X
- McGovern, M. P., Lambert-Harris, C., Gotham, H. J., Claus, R. E., & Xie, H. (2012). Dual Diagnosis Capability in Mental Health and Addiction Treatment Services: An Assessment of Programs Across Multiple State Systems. *Administration and Policy in Mental Health and Mental Health Services Research*, 41(2), 205-214. doi:10.1007/s10488-012-0449-1
- McGovern, M. P., Matzkin, A. L., & Giard, J. (2007). Assessing the Dual Diagnosis Capability of Addiction Treatment Services: The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index. *Journal of Dual Diagnosis*, 3(2), 111-123. doi:10.1300/J374v03n02_13
- McHugo, G. J., Bebout, R. R., Harris, M., Cleghorn, S., Herring, G., Xie, H., . . . Drake, R. E. (2004). A Randomized Controlled Trial of Integrated Versus Parallel Housing Services for Homeless Adults With Severe Mental Illness. *Schizophrenia Bulletin*, 30(4), 969-982.
- McQuiston, H. L. (2012). Homelessness and Behavioral Health in the New Century. In H. L. McQuiston, W. E. Sowers, J. M. Ranz, & J. M. Feldman (Eds.), *Handbook of Community Psychiatry* (pp. 407-422). New York, NY: Springer.
- Michon, H., Busschbach, J. T. v., Stant, A. D., Vugt, M. D. v., Weeghel, J. v., & Kroon, H. (2014). Effectiveness of individual placement and support for people with severe mental illness in the Netherlands: A 30-month randomized controlled trial *Psychiatric Rehabilitation Journal*, 37(2), 129-136. doi:10.1037/prj0000061
- Miller, J. L. (2000). A post-mortem on healthcare integration: An organizational development approach. *Healthcare Leadership Management Report*, 8(9), 5-15.
- Minkoff, K., & Cline, C. A. (2004). Changing the World: The Design and Implementation of Comprehensive Continuous Integrated Systems of Care for Individuals with Co-occurring Disorders (pp. 1-34). Iowa City: University of Iowa Health Care.
- Minkoff, K., & Cline, C. A. (2012a). CCISC Overview. Retrieved from <http://www.ziapartners.com/resources/comprehensive-continuous-integrated-system-of-care-ccisc/>
- Minkoff, K., & Cline, C. A. (2012b). CODECAT-EZ. Retrieved from <http://www.ziapartners.com/tools/codecat-ez/>
- Minkoff, K., & Cline, C. A. (2012c). COMPASS-PH/BH. Retrieved from <http://www.ziapartners.com/tools/compass-phbh/>

- Minkoff, K., & Cline, C. A. (2012d). COMPASS EZ. Retrieved from <http://www.ziapartners.com/tools/compass-ez/>
- Moll, S., Huff, J., & Detwiler, L. (2003). Supported employment: Evidence for a best practice model in psychosocial rehabilitation. *The Canadian Journal of Occupational Therapy, 70*(5), 298-310.
- Monroe-DeVita, M., Teague, G. B., & Moser, L. L. (2011). The TMACT: A New Tool for Measuring Fidelity to Assertive Community Treatment. *Journal of the American Psychiatric Nurses Association, 17*(1), 17-29. doi:10.1177/1078390310394658
- Montgomery, A. E., Hill, L. L., Kane, V., & Culhane, D. P. (2013). Housing Chronically Homeless Veterans: Evaluating the Efficacy of a Housing First Approach to HUD-VASH. *Journal of Community Psychology, 41*(4), 505-514. doi:10.1002/jcop.21554
- Montgomery, A. E., Metraux, S., & Culhane, D. (2013). Rethinking Homelessness Prevention among Persons with Serious Mental Illness. *Social Issues and Policy Review, 7*(1), 58-82. doi:10.1111/j.1751-2409.2012.01043.x
- Moore, K. A., Young, M. S., Barrett, B., & Ochshorn, E. (2009). A 12-Month Follow-Up Evaluation of Integrated Treatment for Homeless Individuals With Co-Occurring Disorders. *Journal of Social Service Research, 35*(4), 322-335. doi:10.1080/01488370903110829
- MPA Society. (n.d.-a). Media Kit - MPA Society. Retrieved from <http://www.mpa-society.org/publications-resources/mpa-in-the-news/media-kit>
- MPA Society. (n.d.-b). MPA Society: Empowerment in Mental Health Since 1971. Retrieved from <http://www.mpa-society.org/>
- MPA Society. (n.d.-c). Psychosocial Rehabilitation - MPA Society. Retrieved from <http://www.mpa-society.org/programs-services/psychosocial-rehabilitation>
- NAMI. (2007). *Fact Sheet: Assertive Community Treatment, Investment Yields Outcomes*. Arlington, VA: National Alliance on Mental Health, Retrieved from https://www2.nami.org/Template.cfm?Section=act-ta_center&template=/ContentManagement/ContentDisplay.cfm&ContentID=52382.
- Neale, K., Buultjens, J., & Evans, T. (2012). Integrating service delivery in a regional homelessness service system. *Australian Journal of Social Issues, 47*(2), 243-261.
- Nelson, G., & Aubry, T. (2014). Implementation Evaluation of Canada's At Home/Chez Soi Housing First Program (pp. 33): Mental Health Commission of Canada.
- Nelson, G., Aubry, T., & Lafrance, A. (2007). A Review of the Literature on the Effectiveness of Housing and Support, Assertive Community Treatment, and Intensive Case Management Interventions for Persons With Mental Illness Who Have Been Homeless. *American Journal of Orthopsychiatry, 77*(3), 350-361. doi:10.1037/0002-9432.77.3.350
- Nelson, G., Macnaughton, E., Caplan, R., Macleod, T., Townley, G., Piat, M., . . . Goering, P. (2013). *Follow-up Implementation and Fidelity Evaluation of the Mental Health Commission of Canada's At Home/Chez Soi Project: Cross-site Report*. Retrieved from Calgary, AB: http://www.mentalhealthcommission.ca/English/system/files/private/document/Housing_At_Home_Qualitative_Report_Follow-up_Implementation_Fidelity_Evaluation_Cross_Site_ENG.pdf
- Neumiller, S., Bennett-Clark, F., Young, M. S., Dates, B., Broner, N., Leddy, J., . . . Jong, F. D. (2009). Implementing Assertive Community Treatment in Diverse Settings for People Who Are Homeless With Co-Occurring Mental and Addictive Disorders: A Series of Case Studies. *Journal of Dual Diagnosis, 5*(3-4), 239-263. doi:10.1080/15504260903175973
- O'Connell, B., Kristjanson, L., & Orb, A. (2000). Models of integrated cancer care: a critique of the literature. *Australian Health Review, 23*(1), 163-178. doi:10.1071/AH000163

- O'Brien, C. P., Charney, D. S., Lewis, L., Cornish, J. W., Post, R. M., Woody, G. E., . . . Weisner, C. (2004). Priority actions to improve the care of persons with co-occurring substance abuse and other mental disorders: A call to action. *Biological Psychiatry*, *56*(10), 703-713. doi:<http://dx.doi.org/10.1016/j.biopsych.2004.10.002>
- O'Campo, P., Kirst, M., Schaefer-McDaniel, N., Firestone, M., Scott, A., & McShane, K. (2009). Community-Based Services for Homeless Adults Experiencing Concurrent Mental Health and Substance Use Disorders: A Realist Approach to Synthesizing Evidence. *Journal of Urban Health*, *86*(6), 965-989. doi:10.1007/s11524-009-9392-1
- O'Connell, J. (2009). Boston HealthCare for the Homeless Program: A Success Story. *American Medical Association Journal of Ethics*, *11*(1), 78-82.
- Off, C., & Douglas, J. (2015). Medicine Hat becomes the first city in Canada to eliminate homelessness. *As It Happens*. Retrieved from <http://www.cbc.ca/radio/asithappens/as-it-happens-thursday-edition-1.3074402/medicine-hat-becomes-the-first-city-in-canada-to-eliminate-homelessness-1.3074742>
- Workforce Innovation and Opportunity Act, H. R. 803, Congress of the United States of America (2014). Ontario ACTT Association. (2015). ACT Model. Retrieved from <http://ontarioacttassociation.com/act-model/>
- Ontario Government. (2005). *Intensive Case Management Service Standards for Mental Health Services and Supports*. Toronto, ON: Queen's Printer of Ontario Retrieved from http://www.southwestlin.on.ca/~media/sites/sw/uploadedfiles/Public_Community/Health_Service_Providers/NEW_Community/4%20Intensive%20Case%20Management%20Service%20Standards%20for%20Mental%20Health%20Services%202005.pdf.
- OrgCode Consulting Inc. (2016). Product Categories. Retrieved from <http://www.orgcode.com/product-category/tools/spdat-tools/>
- Oshima, I., Sono, T., Bond, G. R., Nishio, M., & Ito, J. (2014). A Randomized Controlled Trial of Individual Placement and Support in Japan. *Psychiatric Rehabilitation Journal*, *37*(2), 137-143. doi:10.1037/prj0000085
- Padgett, D. K., Gulcur, L., & Tsemberis, S. (2006). Housing First Services for People Who Are Homeless With Co-Occurring Serious Mental Illness and Substance Abuse. *Research on Social Work Practice*, *16*(1), 74-83. doi:10.1177/1049731505282593
- PARC. (n.d.-a). Parkdale Activity Recreation Centre » Activity and Recreation. Retrieved from <http://parc.on.ca/activity-and-recreation/>
- PARC. (n.d.-b). Parkdale Activity Recreation Centre » History of PARC. Retrieved from <http://parc.on.ca/about/history-of-parc/>
- PARC. (n.d.-c). Parkdale Activity Recreation Centre » PARC Ambassadors. Retrieved from <http://parc.on.ca/members/parc-ambassadors/>
- Parkes, R., Holt, E., Lee, K., Theodore, N., & Cook, D. (2012). *Opportunity Chicago: 2006-2010: Improving Access to Employment for Public Housing Residents in Chicago*. Retrieved from Chicago, IL: http://cjc.net/wp-content/uploads/2012/06/OC-Evaluation_July2012.pdf
- Parsell, C., Fitzpatrick, S., & Busch-Geertsema, V. (2014). Common Ground in Australia: An Object Lesson in Evidence Hierarchies and Policy Transfer. *Housing Studies*, *29*(1), 69-87. doi:10.1080/02673037.2013.824558
- Patterson, M., Moniruzzaman, A., Palepu, A., Zabkiewicz, D., Frankish, C. J., Krausz, M., & Somers, J. M. (2013). Housing First improves subjective quality of life among homeless adults with mental illness: 12-month findings from a randomized controlled trial in Vancouver, British Columbia. *Social Psychiatry and Psychiatric Epidemiology*, *48*(8), 1245-1259. doi:10.1007/s00127-013-0719-6

- Patterson, M., Somers, J. M., McIntosh, K., Sheill, A., & Frankish, C. J. (2008). *Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia*. Retrieved from Burnaby, British Columbia: <http://www.sfu.ca/content/dam/sfu/carmha/resources/hsami/Housing-SAMI-BC-FINAL-PD.pdf>
- Peters, B. G. (1998). Managing Horizontal Government: The Politics of Coordination. *Public Administration*, 76(Summer), 295-311. doi:10.1111/1467-9299.00102
- Pleace, N. (2013). *Evaluating homelessness services and strategies: A Review*. Retrieved from Heslington, York: http://www.habitact.eu/files/activity/actionresearch/evaluationreview_habitact.pdf
- Polvere, L., MacLeod, T., Macnaughton, E., Caplan, R., Piat, M., Nelson, G., . . . Goering, P. (2014a). Canadian Housing First Toolkit: Key Questions. Retrieved from <http://housingfirsttoolkit.ca/key-questions2>
- Polvere, L., MacLeod, T., Macnaughton, E., Caplan, R., Piat, M., Nelson, G., . . . Goering, P. (2014b). *Canadian Housing First Toolkit: The At Home/Chez Soi experience*. Calgary, AB and Toronto, ON: Mental Health Commission of Canada and the Homeless Hub Retrieved from <http://www.housingfirsttoolkit.ca/sites/default/files/pdfs/CanadianHousingFirstToolkit.pdf>.
- Poremski, D., Distasio, J., Hwang, S. W., & Latimer, E. (2015). Employment and Income of People Who Experience Mental Illness and Homelessness in a Large Canadian Sample. *Canadian Journal of Psychiatry*, 60(9), 379-385.
- Poremski, D., Rabouin, D., & Latimer, E. (2015). A Randomised Controlled Trial of Evidence Based Supported Employment for People Who have Recently been Homeless and have a Mental Illness. *Administrative and Policy in Mental Health and Mental Health Services Research*. doi:10.1007/s10488-015-0713-2
- Poremski, D., Whitley, R., & Latimer, E. (2016). Building trust with people receiving supported employment and housing first services. *Psychiatric Rehabilitation Journal*, 39(1), 20-26. doi:10.1037/prj0000137
- Putnam, M., Shamseldin, T., Rumpf, B., Wertheimer, D., & Rio, J. (2007). *Developing Community Employment Pathways*. Retrieved from Seattle, WA: <https://www.hudexchange.info/resources/documents/CEPGuidebook.pdf>
- Quilgars, D., Johnsen, S., & Pleace, N. (2008). *Youth Homelessness in the UK: A Decade of Progress? : Joseph Rowntree Foundation*.
- R.A. Malatest & Associates Ltd. (2006). *Working, Expected to Work*. Retrieved from Edmonton, AB: http://www.humanservices.alberta.ca/documents/FCH-IS_working_expectedtowork.pdf
- REDF. (2016a). REDF Announces New Nationwide Portfolio. Retrieved from <http://redf.org/redf-announces-new-nation-wide-portfolio/>
- REDF. (2016b). What We Do. Retrieved from <http://redf.org/what-we-do/>
- Rinaldi, M., Miller, L., & Perkins, R. (2010). Implementing the individual placement and support (IPS) approach for people with mental health conditions in England. *International Review of Psychiatry*, 22(2), 163-172. doi:10.3109/09540261003720456
- Rio, J., Ware, L., Tucker, P., & Martinez, J. (2008). *Ending Chronic Homelessness Through Employment and Housing: A Program and Policy Handbook for Successfully Linking Supportive Housing and Employment Services for Chronically Homeless Adults*. Retrieved from New York: http://www.csh.org/wp-content/uploads/2011/12/Report_CHETA_ProgramPolicy_Handbook1.pdf
- Rog, D. J., Marshall, T., Dougherty, R. H., George, P., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Permanent Supportive Housing: Assessing the Evidence. *Psychiatric Services*, 65(3), 287-294.

- Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Johnsen, M., Goldman, H., . . . Teague, G. (1998). Service System Integration, Access to Services, and Housing Outcomes in a Program for Homeless Persons With Severe Mental Illness. *American Journal Of Public Health, 88*(11), 1610-1615.
- Rosenheck, R. A., Lam, J., Morrissey, J. P., Calloway, M. O., Stolar, M., Randolph, F., & ACCESS National Evaluation Team. (2002). Service Systems Integration and Outcomes for Mentally Ill Homeless Persons in the ACCESS Program. *Psychiatric Services, 53*(8), 958-966.
doi:10.1176/appi.ps.53.8.958
- Sacks, S., Chandler, R., & Gonzales, J. (2008). Responding to the challenge of co-occurring disorders: Suggestions for future research. *Journal of Substance Abuse Treatment, 34*(1), 139-146.
doi:<http://dx.doi.org/10.1016/j.jsat.2007.03.008>
- Sadeghi, H., Habibi, Z., Haghtrangbar, F., & Madanipour, K. (2013). The Effectiveness of Harm Reduction Programs on Reduce Crimes of Addicts Referred the Drop in Centers (DIC). *Procedia - Social and Behavioral Sciences, 84*, 496-500. doi:<http://dx.doi.org/10.1016/j.sbspro.2013.06.591>
- SAMHSA. (2008a). *Evaluating Your Program: Assertive Community Treatment*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Service Retrieved from <http://store.samhsa.gov/shin/content//SMA08-4345/EvaluatingYourProgram-ACT.pdf>.
- SAMHSA. (2008b). *The Evidence: Assertive Community Treatment*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Service Retrieved from <http://store.samhsa.gov/shin/content//SMA08-4345/TheEvidence.pdf>.
- SAMHSA. (2009a). *Building Your Program: Supported Employment*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Service Retrieved from <http://store.samhsa.gov/shin/content//SMA08-4365/BuildingYourProgram-SE.pdf>.
- SAMHSA. (2009b). *The Evidence: Supported Employment*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Service Retrieved from <https://store.samhsa.gov/shin/content/SMA08-4365/TheEvidence-SE.pdf>.
- SAMHSA. (2010a). *Building Your Program: Permanent Supportive Housing*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Service Retrieved from <http://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-06-BuildingYourProgram-PSH.pdf>.
- SAMHSA. (2010b). *Evaluating Your Program: Permanent Supportive Housing*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Service Retrieved from <https://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-05-EvaluatingYourProgram-PSH.pdf>.
- SAMHSA. (2011). *Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit Version 4.0*. Retrieved from Rockland, MD: http://dartmouthprc.org/wp-content/uploads/DDCAT_Toolkit.pdf
- SAMHSA. (2013a). *Behavioural Services for People Who Are Homeless: A Treatment Improvement Protocol TIP 55*. Rockville, MD: U.S. Department of Health and Human Services Retrieved from <http://store.samhsa.gov/shin/content//SMA13-4734/SMA13-4734.pdf>.

- SAMHSA. (2013b). *Substance Abuse Treatment for Persons with Co-occurring Disorders: A Treatment Improvement Protocol TIP 42*. Rockville, MD: Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment Retrieved from <http://store.samhsa.gov/shin/content/SMA13-3992/SMA13-3992.pdf>.
- SAMHSA. (2014a). Intervention Summary: Critical Time Intervention. *National Registry of Evidence-based Programs and Practices*. Retrieved from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=367>
- SAMHSA. (2014b). Motivational Interviewing. Retrieved from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=346>
- Schutt, R. K., Goldfinger, S. M., & Penk, W. E. (1997). Satisfaction with residence and with life: When homeless mentally ill persons are housed. *Evaluation and Program Planning*, 20(2), 185-194. doi:[http://dx.doi.org/10.1016/S0149-7189\(96\)00049-3](http://dx.doi.org/10.1016/S0149-7189(96)00049-3)
- Serge, L., Kraus, D., & Eberle, M. (2006). *What Works: Effective Policies and Programs for the Homeless Population in Canada: Final Report*. Ottawa, ON: Human Resources and Social Development Canada Retrieved from http://publications.gc.ca/collections/collection_2013/rhdcc-hrsdc/HS28-75-2007-eng.pdf.
- Shaheen, G., & Rio, J. (2007). Recognizing Work as a Priority in Preventing or Ending Homelessness. *Journal of Primary Prevention*, 28(3), 341-358. doi:10.1007/s10935-007-0097-5
- Shergold, P. (2013). *Service Sector Reform: A roadmap for community and human service reform*. Retrieved from Melbourne, VIC: <http://vcoss.org.au/documents/2013/07/FINAL-Report-Service-Sector-Reform.pdf>
- Silberman School of Social Work. (n.d.). CTI Model. Retrieved from <http://sssw.hunter.cuny.edu/cti/cti-model/>
- Somers, J. M., Moniruzzaman, A., & Palepu, A. (2015). Changes in daily substance use among people experiencing homelessness and mental illness: 24-month outcomes following randomization to Housing First or usual care. *Addiction*, 110(10), 1605-1614. doi:10.1111/add.13011
- Stefancic, A. (2016, April 4). [Re: Research - Best Practices in Integrating Housing, Health, and Employment Supports for the Homeless].
- Stefancic, A., Tsemberis, S., Messeri, P., Drake, R., & Goering, P. (2013). The Pathways Housing First Fidelity Scale for Individuals With Psychiatric Disabilities. *American Journal of Psychiatric Rehabilitation*, 16(4), 240-261. doi:10.1080/15487768.2013.847741
- Stergiopoulos, V., Gozdzik, A., Misir, V., Skosireva, A., Connelly, J., Sarang, A., . . . McKenzie, K. (2015). Effectiveness of Housing First with Intensive Case Management in an Ethnically Diverse Sample of Homeless Adults with Mental Illness: A Randomized Controlled Trial. *PloS ONE*, 10(7), 1-21. doi:10.1371/journal.pone.0130281
- Stergiopoulos, V., Hwang, S. W., Gozdzik, A., Nisenbaum, R., Latimer, E., Rabouin, D., . . . Goering, P. N. (2015). Effect of Scattered-Site Housing Using Rent Supplements and Intensive Case Management on Housing Stability Among Homeless Adults With Mental Illness. *The Journal of the American Medical Association*, 313(9), 905-915. doi:10.1001/jama.2015.1163
- Suter, E., Oelke, N. D., Adair, C. E., Waddell, C., Armitage, G. D., & Huebner, L.-A. (2007). *Health Systems Integration - Definitions, Processes & Impact: A Research Synthesis*. Retrieved from Edmonton, AB: <http://www.albertahealthservices.ca/assets/info/res/if-res-hswru-hs-integration-report-2007.pdf>
- Talen, M. R., & Valeras, A. B. (2013). Introduction and Overview of Integrated Behavioral Health in Primary Care. In M. R. Talen & A. B. Valeras (Eds.), *Integrated Behavioral Health in Primary Care: Evaluating the Evidence, Identifying the Essentials* (pp. 3-8). New York, NY: Springer.

- Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry*, 68(2), 216-232. doi:10.1037/h0080331
- The Bissell Centre. (2014a). *Bissell Centre's 2014-2015 Business Plan*. Retrieved from Edmonton, AB: <http://static1.squarespace.com/static/5447d671e4b0f248738981fe/t/54556ab0e4b01cb0215c595f/1414884016890/Bissell+Centre+Plan+2014-15.pdf>
- The Bissell Centre. (2014b). Bissell Centre - Employment Services (Casual Labour). Retrieved from <http://www.bissellcentre.org/individual/employmentservices/>
- The Bissell Centre. (2014c). Bissell Centre - Our History. Retrieved from <http://www.bissellcentre.org/our-history>
- The Bissell Centre. (2014d). Bissell Centre - Our Programs. Retrieved from <http://www.bissellcentre.org/programs/>
- The Calgary Foundation. (2016). Calgary Urban Project Society (CUPS) | Community Knowledge Centre - The Calgary Foundation. Retrieved from <http://ckc.calgaryfoundation.org/org/calgary-urban-project-society-cups>
- The Foyer Foundation. (2016). Can a Foyer Help You? Retrieved from <http://foyer.net/about-foyers/can-a-foyer-help-you/>
- The Foyer Foundation. (2016). Accreditation & Quality Assurance. Retrieved from <http://foyer.net/what-we-do/accreditation-quality-assurance/>
- The Kettle Society. (n.d.). Our Programs - The Kettle Society. Retrieved from <http://www.thekettle.ca/our-programs/>
- The Parkdale People's Economy Project. (n.d.-a). About PPE | The Parkdale People's Economy Project. Retrieved from <https://parkdalecommunityeconomies.wordpress.com/about/>
- The Parkdale People's Economy Project. (n.d.-b). Community Land Trust | The Parkdale People's Economy Project. Retrieved from <https://parkdalecommunityeconomies.wordpress.com/community-land-trust/>
- The Parkdale People's Economy Project. (n.d.-c). Coop-Cred | The Parkdale People's Economy Project Retrieved from <https://parkdalecommunityeconomies.wordpress.com/co-op-cred-program/>
- Toro, P. A. (2007). Toward an International Understanding of Homelessness. *Journal of Social Issues*, 63(3), 461-481.
- Triangle Consulting Social Enterprise Limited. (2015). About the Outcomes Star. Retrieved from <http://www.outcomesstar.org.uk/about-the-outcomes-star/>
- Trutko, J. W., Barnow, B. S., Beck, S. K., & Rothstein, F. R. (1994). *Employment and Training for America's Homeless: Report on the Job Training for the Homeless Demonstration Project*. United States Department of Labor Retrieved from <https://wdr.doleta.gov/opr/fulltext/94-homeless.pdf>.
- Tsemberis, S., Henwood, B., Yu, V., Whoriskey, A., & Stefancic, A. (2012). The Role of Psychiatry in Permanent Supported Housing. In H. L. McQuiston, W. E. Sowers, J. M. Ranz, & J. M. Feldman (Eds.), *Handbook of Community Psychiatry* (pp. 349-368). New York NY: Springer.
- Turnbull, R. (2014). Informing practice by `what we don't know` and moving to an evidence base for employing formerly homeless, sheltered and at-risk individuals in Vancouver. In Streetohome Foundation (Ed.). Vancouver, British Columbia: Streetohome Foundation.
- Turner, A. (2014). *Beyond Housing First: Essential Elements of a System-Planning Approach to Ending Homelessness*. Retrieved from Calgary, AB: <http://policyschool.ucalgary.ca/?q=content/beyond-housing-first-essential-elements-system-planning-approach-ending-homelessness>
- Turner, A. (2015). *Performance Management in a Housing First Context: A Guide for Community Entities*. Retrieved from Toronto, ON: http://homelesshub.ca/sites/default/files/CEGuide-final_0.pdf

- U.S. Department of Health and Human Services. (2003a). *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders*. Rockville, MD: Substance Abuse and Mental Health Services Administration Center for Mental Health Services Retrieved from <http://store.samhsa.gov/shin/content//SMA04-3870/SMA04-3870.pdf>.
- U.S. Department of Health and Human Services. (2003b). *Supported Employment: A guide for mental health planning + advisory councils*. Retrieved from <http://www.namhpac.org/PDFs/SE.pdf>.
- USICH. (2013). Housing First. Retrieved from http://usich.gov/usich_resources/solutions/explore/housing_first/
- Viering, S., Jäger, M., Nordt, C., Bühler, F., Bärtsch, B., Leimer, H., . . . Kawohl, W. (2015). Does “Individual Placement and Support” Satisfy the Users’ Needs? *Frontiers in Public Health*, 3(160), 1-4. doi:10.3389/fpubh.2015.00160
- Vila-Rodriguez, F., Panenka, W. J., Lang, D. J., Thornton, A. E., Vertinsky, T., Wong, H., . . . Honer, W. G. (2013). The Hotel Study: Multimorbidity in a Community Sample Living in Marginal Housing. *American Journal of Psychiatry*, 170(12), 1413-1422. doi:10.1176/appi.ajp.2013.12111439
- Waegemakers Schiff, J. (2014). *Comparison of Four Housing First Programs*. Retrieved from Calgary, AB: <http://www.houselink.on.ca/wp-content/uploads/2011/01/Comparison-of-Four-Housing-First-Programs-Final-Aug-1-v2.pdf>
- Waegemakers Schiff, J., & Rook, J. (2012). *Housing First: Where Is the Evidence?* Retrieved from Toronto, ON: <http://homelesshub.ca/resource/housing-first-where-evidence>
- Walsh, C., Bell, M., Jackson, N., Graham, J., Sajid, S., & Milaney, K. (2014). *Permanent Supportive Housing for Families with Multiple Needs: A Report to Employment and Social Development Canada*. Retrieved from Ottawa, ON: <http://homelesshub.ca/resource/permanent-supportive-housing-families-multiple-needs-report-employment-and-social>
- WBF. (2015a). About Women Building Futures. Retrieved from <http://www.womenbuildingfutures.com/AboutWBF/AboutWomenBuildingFutures.aspx>
- WBF. (2015b). Affordable, Fully Furnished Housing for Students. In *Women Building Futures* (Ed.), (pp. 2). Calgary, AB: Women Building Futures,.
- WBF. (2015c). Employer Services. Retrieved from <http://www.womenbuildingfutures.com/EmployerServices/EmployerServices.aspx>
- WBF. (2015d). How to Become Involved. Retrieved from <http://www.womenbuildingfutures.com/EmployerServices/HowtoBecomeInvolved.aspx>
- WBF. (2015e). Women Building Futures. Retrieved from <http://www.womenbuildingfutures.com/>
- Weiss, M. E. (1998). Case management as a tool for clinical integration. *Advanced Practical Nursing Quarterly*, 4(1), 9-15.
- Wilson, D. P., Donald, B., Shattock, A. J., Wilson, D., & Fraser-Hurt, N. (2015). The cost-effectiveness of harm reduction. *International Journal of Drug Policy*, 26, Supplement 1, S5-S11. doi:<http://dx.doi.org/10.1016/j.drugpo.2014.11.007>
- Wodak, A., & Maher, L. (2010). The effectiveness of harm reduction in preventing HIV among injecting drug users. *New South Wales Public Health Bulletin*, 2(3-4), 69-73. doi:10.1071/NB10007
- Wong, Y.-L. I., Hadley, T. R., Culhane, D. P., Poulin, S. R., Davis, M. R., Cirksey, B. A., & Brown, J. L. (2006). *Predicting Staying In or Leaving Permanent Supportive Housing That Serves Homeless People with Serious Mental Illness: Final Report*. Retrieved from Washington, DC: http://repository.upenn.edu/cgi/viewcontent.cgi?article=1113&context=spp_papers
- Wong, Y.-L. I., Park, J. M., & Nemon, H. (2006). Homeless Service Delivery in the Context of Continuum of Care. *Administration in Social Work*, 30(1), 67-94. doi:10.1300/J147v30n01_05
- Wulsin, L. R., Söllner, W., & Pincus, H. A. (2006). Models of Integrated Care. *Medical Clinics of North America*, 90(2006), 647-677. doi:10.1016/j.mcna.2006.05.005

- Yerichuk, D. (2009). *Planning to Succeed in Toronto: Integrated Workforce Planning Examples from the US and Europe*. Retrieved from Toronto, ON:
http://www.workforceinnovation.ca/sites/default/files/PlanningtoSucceed_Full.pdf
- Young, M. S., Clark, C., Moore, K., & Barrett, B. (2009). Comparing Two Service Delivery Models for Homeless Individuals With Complex Behavioral Health Needs: Preliminary Data From Two SAMHSA Treatment for Homeless Studies. *Journal of Dual Diagnosis*, 5(3), 287-304.
doi:10.1080/15504260903359015