Building on evidence

13 things to include in Ontario's municipal homelessness reduction strategies

A resource from the Centre for Research
on Inner City Health

CRICH

CENTRE FOR RESEARCH ON INNER CITY HEALTH

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Introduction

The Centre for Research on Inner City Health and homelessness, housing and health

At the Centre for Research on Inner City Health (CRICH) at St. Michael's Hospital, we've been examining the relationship between homelessness, precarious housing* and physical and mental health for more than 15 years. We've also designed and evaluated interventions to improve health care for people facing homelessness, and to address homelessness itself. We work collaboratively with a broad range of partners to produce peer-reviewed, scientific evidence demonstrating what works, and what doesn't. Some of us are also physicians, providing frontline health care to people experiencing homelessness and precarious housing.

* Precarious housing can be defined as housing that is 'not affordable, over-crowded and/or sub-standard.' [1]

About this resource

Right now, as a result of the province's new 'Community Homelessness Prevention Initiative,' [2] municipalities across Ontario are in the process of re-designing their strategies to address homelessness and housing stability. **This resource summarizes what many researchers at CRICH see as essential elements for successful homelessness reduction strategies. It is not comprehensive, but reflects the best of our knowledge as researchers and health care providers working largely in urban settings.** It is meant for community representatives, policy-makers, program administrators, funders and frontline workers.

These recommendations will work best where there is a high degree of formal collaboration between sectors, levels of government, community representatives, community organizations and service-based organizations. When we looked at jurisdictions around the world that have taken a 'whole of government' approach to addressing inequities, we found that substantial action was achieved when stakeholders moved beyond information sharing to create intersectoral committees along with joint budgets and evaluation and monitoring tools. [3]

It should also be noted that many of these recommendations assume that there is an available stock of quality affordable housing. **Although outside the scope of this document, it is clear that policies that ensure adequate income and the creation of new affordable housing; ensure the clean-up and repair of existing social housing; ensure that private rental housing is well-maintained and protect tenant rights must be the cornerstone of any homelessness reduction policy.**

CONTINUING THE CONVERSATION. We see this resource as part of a continuing dialogue with community representatives, policy-makers, program administrators, funders and frontline workers. CRICH is designing, evaluating and implementing interventions related to homelessness, housing and health on an ongoing basis. We have also gathered extensive evidence on the impacts of homelessness and unstable housing on health.

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If we had to sum up our recommendations in one line, it would be this: make sure everyone has timely access to safe, <u>quality</u> and appropriate housing with the right type of support. Below please find information policy-makers, organizations and staff can use to help move us from a system that manages homelessness to one that ends it.

A) ADDRESSING RACISM AND DISCRIMINATION

1. Take on racism and discrimination at every level of the housing and homelessness prevention system.

Racism and discrimination have resulted in the unequal distribution of health and social resources, including housing. This means that groups facing barriers to achieving equality are over-represented among people who are homeless or precariously housed, including Aboriginal persons, youth, and persons who are experiencing chronic medical illnesses, mental illness, substance abuse problems, and/or who are HIV positive. [4] It is essential that any homelessness reduction strategy addresses racism and discrimination throughout the system, from shelters to programs to housing providers. This includes discrimination based on factors like race, ethnic background, cultural background, gender, gender identity, sexual orientation, ability, socio-economic status, immigration status, receipt of social assistance, criminal justice involvement, mental health status and/or substance use.

Measures should include:

- Hiring management and frontline staff who share the backgrounds and experiences of clients. [5]

- Hiring management and frontline staff with lived experience of addictions or mental health problems.

- Making the evaluation of discrimination within programs and facilities <u>a funding requirement</u>, with funders regularly reviewing data collected directly from tenants and clients about their experiences.

- Clear benchmarks of success in terms of addressing discrimination within programs or facilities.

- Reporting back to clients, tenants and the community about how organizations are doing when it comes to anti-racism and anti-discrimination, including in ways that make these reports part of the public record.

- Clearly posted signs at programs and facilities indicating complaint procedures, including complaint lines that are appropriately resourced to take on complaints.

- Strategies for addressing discrimination within the private rental market (ie. landlord outreach and education and support for tenant organizing).

- Mandatory, ongoing anti-racism/anti-oppression [5] AND cultural competency training that addresses the realities of diverse groups. This should be offered to management staff and anyone who comes into contact with clients/tenants from front desk to maintenance to clinical staff. This ongoing training should also be a <u>funding requirement</u>, and can be developed in partnership with organizations and groups. In particular, for urban Aboriginal populations, as demonstrated by the 'Our Health Counts' report, it is important for, "…local and provincial agencies that offer services to significant numbers of low income/marginalized urban Aboriginal populations [to] collaborate directly with urban Aboriginal agencies and organizations and develop and implement mandatory Aboriginal cultural diversity training." [6]

B) ACCESS TO APPROPRIATE HOUSING

2. Make housing quality a criterion for evaluating housing stability.

Housing stability is not just about maintaining housing—any kind of housing. When we asked women leaving situations of domestic violence what housing stability meant to them [7], while it included staying in one place, it also included access to housing that:

- Is in a building and neighbourhood that is safe.
- Is clean and in good repair.
- Is pest and rodent-free.

Additional factors that are crucial to consider when evaluating housing stability include:

- Affordability—which means that households should be spending less than 30 per cent of before-tax income on shelter. (Canada Mortgage and Housing Corporation)
- Adequate space and privacy. One definition of crowding used by Statistics Canada is more than one person per room (excluding bathrooms) in a given dwelling.
- Exposure to physical hazards like lead, asbestos, pests, extreme hot or cold temperatures, tobacco smoke and poor ventilation. [9]
- Location, including access to public transportation, recreation facilities, health services, healthy and low cost food and job opportunities. [8]
- Whether or not people have a feeling of identification with and control over their living space. [8]

For groups facing barriers to achieving equality and people who are sick, the experience of unstable housing could be compounded—and made even worse—by additional negative conditions. [8]

3. Make respite care available.

People facing homelessness are often discharged from the hospital to no fixed address or to inappropriate living situations. It can be very challenging for people who are precariously housed, staying in shelters or staying on the street to keep up with medications, eat healthy food, get sufficient rest and attend follow-up appointments. While people are sick, it is difficult for them to take the steps needed to secure stable housing, and live independently. Research has demonstrated that access to respite care can significantly reduce the use of in-patient services, and improve health outcomes. [10]

Respite care facilities should offer a clean, safe and welcoming place for people to recover, and include healthy food, access to health providers, counselling, case-coordination and help accessing permanent housing.

4. Match people to the level of care and support they need.

We assessed the mental health service needs of men living at Seaton House in Toronto, one of Canada's largest homeless shelters for men. We found that more than half the men surveyed did not have access to an appropriate level of care, despite the fact that there were health services on site. We also found that 9 per cent needed 24-hour supervision and support. There are currently very few options to meet this need in Ontario for people with a history of chronic homelessness and complex health and social needs. [11]

C) PROGRAM APPROACH

5. Offer housing first.

Access to clean, secure housing along with appropriate supports can be the first step to achieving the stability needed to find work, pursue educational opportunities, establish or strengthen connections with friends and family and access social services and health care. It can also be the first step in dealing with addictions and mental health problems. Housing First (HF) programs do not require people to be sober, drug-free or on a particular medication, and have demonstrated success in achieving housing stability. [12,13] Psychiatric care and addictions treatment are offered, but are optional. Housing is made available as soon as possible, with few conditions, although weekly follow-up visits from a HF worker are required.

HF workers support people through the process using Motivational Interviewing (MI), which is built on the principle that 'change is possible, and the desire for change must come from the individual.' [13] MI techniques include avoiding argumentation; expressing genuine empathy; supporting self-efficacy and optimism; exploring (not pushing back against) resistance and helping people to see clearly the relationship between their behaviours and their goals. [13]

6. Make sure people have a meaningful choice.

People should be offered a choice in terms of where and how they want to live. When we conducted a comprehensive review of the research literature on homelessness, mental health, and substance use, we found that client choice was one of the most successful strategies used to help people stay housed and experience better mental health. [14] In order to facilitate empowerment and choice:

- Make rent supplements available. Rent supplements give people a choice of where they want to live. In addition, because they don't force people facing mental health problems or addictions into congregate facilities, they can help facilitate community integration, as long as the right supports are also offered. Rent supplements should be geared to the cost of living in communities so that people can find quality apartments, have some choice of neighbourhood, and don't have to spend more than 30 per cent of their income on rent. Rent supplements should be available for as long as people need them. In some cases, they should be permanent.

- Work with private landlords to secure a roster of quality, affordable housing in different neighbourhoods.

- Keep an up-to-date list and maintain relationships with quality providers of subsidized housing, respite care and supportive housing.

- Make sure people have the resources to set up their homes with furnishings and household items that work for them.

- Ensure choice and agency when it comes to treatment options.

7. Work from a harm reduction framework.

Harm reduction seeks to minimize the harm that addictions can do to individuals, families and communities. This means using techniques like Motivational Interviewing to meet people where they're at, and engaging the reality of their lives. Our research on programs for people facing homelessness and co-occurring substance use and mental health problems suggests that flexible, non-abstinence based approaches and unconditional access to housing contribute to program success. [14] Housing First also takes a harm reduction approach. In the context of housing strategies, this can include:

- Supporting people to maintain successful tenancies.

- Connecting people to services that work for them. This can range from access to clean drug use equipment to methadone programs to addictions counselling.

- Including trained peers—people with lived experience of addiction and/or mental health problems—as part of paid program teams.

8. Take a trauma-informed approach. [15]

The entire homelessness reduction and housing system should take a trauma-informed approach, and be based on the understanding that many of the people it serves are living with individual, family, community, intergenerational, historical and/or ongoing trauma.

A trauma-informed approach requires an awareness of how trauma can impact individuals. It also requires an understanding of how trauma can impact different populations. Staff and decision-makers should collaborate with Aboriginal organizations to design cultural safety training* [6] that speaks to the traumatic impacts of colonial policies [15] past and present. Providers should also receive training on the impacts of experiences like war and migration.

A trauma-informed approach is all-encompassing and extends from intake procedures to consistent scheduling of appointments to the way providers respond to people's behaviour and stories. It also extends to the emotional safety of providers themselves, who often experience vicarious trauma and require supports around this. [15]

* The 'Our Health Counts' report defines culturally safe programs as those that 'are designed and delivered by Aboriginal people' and that include 'the recognition and validation of Aboriginal worldviews…' The report recommends that municipal, provincial and federal governments 'develop and initiate policies towards the implementation of cultural competency and/or cultural safety programs.' [6]

9. Provide appropriate, multi-disciplinary support—not just a place to live.

Housing First programs include two different levels of support—Assertive Community Treatment (ACT), and Intensive Case Management (ICM). ACT teams are generally appropriate for people facing serious mental health problems and/or addictions. Key components include: [13]

- A program team that delivers direct, integrated services in settings that work for clients—at home, out in the community, etc. and assumes a 'we will do whatever it takes' attitude towards service delivery.
- 1-10 staff to client ratio.
- Supports that are available 24 hours a day, seven days a week.
- Skilled team members, including peers with lived experience, team coordinators, psychiatrists and primary health care providers who address:
  - Household concerns like shopping, paying bills and negotiating with landlords.
  - Life issues like employment, daily living skills, social skills and connecting with family and friends.
  - Health issues.
  - Connecting people to community resources, group activities, cultural resources, exercise and group activities.

ICM can be appropriate for people whose mental health and/or addictions problems are less severe, and features a case-manager who connects people to external services. ICM works best in settings where a strong matrix of community services is already in place.

In all cases, the supports follow the person—they are not tied to a particular apartment or facility.

10. Pay attention to transitions.

Transitions from shelters or living on the streets to housing can be challenging. So can transitions from institutions. Onsite, pre-discharge, coordinated referrals to a range of resources can help make sure people have the opportunity to get better, and find permanent housing. Researchers at the Centre for Research on Inner City Health are currently working with community partners to assess the impacts of a program called 'CATCH-Homeless' that offers people who are homeless and leaving the hospital access to a case-coordinator who can connect them to a roster of services including family medicine, psychiatry, case management, transitional housing and peer support. CATCH-Homeless staff also follow-up with people to make sure the referrals worked out, and identify next steps.

Even once people have obtained housing, things can be difficult. Intensive supports are sometimes needed to assist in setting up households including help with choosing and purchasing furniture, grocery shopping, setting up hydro and phone accounts, and getting identification documents. People can also become lonely when they first transition into housing. Checking in on people (to the degree they want you to), and connecting them to a variety of social supports is an important component in maintaining housing stability and health. [16, 17]

D) ACCOUNTABILITY, TRAINING AND EVALUATION

11. Create an accountable evaluation strategy that is able to deal with complexity.

Any homelessness reduction strategy should be accompanied by a robust plan for monitoring, evaluation and improvement. A strong evaluation strategy starts with a clear logic model that explains how a program is designed to achieve intended outcomes. In addition, evaluations should measure meaningful outcomes (like number of people living in quality, safe, appropriate and sustainable housing), not just outputs (like number of shelter bed nights). Outcomes should be measured on an ongoing basis, and strategies should be adjusted accordingly. There should be clear benchmarks for progress and results should be publicly reported at regular intervals through a number of channels that reach diverse audiences.

It is important that evaluations are designed to take into account the complexity of the programs they examine, and the fact that interventions work differently for different people. [18] This means breaking a program down to its constituent parts, and ascertaining 'what works for whom in what circumstances, and how.' [19] It also means developing a flexible, iterative approach. Complex interventions do not call for rigid protocols, but instead should be guided by theory, evaluated at different stages, and refined through practice. [18, 20]

12. Be accountable to people who are facing homelessness or who are precariously housed.

Homelessness reduction strategies should be meaningfully shaped by the voices of people who are homeless and precariously housed. This includes creating evaluation processes that take seriously the voices and priorities of tenants and people staying in shelters and accessing programs. Collect feedback using accessible and non-coercive consultation methods, making sure to include qualitative research methods that capture stories and experiences. [21] In addition, don't just ask people to comment on the status quo. Describe best practices from other jurisdictions and ask people what they feel would work best for them.

Recently, CRICH worked with partners to implement and evaluate Housing First programs in Toronto. The project included an advisory group made up of people with lived experiences of homelessness. Lesssons learned included the need to: [22]

- Create a transparent and purposeful selection process for advisory group participants.

- Clearly delineate the role of advisory group members and expectations for participation.

- Include the advisory group at the early stages of program planning and/or evaluation.

- Put in place mechanisms and supports to ensure that the advisory body is meaningfully shaping the program or evaluation in question.

13. Offer a high level of mandatory training and skilled supervision for people working in the homelessness reduction system.

People who are homeless face a disproportionate burden of physical health problems, mental health problems, addictions and premature death. [23] For example, recent research demonstrated that people facing homelessness are at a much higher risk of traumatic brain injury (TBI) compared to the general population. It also showed that, among people who were homeless with a history of TBI, 70 to 90 per cent experienced their first TBI before they became homeless, and most were injured as teenagers. TBI is associated with seizures, drug use and poorer physical and mental health. [24]

This is just one example of a range of extreme health challenges faced by people who are homeless and precariously housed. As a result, staff requires specialized knowledge in order to work with people facing homelessness, make referrals and design and implement interventions. Research suggests the need for ongoing professional training in mental health, addictions and crisis intervention during paid working hours for everyone working as part of the homelessness prevention system. Case coordination is also an important need for many people who stay in shelters, and staff should receive training on making referrals to appropriate resources. [25,26] Our experience also suggests that all shelter staff should have access to expert supervision.

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