THE FUTURE OF MEN'S SUPPORTIVE HOUSING IN YORK REGION: AN EXPLORATORY STUDY BY THE CANADIAN OBSERVATORY ON HOMELESSNESS AND BLUE DOOR

hub solutions

April 2021

Acknowledgements

Hub Solutions is a social enterprise embedded within the Canadian Observatory on Homelessness (COH). Income generated from Hub Solutions fee-for-service work, is reinvested into the COH to support research, innovation, policy recommendations and knowledge mobilization.

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Background on Blue Door and Transitional Housing

BLUE DOOR

Blue Door provides safe and supportive emergency housing, housing services, and supports for people who are at risk of or currently experiencing homelessness in York Region. Founded in 1982, Blue Door operates three sites: Leeder Place for families, Porter Place for men, and Kevin's Place for male youth.

Blue Door's mission is to support people who are at risk of or currently experiencing homelessness to attain and retain affordable housing. Their vision is to see that everyone in York Region has safe, affordable, and supportive housing. To support their mission and vision, Blue Door operates several programs and provides a variety of different supports to clients, including:

1. **Emergency Housing.** Blue Door operates three emergency housing services that support families, men, and male youth. Housing Navigators, Housing Workers, and Case Managers are available daily to support clients in securing and attaining housing that best fits their needs. In particular, they provide individualized support that includes housing searches to find the "right fit" with the available budget, accompany individuals and families to visit potential housing units, advocate for the individuals, negotiate with the landlords, and provide support in filling out applications.

2. **Supportive Housing.** Blue Door also helps connect residents with other community supports including employment and legal supports, support for women and clients who identify as 2SLGBTQIA+, and mental health and crisis supports. Blue Door is also developing the Abode, Forward, and INNclusion supportive housing programs aimed at providing scattered site supportive second-stage housing options for families, seniors, and 2SLGBTQIA+ youth respectively who need medium to long-term support to overcome barriers.

3. **Housing Retention.** The Housing Retention program provides support to individuals and families desiring to successfully retain their housing. Supports include aid in community connection, support in navigating social services, help with budgeting, and personal capacity building to increase their success. Housing

Retention support is design to help clients journey towards self-sufficiency and independence.

4. **Housing to Health**. Housing to Health is a collaborative effort involving Blue Door, The Krasman Centre, and LOFT Community Services. These agencies provide housing services, peer support, and services to individuals with complex mental and physical health challenges. This program is intended to help house vulnerable people experiencing chronic homelessness and, at the same time, provide a range of supports to improve the individual's quality of life and increase the potential for long-term successful tenancies.

5. **Employment Support.** Construct, a social enterprise by Blue Door (ConstructGTA.ca), connects vulnerable individuals to meaningful and competitive employment by providing rapid eight-week skills training and wraparound supports to lift trainees out of poverty and homelessness and into well-paying careers in the construction trades. Trainees receive in-class training, hands-on experience, and essential employment certifications to break down barriers to employment. Through Construct's competitively priced residential and commercial general labour services, trainees work alongside skilled Construct staff and gain on-the-job real work experience across multiple disciplines. With the support of program partners LiUNA Local 506 Training Centre and the YMCA of Greater Toronto, Construct provides a seamless pathway from unemployment to an in-demand stable career.

6. **Health and Wellness**. Blue Door partners with healthcare service providers to deliver healthcare services to clients. Additionally, Blue Door collaborates with many community partners to deliver programming. Blue Door offers workshops including yoga, art therapy, and cooking classes. These programs encourage clients to regain the ability to express themselves, rebuild a sense of self-worth, and motivate healthy changes.

Description of the Issue

HOMELESSNESS IN YORK REGION

In April 2018, the Region of York in conjunction with community partners, local organizations, and volunteers conducted the *I Count, I'm Not Just a Number* homeless count (Regional Municipality of York, 2019).This count identified 389 people experiencing homelessness in York Region at the time. A survey was also distributed to

individuals experiencing homelessness which received 224 responses with the following socio-demographic characteristics:

- 125 (56%) identified as men and 95 (42%) identified as women
- 58 (26%) were youth between the ages of 16 and 24
- 38 (17%) identified as Indigenous and 78 (35%) identified as part of a minority racial group
- 18 (8%) identified as 2SLGBTQIA+
- 44 (11%) of those experiencing homelessness were living in public spaces
- 221 (57%) individuals were residing in emergency housing facilities or women's shelters
- 124 (32%) individuals were living in temporary accommodations (e.g., couch surfing, hotel, transitional housing, etc.)

Nearly half (45%) of the individuals who identified as homeless during the count in York Region were experiencing chronic homelessness (homeless for six months or more) and 21% were experiencing episodic homelessness (homeless three or more times in a year) (Regional Municipality of York, 2019). Among those who were categorized as chronically homeless, 63% identified as men and 37% as women with the following socio-demographic characteristics:

- 18% identified as Indigenous
- 12% identified as 2SLGBTQIA+
- 84% reported being single
- 12% came to Canada as an immigrant or refugee
- 27% had first experienced homelessness before the age of 16

This survey determined that the top five causes of homelessness in York Region were:

1. Family conflict
2. Loss of a job
3. Illness or medical condition
4. Inability to pay rent/mortgage and
5. Addiction, substance use, mental health, or domestic abuse

Abramovich and Pang (2020) also conducted a study with 2SLGBTQIA+ youth at risk of or experiencing homelessness in York Region. A total of 33 young people were interviewed in this study with the following socio-demographic characteristics:

- 27% were ages of 13 to 16, 45% were ages 17 to 20 and 24% were ages 21 to 26 with a mean age of 18.
- 58% identified as cisgender (cisgender woman and cisgender man), 21% identified as transgender (transgender woman and transgender man), and 21% identified with gender-expansive identities (non-binary, genderfluid, and genderqueer).
- The majority described their sexual orientation as bisexual, followed by pansexual, gay, lesbian, asexual, and demi-sexual.

This study revealed that the main source of income for 31% of youths was income assistance including Ontario Works (OW) or Ontario Disability Support Program (ODSP), followed by 21% of youth who received income from their job. Meanwhile, half of the youths in this study were unemployed or on long-term sick leave (Abramovich & Pang, 2020).

2SLGBTQIA+ youth reported that the main cause of homelessness was family conflict. Identity-based family rejection was the main source of family conflict which was commonly a result of the youth coming out as 2SLGBTQIA+ (Abramovich & Pang, 2020). Many (45%) of the youths had experienced some form of assault (verbal, physical, or sexual) because of their 2SLGBTQIA+ identity. Youths in this study also felt that they needed to hide their identity or chose not to disclose it when seeking help from shelters, health clinics, and schools because of past experiences with homophobic and transphobic discrimination.

Mental health and substance use were major concerns among 2SLGBTQIA+ youth in York Region. The majority (61%) of young people in this study had been formally diagnosed with depression, 52% with chronic anxiety disorder, 30% with post-traumatic stress disorder (PTSD), and 18% with bipolar disorder (Abramovich & Pang, 2020). Three out of four young people reported overdosing or having alcohol poisoning in the past year and expressed concern about overdosing.

As mentioned above, Blue Door operates three emergency housing sites in York Region: Porter Place, Leeder Place, and Kevin’s Place. In addition to Blue Door’s emergency housing services, people experiencing homelessness in York Region can access Belinda's Place, 360°Kids at Richmond Hill Hub, and Sutton Youth Services. Sandgate Women's Shelter and Yellow Brick House Women's Shelter are also available for women and children fleeing abuse. Two winter shelters (Mosaic Interfaith Out of the Cold and Inn from the Cold) operate from November to May.

Summary of Endeavour Consulting Report

The current project built upon a previous report from Endeavour Consulting. This previous project was designed to provide strategic actions that Blue Door can use to design and implement their supportive housing program. To do so, Endeavour's evaluation project had three main phases:

1. Conducting internal research within Blue Door and Porter Place and external research with subject matter experts in the housing and homelessness sector

2. Identifying/assessing strategic options and establishing a prioritization framework for Blue Door and

3. Developing short and long-term recommendations for Blue Door.

Endeavour's initial evaluation yielded many recommendations of which they ranked by prioritization and narrowed down to six priority recommendations within the following categories:

1. Health & Wellness Support
2. Supportive/Transitional Housing
3. Housing Retention Support
    - Eviction-Prevention Measures
    - Discharge Vulnerability Assessment
4. Housing Resiliency Training
5. Peer Support
6. Employment and Training Support

These prioritized recommendations served as guiding points of importance for this evaluation and were further prioritized into only the top two recommendations.

Purpose and Scope of Work

CONTEXT OF THE PROJECT

Blue Door partnered with Hub Solutions, a social enterprise embedded in the Canadian Observatory on Homelessness (COH), to evaluate how to better support their male clients who were experiencing chronic and episodic homelessness.

The COH and Blue Door narrowed down the recommendations made by Endeavour Consulting to focus on the most important needs of clients in York Region and to respond to gaps in services that will have maximum impact. Endeavour's initial evaluation demonstrated the need for clients to have access to a wide variety of mental and physical health needs and to have a thorough understanding of what the provision of a supportive housing program must entail. For this reason, the current project is centered on Endeavour's first two recommendations:

1) Implement a community of care model that leverages community partners to address the health and wellness of men experiencing homelessness. This model should consist of both prevention through health promotion and wellness and treatment through improving access to primary care.

2) Provide private rooms (transitional housing) to a portion of clients by separating the second floor of Porter Place and doubling the capacity of first-floor emergency housing. Transitional housing should offer structure, supervision, supports, skill-building, and in some cases, education, and training (case management, addiction and mental illness treatment, financial counselling, and employment services). Prioritize individuals who need the most support (e.g., those with mental health and addiction issues, or those recovering from traumas) and clients who demonstrate that they are working towards permanent housing goals.

These two recommendations were identified to be the most important recommendations of which to center this evaluation on.

This work was guided by two main evaluation questions:

1. How can Blue Door better support men that are experiencing chronic and episodic homelessness through place-based housing?

2. How can Blue Door better support the health and wellness needs of men experiencing chronic and episodic homelessness?

This work sought to make short-, medium- and long-term recommendations to Blue Door to inform the transformation of their emergency shelter while highlighting opportunities for monitoring and evaluation.

Methodology

To answer the two evaluation questions, multiple methods, including qualitative and quantitative research methodologies were used. The methods are described below.

Review of Endeavour Consulting report. The information provided by Endeavour Consulting was reviewed by the Hub Solutions team to avoid duplication of their work and to build upon the recommendations from the report.

Rapid literature review. The Hub Solutions team conducted two rapid literature reviews. The first was focused on emergency shelter transformation and best practices related to transitional housing (keywords = “transitional housing”, “transitional supportive housing”, “shelter transformation”, “homeless”). The second was focused on the health and wellness needs of individuals experiencing homelessness (keywords = “health”, “wellness”, “homeless”). Both searches used Google Scholar, PsycInfo, and Medline. The search included empirical and grey literature.

Surveys with Blue Door Staff. Blue Door stakeholders distributed the link to the online survey to front-line staff and management. The survey focused on current client needs, design considerations for supportive housing within emergency housing, and strategies to support the wellness of clients. Thirteen staff from Blue Door were surveyed to gain their input on supportive housing and health and wellness supports.

Surveys with Current and Former Blue Door Clients. Two separate surveys were created and distributed to two groups of clients: (1) former clients successfully housed through Blue Door, and (2) clients currently receiving housing services from Blue Door. The survey with former clients focused on supports that helped them attain their own housing and the survey with current clients focused on support that would help them attain their own housing. Blue Door stakeholders distributed the survey to interested clients. All surveys were conducted online. Participants received $15 for their time.

Interviews with Current and Former Blue Door Clients. Semi-structured interviews were conducted with clients currently residing at Blue Door and former clients living in the community who had exited from Blue Door's housing programs. The qualitative interviews provided an opportunity to expand upon the topics in the survey. Blue Door stakeholders identified participants who were interested in participating in the interview. All interviews were conducted over the telephone by the Hub Solutions team. Participants received $25 for their time.

Literature Review

Transitional Supportive Housing

Transitional supportive housing is a type of intervention that provides a supportive living environment focused on skill development and community building (Novac, Brown, & Bourbonnais, 2009). Although not a Housing First program, transitional supportive housing programs can apply a Housing First approach to meet the needs of individuals and families experiencing homelessness (Turner, 2014). In most cases, transitional supportive housing is viewed as a step in the housing continuum that supports individuals and families to move from emergency crisis services to long-term permanent housing (Novac et al., 2009). There can be great variation in the target population, level of service, and intended outcomes of transitional supportive housing programs, but the overarching goals are to support individuals and families with their education, employment, wellbeing, and housing needs (Novac et al., 2009).

Transitional supportive housing is often intended for individuals and families who require a greater level of structure and support to move into permanent housing (Novac et al., 2009). Therefore, transitional supportive housing programs usually provide on-site support that includes case management services to support clients with alcohol and substance use, financial counselling, and employment services (Novac et al., 2009). Groups who have been identified as possibly benefitting from transitional supportive housing include (Novac, Brown, & Bourbonnais, 2004):

1. Individuals and families recovering from trauma;
2. Individuals and families who have a background of multi-generational poverty and lack a supportive network;
3. Emancipated youth, or adults coming from institutions with little or no independent living experience;
4. Young mothers and pregnant teenagers;

5. Individuals and families who have on-going service needs due to mental or physical health problems

The length of stay in transitional supportive housing programs are longer than stays in emergency shelters but are often time limited ranging from three months to three years (Barrow & Zimmer, 1999). Once an individual or family completes their goals within a transitional supportive housing program they are discharged (Novac et al., 2009). Ideally, clients exiting transitional supportive housing options will move into permanent housing, but due to the lack of affordable housing available in most communities, clients may cycle in and out of the homelessness system (Turner, 2014).

The impact of transitional supportive housing, particularly among adult men, in the Canadian context is an under researched area. Examining literature from both Canada and the United States, most of which published in the 1990s and early 2000s, there have been mixed results on the impact of transitional supportive housing programs compared to standard care among adults experiencing homelessness (Aubry, Cherner, Ecker, & Yamin, 2017). Although reductions in homelessness have resulted from enrollment in a transitional supportive housing program, outcomes related to service use and clinical functioning are similar among adults enrolled in transitional supportive housing compared to standard care (Aubry et al., 2017). Tsai, Mares, and Rosenheck (2010) found that individuals moved into permanent housing first had better housing outcomes than individuals who received residential treatment or transitional housing prior to accessing independent housing, but there were no differences in clinical outcomes between the two groups. Rodriguez and Eidelman (2017) found that transitional supportive housing had similar housing outcomes as individuals enrolled in a rapid-rehousing program, indicating that transitional supportive housing be tailored to individuals and families who require a more intensive, therapeutic environment.

Wallace, Pauly, Perkin, and Cross (2019) reported better housing outcomes for a transitional shelter program in Victoria, British Columbia, as 84 percent of participants were in some form of stable housing six months after exiting the 12-month program. Of these participants, 33 percent were living in social or supportive housing and 23 percent were in receipt of rent supplements, highlighting the importance of linking transitional housing participants to some form of affordable housing. It should also be noted that 21 percent of participants reported an episode of homelessness after exiting the program (Wallace et al., 2019).

The relatively weak outcomes of transitional supportive housing programs for adults may be attributed to traditional transitional supportive housing

program requirements. For example, sobriety and active participation in programming are often required of residents in transitional supportive housing programs (Schinka, Casey, Kasprow, & Rosenheck, 2011). If an individual or family violates these requirements, they are often discharged from the program (Schinka et al., 2011). Other challenges of the model include the stress of having to exit time-limited programming and lack of client choice and control in the program (Perreault, Milton, Komaroff, Lévesque, Perron, & Wong, 2016; Wong, Park, & Nemon, 2006). These findings indicate that the rigidity of traditional transitional supportive housing programs may not be a good fit for most adults experiencing homelessness and that a more flexible approach is required. For example, a five-year length of stay was recommended by residents of a Montreal peer-run housing project for individuals who use opioids (Perreault et al., 2016).

To address these challenges, existing transitional supportive housing programs have highlighted key features to improve outcomes.

1. Transitional supportive housing must be coupled with other services and have available permanent housing options for clients (Dorozenko, Gillieatt, Martin, Milbourn, & Jennings, 2018; Novac et al., 2004).

2. Communal settings that offer a mix of privacy and access to supports is important for some clients, as is community development opportunities with other transitional housing clients (Novac et al., 2004).

3. Services should be provided using a flexible, person-centered approach to foster independence and support recovery (Dorozenko, et al., 2018).

One study focused on providing healthcare services to individuals in a transitional supportive housing program (Ciaranello et al., 2006). The authors recognize that most transitional supportive housing programs do not address access to care for acute or chronic health conditions. Thus, the transitional supportive housing program provided on-site medical, dental, and social services, referrals to other health care sites in the community providing diagnostic testing and specialty care, and the provision of a bus pass to enhance access to health care appointments. The service team included a medical director, a nurse practitioner, a medical clerk, and a social worker and provided services once a week. The program resulted in reduced emergency department usage, but there were no significant increases in receipt of dental, optical, or medical specialist care.

Emergency Shelter Transformation

One way emergency shelters are taking a flexible approach in their work is through the application of a housing-focused approach. Being housing-focused means to reinforce the purpose of emergency shelters as facilitators of housing (Regional Municipality of Waterloo, 2017). It recognizes that a ‘one size fits all’ approach will not work, as some individuals and families in emergency shelters will require a sustained period of engagement and a longer shelter stay (Regional Municipality of Waterloo, 2017). Despite the potential need for a longer shelter stay, there is still the expectation that clients will continue to be engaged in the housing search process. To support the housing search process, staff must connect their clients to resources in the community (e.g., non-profit housing providers, housing lists) and on social/affordable housing registries, based upon the preference of the client. If clients are not making progress with their housing plans, staff must deepen their engagement (Regional Municipality of Waterloo, 2017).

Emergency shelters in both large urban centres and rural communities have been successful in shifting toward housing-focused operations (OrgCode Consulting, 2019). In some cases, emergency shelters looking to shift toward housing-focused operations may need to recognize that they have offered a surplus of programs or are ”over-programming” clients which encourages longer stays in the shelter rather than encouraging them to exit into housing (OrgCode Consulting, 2019). Another important part of shifting an emergency shelter toward housing-focused operations is to ensure that clients understand the ultimate goal of their stay in the shelter is to find housing (OrgCode Consulting, 2019). This goal should be articulated during the intake assessment and reiterated throughout check-ins that clients have with staff (OrgCode Consulting, 2019). Transforming an emergency shelter into a housing-focused shelter is a slow process and can take months to years for shelters to find a balance between addressing the challenges that contributed to the loss of housing (e.g., substance abuse) and ensuring clients do not see the shelter as a place to stay indefinitely (OrgCode Consulting, 2019).

In other examples, emergency shelters have integrated affordable housing into their on-site services. In London, Ontario, one emergency shelter converted space in their existing shelter into private rooms (Oudshoorn, Marshall, Befus, & Parsons, 2019). Residents of these private rooms can stay for approximately one year. The rooms are located on a separate floor from emergency shelter residents. The floor includes access to laundry and cleaning facilities, a common area with seating and other potential amenities. Eligibility considerations for the program include being comfortable with communal living, being able to care for one’s own health and care, being able to abide by rules and regulations, and having the ability to pay board and lodging on a monthly

basis. Oudshoorn et al. (2019) suggest staffing resources include a program manager, a housing caseworker who is responsible for determining client eligibility for the private rooms, a maintenance worker, and a housekeeper.

Residents of these rooms said that it provided more privacy, safety, and peacefulness, as well as space for personal items compared to staying in the shelter (Oudshoorn et al., 2019). Concerns about the private rooms included rules that restrict personal freedoms, frequent interactions in the building with individuals experiencing mental health or addiction challenges, and the time-limited length of stay. The establishment of resident meetings was recommended since it provides residents with the opportunity to share any feedback they may have for the program.

In 2020, the United Way of Greater Toronto and city officials from Toronto released a report with recommendations for Toronto, Peel and York's shelter system given the changes that have been implemented during the COVID-19 pandemic (United Way Greater Toronto & Shelter, Support and Housing Administration, 2020). This report recognizes that emergency shelters will always be a necessary part of the homelessness service system, however, some shelters can repurpose their spaces into permanent supportive housing units thereby adding to the affordable housing stock (United Way Greater Toronto & Shelter, Support and Housing Administration, 2020). Transforming shelter spaces and respite centers that are no longer viable will also require investment from local governments and stakeholders (United Way Greater Toronto & Shelter, Support and Housing Administration, 2020).

This brief summary of the evidence on transitional housing demonstrates several considerations. It is important to provide transitional housing services to those who may need structured and intensive supports. For individuals with less intensive needs or who would not benefit from the structure of a transitional housing program, they may be better suited for community-based Housing First programs. The rigidity of traditional transitional housing programs may impact client outcomes, thus rules and regulations of new transitional housing programs, including length of stay, must be carefully created with input from potential residents. Permanent housing, access to education and employment, and enhanced wellbeing should all be considered main goals of a transitional housing program.

Health and Wellness Needs of Individuals Experiencing Homelessness

The poor health outcomes of individuals experiencing homelessness are well documented. People experiencing homelessness report more complex mental, physical and social health needs and overall worse health status than the general public (Bradley et al., 2020; Fajardo-Bullón et al., 2019). Mental health and substance abuse disorders are particularly common among people experiencing homelessness (Fleury et al., 2021). In a review from Health Quality Ontario (2016), one study found that 76% of people experiencing homelessness reported substance abuse issues suggesting the need for more substance use treatment programs for the homeless.

Individuals experiencing homelessness are also at a higher risk of mortality than the general population (Fazel et al., 2014). Causes of mortality in the homeless population include infection (HIV, tuberculosis), complications due to substance abuse, chronic diseases (e.g., heart disease), suicide, homicide and unintentional injuries (Fazel et al., 2014; Fleury et al., 2021). Individuals experiencing homelessness that access shelters have a lower risk of death than those that do not access shelters, but long-term shelter use is associated with an increased risk of mortality (Metraux et al., 2011). Similarly, life expectancies for individuals experiencing homelessness are shorter than that of the general public (Hwang et al., 2009). In Canada, Hwang et al., (2009) found that men and women aged 25 who were living in shelters, rooming houses, or hotels were less likely to live to age 75 compared to Canadians in any income group. Specifically, young women living in shelters, rooming houses, or hotels had a 60% chance of living to age 75, compared to a 70% among women in the lowest income group and young men in the same situation had a 32% chance of living to age 75 compared to a 50% among men in the lowest income group.

Barriers to Healthcare Access for Shelter Users

Homelessness complicates access to healthcare services which in turn impacts the health and well-being of people experiencing homelessness (Hoshide et al., 2011). There are many obstacles that impact a homeless person's ability to access healthcare. To start, shelter users commonly point to a lack of transportation to and from health care facilities as a major obstacle (Fokuo et al., 2020). Some individuals experiencing homelessness are also distrustful of the healthcare system and health care providers which discourages them from seeking medical care (Fokuo et al., 2020; Hauff & Secor-Turner, 2014). People experiencing homelessness have encountered discrimination and judgement from healthcare providers, which has contributed to this sense of distrust of healthcare providers (Hauff & Secor-Turner, 2014; Khandor et al., 2011; Winiarski et al., 2020).

The setting of healthcare facilities can also have an impact. In one study, individuals experiencing homelessness felt less welcomed in brand new buildings (Campbell et al., 2015). Campbell et al., (2015) described how some individuals experiencing homelessness at these new facilities were reportedly kicked-out of clinics by security guards before they were seen for their medical issues (Campbell et al., 2015). Campbell et al., (2015) also explained that the task of checking-in at clinics may not seem like an obstacle to most people, but to people experiencing homelessness, this may be a major hurdle that makes them uncomfortable seeking care.

In addition, not having a family doctor was found to be an obstacle that impacted emergency shelter residents' access to healthcare (Fleury et al., 2021; Khandor et al., 2011). A study in Canada, that included emergency shelter users, temporary housing occupants, and permanent housing residents (through Housing First) discovered that only half of people experiencing homelessness had a family physician (Fleury et al., 2021). More individuals with permanent housing had a family physician or case manager compared to the other two groups and emergency shelter residents used emergency department visits more than either temporary or permanent housing occupants (Fleury et al., 2021). The use of emergency departments (ED) is 0.5 to 5 times higher among the homeless population than the general public, and the lack of a family doctor is only one factor that contributes to the high rates of ED usage (Fleury et al., 2021).

Next, many people experiencing homelessness do not have health insurance, and so healthcare is not accessible because the out-of-pocket costs of healthcare are unaffordable for this population (Hauff & Secor-Turner, 2014; Khandor et al., 2011). There are very few primary care clinics that supply care to people that are underinsured/uninsured which leaves people experiencing homelessness to go without care (Cabán-Alemán et al., 2020). The lack of insurance is less of a barrier for people experiencing homelessness in Canada where there is universal healthcare (Khandor et al., 2011). However, in Canada, many people experiencing homelessness do not have a health card largely because they get lost or stolen and without a health card these individuals will be turned away from most care facilities (Khandor et al., 2011). A small segment (7%) of the homeless Ontarians in the study from Khandor et al., (2011) did not have a health card because they did not qualify for the provincially funded health coverage (e.g., a person needs to be a Canadian citizen or a legal immigrant and be a permanent resident of Ontario). This suggests that certain groups (e.g., newcomers) of the already marginalized homeless population are further marginalized because of immigrant status, and language barriers (Klodawsky et al., 2014).

Other healthcare barriers reported by shelter residents include not knowing where to find appropriate services, long wait times at clinics, long waitlists for specialty care, restrictive hours of operation, and limited availability of nursing care at shelters (Hauff & Secor-Turner, 2014; Weber et al., 2013). Shelter residents may have to choose between work and waiting in line for eight hours at a clinic or taking an appointment at a time that they would normally be working because the clinic is only open during the day (Campbell et al., 2015). Previous research has also discovered that dealing with survival needs is a higher priority than healthcare needs among emergency shelter users, and so seeking medical care is often put off (Hoshide et al., 2011; Weber et al., 2013). Given that individuals experiencing homelessness are a marginalized population, advocating for themselves to get the healthcare services they need can also be very difficult (Winiarski et al., 2020).

Facilitating Access to Healthcare in Shelters

Education and Policies: Providing healthcare resources at shelters can help shelter users access care, but research has shown that this strategy alone is not enough to make a significant difference in healthcare usage (Fokuo et al., 2020; Stergiopoulos & Yoder, 2007). Educating shelter users about the healthcare services available on-site or in the community and building trusting relationships between shelter users and staff are important pieces to ensuring people experiencing homelessness have the healthcare they need (Fokuo et al., 2020; Stergiopoulos & Yoder, 2007; Winiarski et al., 2020). Increased visibility and availability of health programs at shelters, which is achieved through more promotion and outreach, has led to an increase in enrollment in these programs (Pauley et al., 2016). At times shelter policies, particularly those that limit clients' length of stay, prevent shelter users from completing the full duration of treatment (Fokuo, et al., 2020). Shelters that do not let residents stay during the daytime can also make recovering from illnesses harder especially if they cannot easily access healthcare (Ciambrone & Edgington, 2009). Less restrictive eligibility criteria for programs and more flexible shelter policies would improve access to important health care resources (Fokuo et al., 2020).

Staff: Adequate staff levels and staff who have the right training to deal with a wide range of health problems are facilitators for healthcare access for shelter users and other individuals experiencing homelessness (Hauff & Secor-Turner, 2014). Winiarski et al., (2020) explained that youth experiencing homelessness prefer to go to youth shelters and drop-in centres for their health needs because staff are trained to meet their needs better than other care options. Further, intensive case management can facilitate shelter users' access to health services at the shelter and in the community

(Fleury et al., 2021). Case managers can make people experiencing homelessness aware of available resources, connect them with transportation to and from appointments, accompany them to their appointments, and help teach them to advocate for their own health needs (Fleury et al., 2021; Hauff & Secor-Turner, 2014). Many shelters would also like more nursing care available onsite for residents (Hauff & Secor-Turner, 2014).

Programs: Shelters could provide programs/services that help residents replace and store their health cards, birth certificates, and driver's licenses (Khandor et al., 2011). This would assist shelter users to obtain a family doctor and access services at care facilities outside of the shelter. Having identification could also help them to access specialty care options that may be beyond the capabilities of shelters.

Podymow et al., (2006) evaluated a shelter-based hospice program that helped to prevent the use of emergency care for terminally ill homeless individuals and ensured that patients had access to pain management, spiritual care, and hospital appointments. A shelter-based hospice program reduced the costs to the healthcare system given that many individuals experiencing homelessness who have terminal conditions seek care at hospitals (Podymow et al., 2006). This hospice program generated an estimated $1.9 million (USD) in savings to patients who spent an average of four months in the program before they passed away (Podymow et al., 2006).

Likewise, offering mental health and substance abuse programs in shelters decreases the strain on certain parts of the healthcare system (Stergiopoulos & Yoder, 2007). Financial incentives attached to the use of certain treatment programs have been found to motivate shelter residents to use certain shelter-based programs like rapid testing for the Hepatitis C virus (HCV) and a direct-acting antiviral treatment (DAA) for HCV (Fokuo et al., 2020; Masson et al., 2020).

Models of Care

Medical respite care: Medical respite care is one approach to delivering care to people experiencing homelessness that are not sick enough to remain in a hospital but are too sick to stay at emergency shelters (Ciambrone & Edgington, 2009). Multiple models can be used to offer medical respite care to the homeless and they differ by the level of medical care offered and the facility they are offered at (Ciambrone & Edgington, 2009). One model is the freestanding medical respite unit. Freestanding medical respite units that serve people experiencing homelessness are built separate from the shelter

site (Ciambrone & Edgington, 2009). While these units are not located at shelters, they typically begin through collaboration with local shelters Ciambrone & Edgington, 2009). Freestanding units are designed so that a comprehensive range of medical services can be accessed onsite (Ciambrone & Edgington, 2009).

The arrangement of shelter-based models depends on what medical services the shelter is capable of offering (Ciambrone & Edgington, 2009). Respite spaces can be created in the shelter, with an outside agency providing medical staff and comprehensive services (Ciambrone & Edgington, 2009). Alternatively, spaces in the shelter can be set aside for basic respite care which is provided by trained shelter staff (Ciambrone & Edgington, 2009). Another model for medical respite care is the motel/hotel model typically run through local government where rooms are rented at motels/hotels and medical staff visit these locations (Ciambrone & Edgington, 2009). Shelters and other organizations in the community are given vouchers to these programs and distribute them at their own discretion (Ciambrone & Edgington, 2009). Individuals experiencing homelessness who have used medical respite care programs have seen an improvement in their conditions, gained access to primary care, housing supports, and financial resources, and decreased their use of hospital services (Ciambrone & Edgington, 2009).

Collaborative care: A few studies have evaluated the effectiveness of shelter-based collaborative mental health care models (Stergiopoulos et al., 2015; Stergiopoulos & Yoder, 2007). Collaborative mental health care refers to practices that involve the patient with mental health needs, their family, and a multidisciplinary care team from both primary care and mental health care settings who work together to provide more coordinated and effective care to the patient (Stergiopoulpos & Yoder 2007). Fusion of Care is one example of this type of model that was evaluated at Seaton House in Toronto (Stergiopoulos et al., 2008; Stergiopoulos & Yoder, 2007). Among the shelter clients that received care from the Fusion of Care program, 35 percent had improved clinical outcomes and 49 percent had improved housing outcomes six months after being enrolled in the program (Stergiopoulos et al., 2008). Similarly, the shelter-based Integrated Multidisciplinary Collaborative Care (IMCC) and Shifted Outpatient Collaborative Care (SOCC) models showed improvement in shelter clients' community functioning, housing stability and health care use six and 12 months after first receiving care (Stergiopoulos et al., 2015). The IMCC model was designed to have shelter staff and health care providers work as a team with a psychiatric consultant onsite four half days per week (Stergiopoulos et al., 2015). In contrast, the SOCC model had an external psychiatric consultant provide outpatient care at the shelter (Stergiopoulos et al., 2015).

Cluster care: Pauley et al., (2016) evaluated a program that combined cluster care and supportive housing models. Cluster care offers care from a team of healthcare providers to clients living in the same building or area (Pauley et al., 2016). Usually, one provider agency sends out teams of care providers rather than individual caregivers and care plans are set up around assessments and care tasks and not blocks of time (Pauley et al., 2016). Supportive housing models provide health and human services, and housing supports at the same location (Pauley et al., 2016). The integrated model involves an interdisciplinary team with a doctor, psychiatrist, shelter/housing workers, registered nurse, personal support worker and a care coordinator (Pauley et al., 2016). Through this integrated model, enrollment in programs increased, services were provided faster, and clients felt they had higher goal achievement three months after implementation (Pauley et al., 2016).

Clinics: Shelter-based clinics have also been set up to improve healthcare access for people experiencing homelessness (Winiarski et al., 2020). Winiarski et al., (2020) evaluated a shelter-based clinic for youth that is open two to three times a week for four hours at a time in the mornings and evenings to meet the youths' schedules. The participants were either self-referred or referred by their case managers and mental health services were provided by five psychology postdoctoral fellows (Winiarski et al., 2020). Nearly half (49.4%) of youth that were referred to the clinic attended the first intake sessions, but attendance declined at follow-up appointments (Winiarski et al., 2020). Additional research is needed to evaluate whether shelter-based clinics make a significant difference in the health outcomes and access of healthcare services for people experiencing homelessness.

Models in the Canadian Context

The Canadian Network for the Health and Housing of People Experiencing Homelessness features four models of care.

Ottawa Inner City Health Inc. (OICH): OICH aims to improve health and access to health care for people experiencing chronic homelessness through the coordination and integration of health care services. They operate special health care units located within Ottawa's shelter system staffed by personal support workers and supported by visiting nurses and doctors. Examples of their services are:

- The Ottawa Mission Primary Care Clinic is open seven days a week to provide health care. In addition to primary care, the clinic offers HIV and mental health clinics. The primary care clinic is operated by a team of nurse

practitioners. The clinic operates from a flexible, patient-centered approach to health care.
- Special Care for Men. Located at the Salvation Army Booth Centre, this unit provides space for 30 men needing intensive supports for mental health, substance abuse and mental illness.
- Special Care for Women. Provides treatment, care and support from a team of nurses, doctors, client care workers, peer workers, and case managers to 16 women who are homeless and live with complex health needs. Located in the basement of the Shepherds of Good Hope.
- The Targeted Emergency Diversion (TED) Program. A health care service which is embedded in the Temporary Enhanced Shelter Program (TESP) operated by the Shepherds of Good Hope. TED consists of two services. The first is a 24-hour monitored program for individuals experiencing homelessness who are under the influence of drugs and alcohol, which allows them to safely detox in the community rather than a hospital emergency department. The second provides accessible treatment and care for health problems. This includes nursing, mental health services, intensive case management, peer support for appointments, nurse practitioners, psychiatry, access to an internist, and medical monitoring.

Inner City Health Associates (ICHA): ICHA is a group of 200 physicians and nurses offering specialized services to people experiencing homelessness. ICHA receives funding from the Ontario Ministry of Health and Long-Term Care. ICHA has two main functions:

- Transitional Primary Care. Bring primary care to individuals in shelters and drop-ins through outreach clinics. The aim is to assist patients with their health and psychosocial needs and to help them navigate the health and social service systems in order to transition to long-term care with a family physician in the community.
- Psychiatric Care. ICHA psychiatrists care for patients in shelters, respite centres and drop-in sites. They also offer services through three outreach programs:

1. **Coordinated Access to Care for the Homeless (CATCH**). Helps people who have unmet complex health care needs to access health resources in the community. People have or do not have mental health or addiction problems. A collaboration between St. Michael's Hospital, ICHA, and Toronto North Support Services.

2. **Multi-Disciplinary Outreach Team (M-DOT):** An interdisciplinary team of providers who deliver services to individuals experiencing homelessness. Includes outreach workers, case managers, a registered nurse, a housing worker, and a part-time psychiatrist.

3. **Multi-Disciplinary Access to Care & Housing (MATCH).** Provides ongoing intensive supports to individuals referred from M-DOT and CATCH teams who require ongoing involvement of an interdisciplinary team. Includes case managers, a registered nurse, and a part-time psychiatrist.

Palliative Care: The Palliative Education and Care for the Homeless (PEACH) program delivers palliative care to vulnerably housed people with life-limiting illnesses, providing services through mobile care in shelters and on the streets.

Lookout Housing + Health Society: Vancouver, BC. Lookout contracts with licensed registered nurses to provide onsite medical support. Medical services include basic First Aid, foot care clinics, physical exams, annual flu vaccinations and health testing, health education and promotion of harm reduction services. The nurses provide clinical support services, particularly to individuals diagnosed with HIV or Hepatitis C. The nurses work closely with Lookout staff, health care teams, and pharmacies to ensure that health issues are addressed appropriately.

Portland Hotel Society: Vancouver, BC. Operates the Columbia Street Community Clinic. The clinic as two physicians on staff each day, from a team of 13 General Practitioners and addictions specialists seeing up to 50 patients a day, five days a week. The clinic provides access to low-barrier primary care services, mental health and addiction treatment services. This includes assessment and same-day prescriptions for methadone and suboxone, along with various opioid agonist treatment options. It also offers access to lab work, immunizations, monthly Hepatitis C and women's health clinics, as well as other in-house specialist clinics, including internal medicine and neurology.

The Alex: Calgary, Alberta. The Alex has a complement of health, housing, social and wellness programs. It provides a hub of supports within reach of Calgary's highest-need areas. It serves a community with complex health challenges.

Results

INTERVIEW AND SURVEY DATA

Survey Participant Socio-demographics

Socio-demographic information was not collected on the staff survey. The following is a summary of the characteristics of both current and former clients who responded to the surveys.

Current and Former Clients

The average age of all clients who participated was 52. The majority of clients identified as white, heterosexual, and male.

Former clients who participated in the survey currently live in some form of congregate living, with 63% living in a rooming house, one in their own apartment, one in permanent supportive housing, and one described themself living in a “group setting”.

Table 1: Socio-demographics of current and former clients (Survey)

Demographics	Total (N:29)	Current Clients (N:21)	Former Clients (N:8)
Age			
Mean	52 Years old	49 Years old	50 Years old
Median	54 Years old	54 Years old	54 Years old
Minimum	25 Years old	25 Years old	28 Years old
Maximum	81 Years old	81 Years old	62 Years old
Racial/Cultural Identity			
White	23 (79%)	17 (81%)	6 (75%)
Indigenous	3 (10%)	2 (10%)	1 (13%)
Black or African Canadian	1 (3%)	1 (5%)	0
Arab	1 (3%)	0	1 (13%)
Other (Did not clarify)	1 (3%)	1 (5%)	0
Sexual Orientation	*N=28		*N=7
Straight/Heterosexual	25 (89%)	19 (90 %)	6 (86%)
Queer	1 (4%)	1 (5%)	0
Bisexual	1 (4%)	0	1 (14%)
Prefer not to answer	1 (4%)	1 (5%)	0

Gender			
Male	28 (97%)	20 (95%)	8 (100%)
Female	1 (3%)	1 (5%)	0

Overview of Blue Door Staff

A description of the participating staff members is presented below. 13 staff responded to this survey.

Eight (62%) of the participants listed their role as Housing Navigators/Residential Counsellors, two as Client Services Supervisors, two as Community Housing Workers, and one as a Program Manager.

The majority (46%) of participants started working at Blue Door within the past six months. Three participants worked at Blue Door for one to two years, one participant worked at Blue Door for three and a half years and three participants worked at Blue Door for over four years.

Interview Participant Socio-demographics

Qualitative interviews were conducted with five clients currently residing at Blue Door and four former clients who no longer reside at Blue Door. The data from these interviews supplemented the information provided by clients on the surveys to inform the development of a new supportive housing program at Blue Door.

All four former clients provided personal information and information on past history of shelter use, and only two out of the five current client participants shared this information.

Table 2: Socio-demographics of current and former clients (interviews)

Demographic Info	**Total (N=6, %)**	**Current Clients (N=2, %)**	**Former Clients (N=4, %)**
Age			
Mean	50 Years Old	51 Years old	46 Years old
Minimum	28 Years Old	38 Years old	28 Years old
Maximum	75 Years old	75 Years old	61 Years old
Racial/Ethnic Identity			
White/European-Canadian	3 (50%)	1 (50%)	2 (50%)
Black/African Canadian	1 (17%)	0	1 (25%)

White/European-Canadian and Indigenous (Inuit, Metis, First Nations, Cree)	2 (33%)	1 (50%)	1 (25%)
Sexual Orientation			
Straight/Heterosexual	5 (83%)	2 (100%)	3 (75%)
Bisexual	1 (17%)	0	1 (25%)
Gender Identity			
Male	6 (100%)	2 (100%)	4 (100%)

Staff Perspectives of Housing and Service Barriers for Clients

The survey distributed to Blue Door staff included a series of questions about common housing and service barriers faced by clients. These questions were excluded from surveys distributed to current and former clients.

Housing Barriers

Staff were asked to rank the top five most significant housing barriers faced by their clients experiencing chronic and episodic homelessness. A list of ten common barriers was provided and staff ranked their top five (Table 3).

The top five barriers identified by staff were:

1. A lack of affordable housing in York Region
2. Inadequate income to sustain housing
3. Mental health challenges impeding housing searches
4. Substance use challenges impeding housing searches
5. Discrimination and racism from landlords

Table 3: Ranking of Housing Barriers

Housing Barriers	Total Score (Max = 65)	Total Votes (N:13, %)
Lack of affordable housing in York Region	**52**	**12 (92%)**
Inadequate income to sustain housing	**32**	**10 (77%)**
Mental health challenges impeding housing searches	**28**	**10 (77%)**
Substance use challenges impeding housing searches	**22**	**8 (62%)**
Discrimination and racism from landlords	**18**	**6 (46%)**
Lacking the skills to maintain independent housing (e.g., budgeting, life skills, cleanliness)	17	9 (69%)
Lack of employment to sustain housing	12	5 (38%)
Lack of credit or poor credit	6	2 (15%)

Lack of housing benefits (e.g., rent supplements)	5	2 (15%)
Other (please specify) Lack of sufficient wrap-around supports to maintain housing	3	1 (8%)
Prefer to live outside of York Region	0	0

* Each rank (1 = most significant to 5 = least significant) was given a score from 1 to 5 (most significant = 5 points, least significant = 1 point). Total score derived from total points given by 13 participants for a total possible score of 65 points.

Service Barriers

Staff were asked to rank the five most significant service barriers that they have encountered when working with clients experiencing homelessness (Table 4).

The five most significant service barriers were:

1. Mental health challenges
2. Substance use challenges
3. Unaddressed trauma experienced in their life
4. Alcohol use challenges
5. Physical health limitations

Table 4: Ranking of Service Barriers

Services Barriers	Total Score (Max = 65)	Total Votes (N:13, %)
Mental health challenges	**52**	**12 (92%)**
Substance use challenges	**36**	**10 (77%)**
Unaddressed trauma experienced in their life	**27**	**8 (62%)**
Alcohol use challenges	**25**	**10 (77%)**
Physical health limitations	**23**	**9 (69%)**
Client unwilling to engage in programming and housing searches	12	4 (31%)
Negative peer influences	8	4 (31%)
Trust building and rapport development with clients	6	2 (15%)
Other (please specify: Not having case managers or peer support workers at Porter Place	5	1 (8%)
Language barriers	3	1 (8%)

Examples of Health-related Service Barriers

Staff were asked to provide specific examples of mental health, substance and alcohol use, and physical health service barriers. Common themes were developed from staff short answer responses.

Mental health. Specific mental health challenges described by staff included difficulty adhering to medications and undiagnosed mental health concerns. A comment from one participant demonstrates that a supportive housing program at Blue Door should be equipped to handle clients with complex/high needs who may have been turned away from other resources and programs:

> *We see a lot of people with undiagnosed mental health [issues] who seem to fall through the cracks everywhere they go. Also, violent outbursts due to mental health which usually results in a person being closed from services.*
>
> *- Staff member at Blue Door*

Depression, anxiety, attention deficit hyperactivity disorder (ADHD), and schizophrenia were described by staff as specific mental health conditions that can impact clients' ability to access services. Clients may also experience mental health challenges related to exiting Blue Door and finding housing in the community. For example, one staff member explained that some clients experience high levels of anxiety about living independently and having to speak with their landlords. Some clients may also experience anxiety around the possibility of facing discrimination from landlords for accessing Ontario Disability Support Program (ODSP) and mental health supports.

Substance and alcohol use. On the survey, staff expressed the belief that clients who use fentanyl, heroin, cocaine and crystal meth experience the greatest service barriers. The lack of accessible treatment and detox centers in York Region for these substance and alcohol use challenges was also described by staff as significant service barrier. One staff explained:

> *…the ones [treatment programs] we do have are geared toward youth or cannot serve people with physical health needs. They also don't help with the search for housing, so most people end up back on the street after completing treatment.*
>
> *- Staff member at Blue Door*

Physical health. Nine staff members selected physical health limitations as one of the top five most significant service barriers. Staff explained that they have observed that physical accessibility or lack thereof at healthcare facilities was a significant barrier for clients to access services at these facilities. Staff also noted that they have observed situations where landlords are unwilling to accept tenants with visible physical disabilities or are unwilling to pay for renovations to make the unit accessible. Blue Door staff also highlighted the fact that clients with physical health challenges may incur additional financial expenses to manage these challenges (e.g., medication, accessibility equipment). These additional expenses create further financial barriers for clients to find housing that is both affordable and accessible. One participant commented:

> *Most housing within the budget [that] our client population can afford is not accessible and very few government-funded organizations/housing programs have accessible units. Generally, people with mobility issues will have a longer length of stay at Porter [Place]. Also, living on a low-income, people generally cannot afford mobility equipment for a unit they do find, and most landlords are not willing to pay to make a unit accessible.*
>
> *- Staff member at Blue Door*

Unaddressed trauma. This service barrier was selected by eight staff members. Three ranked this as the most significant barrier while the other five ranked it as the second most significant barrier or below. Previous research has shown a connection between homelessness and past trauma such as domestic violence, substance use, mental health, poverty, and adverse childhood experiences (Homelessness Research and Action Collaborative, 2019). The responses from Blue Door staff emphasized that people experiencing homelessness may have past traumas that inhibit them from accessing much needed supports.

Less significant barriers. Four staff members each chose clients' negative peer influences, and unwillingness to engage in programming and housing searches, as other significant barriers to services at Porter Place. Two staff participants ranked language barriers as significant service barriers for their clients. One staff member named Russian, Arabic, and Farsi as the main language barriers. One staff member suggested that the service barriers that staff have encountered when working with clients experiencing chronic and episodic homelessness at Porter Place could be addressed if Blue Door provided increased staff support. The staff participant wrote:

> *I feel we need Case Managers and Peer Support Workers right at Porter [Place]. A lot of the other barriers I feel would not be as insurmountable with these services readily available at Porter [Place] and some of the other barriers would be lifted.*
>
> *- Staff member at Blue Door*

Supportive Housing Protocols: Perspectives from all Participants

Blue Door staff, current and former clients were asked questions about the structure and policies of a potential supportive housing program at Blue Door. Tables 5 and 6 provide a summary of participant survey responses. The responses from current and former client interviews are also described below.

Survey Results: Length of Stay

Staff*.* Five staff selected a length of stay in the supportive housing program of six to 12 months, three selected 12 to 18 months, two selected zero to six months, one selected 18 to 24 months and one specified that individuals should be allowed to stay for as long as they need to.

Current clients*.* Ten (48%) of current clients selected zero to six months for the length of stay in a supportive housing program. Four current clients suggested six months to one year while six suggested that the length of stay should be dependent on individual need and life circumstance, and that a strict timeline should not be put in place at all.

Former clients. Four (50%) of former clients suggested that zero to six months should be the length of stay, two suggested six to 12 months, and one former client suggested 18 to 24 months.

Current and former clients most frequently responded that a length of staying from zero to six months (48%) would be expected, followed by six to 12 months (21%) and “Other” (21%). Interestingly, of the six current clients who responded with “Other” five suggested that length of stay should be dependent on individual need and life circumstance, and that a strict timeline should not be put in place at all.

In contrast, staff responded that six to 12 months, followed by 12 to 18 months should be the expected length of stay for clients in the supportive housing program.

Table 5. Length of Stay Policy

Question	Total (*N*:42)	Staff (*N*:13)	Current (*N*:21)	Former (*N*:8)
How long should you/clients expect to stay in supportive housing?				
0-6 months	16 (38%)	2 (15%)	10 (48%)	4 (50%)
6-12 months	11 (26%)	5 (38%)	4 (19%)	2 (25%)
12-18 months	4 (10%)	3 (23%)	1 (5%)	0
18-24 months	2 (5%)	1 (8%)	0	1 (12.5%)
Other*	7 (17%)	1 (8%)	6 (28%)	0
Decline to answer	2 (5%)	1 (8%)	0	1 (12.5%)

* When "Other" was selected by current clients on the survey they explained that the length of stay should be dependent on the needs of the individual rather than a strict deadline to exit the program.

Interview Results: Length of Stay

Current and former clients of Blue Door were also asked in interviews what they believed would be an appropriate length of stay for clients in the supportive housing program.

Current clients: When asked how long clients should stay in the program several current client participants suggested timelines of six months and two years, however, not having a firm timeline was consistently discussed by current clients. Participants stressed that each client accessing the supportive housing program will be at a different place in their life and will have different support needs. This was reflected in an interview with one current client:

> *Depends how fast they are doing it. It just depends on the person definitely. It depends on the person when timelines are concerned. There are certain aspects that are important that are different for each person.*
>
> *- Current Client*

Current clients also suggested that when clients have achieved a feeling of stability in their own lives and have secured their own independent housing, only then would it be

an appropriate time to exit the supportive housing program. Current clients stressed the difficulty there can be in finding appropriate housing in York Region, in particular affordable housing. The lack of affordable housing was also identified by 92% of staff in the survey as the most significant housing barrier faced by clients. As one current client stated:

> *As long as it takes till they find housing. Because there is no affordable housing. They should stay until they have housing. As long as they get housed.*
>
> *- Current Client*

Former clients: In the interviews, one former client explained that they would expect to stay four months, two would expect to stay six months, and one would expect to stay for at least a year in a supportive housing program at Blue Door. The former clients' responses were informed by their previous experience staying at Blue Door. Three former clients were able to find housing within six months while at Blue Door, therefore they felt clients in a supportive housing program could successfully find housing within six months as well. The one former client that felt they would expect to stay for at least a year had stayed at Blue Door for one year before finding housing which he felt was because of his complex health needs which made it more difficult to find housing. The four former clients explained in the interviews that if Blue Door could offer a longer stay it would help them to find permanent housing to fit their needs and set up supports to help them maintain this housing. One former client noted:

> *I don't want to look for an apartment in a stressful situation. In this case, I might rent just anything, I can rent something which will be bad for me in the future.*
>
> *- Former Client*

Survey Results: Curfew

Current clients: There were mixed responses about including a curfew in a supportive housing program. Ten clients did not want a curfew while eleven did want a curfew. Clients in favour of a curfew felt that the curfew should be set between 10 to 12 PM, four suggested midnight, and three suggested after midnight.

Former clients: Similarly, three were in favour of a curfew, and five were opposed. The three in favour of a curfew suggested that the curfew be set between 10 to 12 PM.

Survey Results: Guests

Current clients: Ten participants felt that guests should be allowed and ten felt that they should not be allowed. Two participants suggested that guests should be allowed during business hours, three felt they should only be allowed in the evening until 8 or 9 PM and five felt that guests should be allowed throughout the day until 9 P.M.

Former clients: Six participants felt that guests should be allowed and two felt that they should not be allowed. Suggestions of admissible times from this group included once a week (1), only on weekends (1), and no restrictions at all (3).

Table 6: Curfew and Guest Policies

Question	Total (N:29)	Current (N:21)	Former (N:8)
Would you like a curfew?			
Yes	14 (48%)	11 (52 %)	3 (38%)
No	15 (52%)	10 (48%)	5 (62%)
Decline to answer	0	0	0
Would you like there to be guests allowed to visit?			
Yes	16 (55 %)	10 (48%)	6 (75%)
No	12 (41%)	10 (48%)	2 (25%)
Decline to answer	1 (4%)	1 (4%)	0

Interview Results: Curfew

Current Clients. The interviews revealed that current clients were divided on whether a curfew should be put in place for Blue Door's supportive housing program, with three participants being in favour of a curfew and two in favour of a curfew. These interview responses are consistent with survey responses from current clients with 52% on the survey in favour of a curfew and 48% not in favour of a curfew (See Table 6). Participants who supported the use of a curfew thought it would be helpful for clients to be accountable and ensure residents do not disturb others who are living within the building during the night.

For current clients who did not support a curfew during the interview, they believed that a curfew would take away some of their freedoms and ability to come and go as they saw best. One participant commented that clients may not be going out late at night for any negative reason and thought that clients may just be living their lives as they normally would outside of the program. The participant commented:

> *I don't think so, no. Because people might just go out for walks or these things and they may stay out late.*
>
> *- Current Client*

Former Clients. For the former clients during the interviews, there were mixed opinions about whether the program should include a curfew. Two participants were adamant that a curfew no later than midnight should be in place. These two individuals felt that a curfew would prevent residents from staying out late at night to use alcohol or substances as described by one former client:

> *Absolutely yes, 11 o'clock to midnight tops otherwise you're playing with fire. I just don't believe you need to be out all night if you're there [Blue Door] for help.*
>
> *- Former Client*

Comparatively, one participant felt strongly that there should not be a curfew because residents who break the curfew may lose their place in the supportive housing program. This former client explained:

> *That [a curfew] would just jeopardize people's housing you know like people like to go out. You know, outside [the program] people are going to party. I'm not going to but there are people that are going to.*
>
> *- Former Client*

The other former client explained that Blue Door should decide to implement a curfew based on the type of residents in the program. If the residents were under the age of 18, they felt there should be a curfew, but if the program is offered to adults, then they are responsible enough to live without a curfew. On the survey, however, it was clear that the majority (62%) of former clients were not in favour of a curfew.

Interview Results: Should Guests be Allowed

Current Clients. Current clients that were interviewed were split on whether guests should be allowed to visit in the supportive housing program at Blue Door. Three current clients were in favour and three were against having guests visit. Similarly, current clients who responded to the survey were split about the guest policy with 48% in favour of allowing guests and 48% against allowing guests. In comparison, the majority (75%) of former clients on the survey were in favour of allowing guests to visit. Participants in favour of guests visiting thought having support from friends and family would help provide emotional and social support. However, participants expressed concerns about their right toconfidentiality if guests could visit. Some participants were worried, particularly if they were living in shared accommodations, that their personal spaces may be accessible to guests who may recognize clients in the program, which could violate their privacy. One participant stated:

> *It's hard to say because, yeah, I guess you want the visit, but it also could breach confidentiality*.
>
> - Current Client

Current clients who were not in favour of allowing guests to visit stated that the supportive housing program is meant for healing and that Blue Door should help facilitate interactions and connections with family and chosen supports outside of the living spaces, but not within. One participant commented:

> *No, I don't think it is a good idea because it's not like an apartment*.
>
> - Current Client

Survey Results: Staff Ranking of Priority Populations

Staff were asked which populations (e.g., chronic homeless, older adults) should be prioritized for a supportive housing program. A summary of their responses is presented in Table 7.

Table 7: Ranking of Priority Populations

Populations	Total score (Max = 39)	Total Votes (N:13, %)

Individuals with the longest time spent homeless/the greatest number of homeless episodes	**26**	**10 (77%)**
Individuals with shorter periods of homelessness (e.g., less than 6 months) who have mental health and substance use issues	**21**	**11 (85%)**
Individuals with shorter periods of homelessness (e.g., less than 6 months) who have physical health needs	9	6 (46%)
Older adults (e.g., 50 years or older)	9	5 (38%)
Individuals who have said they are working toward permanent housing goals	3	2 (15%)

Individuals with the longest time spent homeless/the greatest number of homeless episodes were ranked as the number one population to target with this program. The second population staff felt should be prioritized were individuals with shorter periods of homelessness (e.g., less than 6 months) who have mental health and substance use issues. Based on survey responses from staff, mental health and substance use challenges are highly prevalent among the clients they serve at Blue Door and clients typically require additional supports to begin to address these challenges. One former client also explained that they have the most difficulty trying to access mental health services in the community:

> *A lot of people have undiagnosed mental health issues. I've been trying to get a hold of a psychiatrist for a year now. If they [Blue Door] could help with that, that would help a lot.*
>
> - *Former Client*

Individuals with shorter periods of homelessness (e.g., less than 6 months) who have physical health needs and older adults were tied as the third population to prioritize in this supportive housing program. After exiting Blue Door, clients described in the interviews how they have set up access to physical health supports (e.g., family doctor, optometrist), but remain unable to access mental health supports due in part to long waitlists before and during the COVID-19 pandemic. This may contribute to the prioritization of clients with mental health challenges over clients with physical health challenges.

One staff member added:

This is tough to answer because it really depends on how the program is developed. I would love to see our most chronically homeless clients be offered supportive housing but if we are going to pile them all into a small space and offer limited case management, it isn't going to work. I think we really need to be following best practices for whichever population we choose, and the decision should be made on who to support based on the services Blue Door can realistically offer.

- Staff member at Blue Door

Survey Results: Features of the Supportive Housing Program

Staff and clients were asked a series of questions to determine what types of supports should be included in a supportive housing program at Porter Place.

There were very few supports that staff did not think should be part of the supportive housing program (Table 8). Case management was the support that received unanimous support from staff while support with getting on social assistance received the most support from both former and current clients. Cultural supports received the least support from both staff and clients.

Table 8: Participant decision for well-being supports

Supports Related to Wellbeing	Total (N:42, %)	Staff (N:13, %)	Current Clients (N:21, %)	Former Clients (N:8, %)
Life skills development				
Strongly Agree/Agree or Yes	32 (76%)	12 (92%)	15 (71%)	5 (63%)
Strongly Disagree/Disagree or No	9 (21.5%)	0	6 (29%)	3 (37%)
Neither Agree nor Disagree	1 (2.5%)	1 (8%)	0	0
Decline to Answer	0	0	0	0
Employment training				
Strongly Agree/Agree or Yes	33 (78.5%)	12 (92%)	16 (76%)	5 (63%)
Strongly Disagree/Disagree or No	8 (19%)	0	5 (24%)	3 (37%)
Neither Agree nor Disagree	1 (2.5%)	1 (8%)	0	0
Decline to Answer	0	0	0	0
Support with getting on social assistance				
Strongly Agree/Agree or Yes	36 (86%)	11 (85%)	18 (86%)	7 (100%)
Strongly Disagree/Disagree or No	3 (7%)	0	3 (14%)	0
Neither Agree nor Disagree	2 (5%)	2 (15%)	0	0

Decline to Answer	1 (2%)	0	0	1
Cultural supports				
Strongly Agree/Agree or Yes	27 (64%)	11 (84.6%)	13 (62%)	3 (50%)
Strongly Disagree/Disagree or No	12 (28.5)	1 (7.7%)	8 (38%)	3 (50%)
Neither Agree nor Disagree	1 (2.5%)	1 (7.7%)	0	0
Decline to Answer	2 (5%)	0	0	2
Case management * (N=13)				
Strongly Agree/Agree or Yes	13 (100%)	13 (100%)	N/A	N/A
Strongly Disagree/Disagree or No	0	0	N/A	N/A
Neither Agree or Disagree	0	0	N/A	N/A
Decline to Answer	0	0	N/A	N/A

*Staff were asked to respond with Strongly Agree to Strongly Disagree and both client groups were asked to respond with Yes or No.

Interview Results: Features of the Supportive Housing program

Current Clients

The Meaning of Supportive Housing. Several of the current clients had never heard of the term “supportive housing” before and felt because they are new to the homelessness system that they do not yet have a firm knowledge of all the available services. Other current clients conceptualized supportive housing as being a way to support those in the community who need help through the provision of housing and other needed supports for daily living. As one participant shared:

> *Just somewhere where people are assisting you with your day-to-day life like to help you with your cooking or your meals, or you know just dealing with life*.
>
> - Current Client

Current clients also suggested that supportive housing should be centered on providing all needed supports for clients while they are in the program, with the end goal of acquiring their own independent housing. This is consistent with the survey responses from all participants with 92% of staff, 100% of current clients and 88% of former clients indicating that supports to help them identify potential housing opportunities should be included in the supportive housing program. One current client commented:

> *Well kind of like what it sounds, just helping somebody. Probably just trying to help somebody as much as you can. And then to get your own housing in the end*.
>
> - Current Client

Living arrangements. If given the choice between a private room or a shared room in a supportive housing program, 100% of the clients would prefer to have a private room. However, they would still use the program if the only option was a shared room. The two main reasons for wanting a private room were privacy and safety. These preferences stated by participants is particularly important to consider given that social distancing safety measures have been implemented in all congregate-style housing and emergency shelter spaces in Ontario due to the COVID-19 outbreak.

Survey Results: Health-Related Supports

There were consistent responses among all three groups of participants about which health-related supports should be included in a supportive housing program (Table 9). Supports for mental health were chosen frequently by both staff (100%), current clients (81%) and former clients (87.5%). The inclusion of physical health supports/supports to address medical needs were supported by 92% of staff, 81% of current clients and 75% of former clients. More staff (92%) compared to current (67%) and former (63%) clients felt that supports for substance use challenges should be part of this program. One staff member emphasized the need to consider the various health challenges when developing the program:

> *We cannot accept people who use substances and expect them to suddenly become people who do not use substances. If we are working with people who use substances, we need substance-friendly policies in place to support them.*
>
> *- Staff member at Blue Door*

Staff provided many specific examples of health-related supports that should be included in a supportive housing program. The most common answers were:

1. Frequent access to physicians, psychiatrists/psychotherapists, and other healthcare professionals outside of Blue Door and onsite
2. Psychological assessments to address undiagnosed mental health challenges

3. Medication management.

One staff member expanded on improving care coordination with other programs, such as hospital inpatient programs:

> *Also, I think we need to increase support for people entering the hospital. Someone should be supporting with continued payment of rent if the person is going to have an extended hospital stay. I see quite a few people lose their housing due to entering the hospital, not being able to pay rent and upon exiting the hospital they find out they have lost their housing.*
>
> *- Staff member at Blue Door*

Table 9: Participant decision on health-related supports

Supports Related to Health	Total (N:42, %)	Staff (N:13, %)	Current Clients (N:21, %)	Former Clients (N:8,%)
Addressing mental health challenges				
Strongly Agree/Agree or Yes	37 (88%)	13 (100%)	17 (81%)	7 (87.5%)
Strongly Disagree/Disagree or No	5 (12%)	0	4 (19%)	1 (12.5%)
Neither Agree nor Disagree	0	0	0	0
Decline to Answer	0	0	0	0
Addressing physical health/medical needs				
Strongly Agree/Agree or Yes	34 (81%)	12 (92%)	17 (81%)	6 (75%)
Strongly Disagree/Disagree or No	7 (16.5%)	0	4 (19%)	2 (25%)
Neither Agree nor Disagree	1 (2.5%)	1 (8%)	0	0
Decline to Answer	0	0	0	0
Addressing substance use challenges				
Strongly Agree/Agree or Yes	31 (74%)	12 (92%)	14 (67%)	5 (63%)
Strongly Disagree/Disagree or No	10 (23.5%)	0	7 (33%)	3 (37%)
Neither Agree nor Disagree	1 (2.5%)	1 (8%)	0	0
Decline to Answer	0	0	0	0

*Staff were asked to respond with Strongly Agree to Strongly Disagree and both client groups were asked to respond with Yes or No.

Interview Results: Health Related Supports

Based on both the interview and survey responses there is consensus among staff, current and former clients that supports related to health should be provided in a supportive housing program.

Current Clients. During the interviews when asked what supports should be available in the supportive housing program current clients commonly suggested access to supports to address health needs. All current clients agreed that access to physical and mental health supports were important and that these supports should be very easily accessible and individualized. Similarly, when responding to the survey 81% of current clients were in favour of including supports to address mental health challenges and physical health needs. As one participant stated:

> *[mental health, physical health and harm reduction supports] That's important, but that's also very individual, right. You can't use that as a general rule…it's good to have but it's very individual.*
>
> *- Current Client*

Specific types of health-related supports described by current clients during the interviews included access to healthcare providers, and harm reduction services. Current clients stated that these health-related services should be easily accessible and could be offered onsite to improve accessibility for clients. Survey responses from staff align with the clients' suggestions of offering healthcare supports onsite to enhance access to these supports. Participants further stressed the importance of a needs-based approach where all health-related supports are based on the needs of the clients. One current client participant commented:

> *Some people need access to health services, I believe if people have some problems, they should have a doctor. There should be some nurses or some special access to help people. Services should be based on the needs of the clients, whatever they need help with, they should have support with.*
>
> *- Current Client*

Current clients expressed the need to meet clients where they are at in their lives and to meet their support needs, whatever they may be. Understanding that support needs for clients will change over time and that regular assessments will be needed was also stressed by current client participants. One current client shared:

> *Just individual, one person needs more support. It depends on your background right…it's very hard to determine. I find, personally, it depends on your age, also*

has a lot to do with what kind of lived experience you have. Right, compared to your support, which is available.

- Current Client

Former Clients. When the former clients were asked what types of services should be offered to support residents of the supportive housing program, employment supports, physical health supports, and mental health and addiction supports were mentioned most frequently. In the interviews participants felt that services to help clients find employment were lower priority compared to health-related supports. For example, one former client stated:

I think also that my health is more important than employment supports because [with] employment I can look for [a] job by myself. But for my health I think that I need important supports.

- Former Client

Other examples of services mentioned by former clients included gift cards for grocery stores and legal services such as Duty Counsel for residents dealing with issues in court. One former client also explained that residents in the supportive housing program could benefit from Blue Door providing references to landlords on their behalf. This participant explained that landlords may be hesitant to rent to potential tenants living in a supportive housing program therefore a reference from Blue Door could help them secure housing to exit the program.

One former client also explained that a lot of residents in the program would benefit from a service that helps them to get identification (e.g., health card, passport):

Like help getting IDs definitely. Because a lot of homeless people you might get robbed or like you might… I don't know anything could happen right? And if you lose your IDs – like I got my bag stolen in Vancouver when I hitchhiked. I hitchhiked out here, but I didn't have any IDs for the longest time. I couldn't even get Ontario Works; you know, it was stressful.
- Former Client

Interview Results: Substance and Alcohol Use Policies

Former clients. Overall, former clients agreed that residents in the supportive housing program should not be removed from the program for substance use issues. Two participants stressed that residents dealing with alcohol and substance use should be permitted into the supportive housing program. One individual commented that he would like Blue Door to be understanding of addictions and not remove residents from the program for violating policies related to alcohol and substance use. This participant explained:

> *A lot of people have addictions right, so I mean if people got like really easily kicked out for their addictions. And they'd be stuck on the street forever you know, and I don't know what can be done about it, but I mean everyone deserves a roof over their head, you know?*
>
> *- Former Client*

While the participants agreed that residents coping with alcohol and substance use challenges should be allowed into the program there were mixed opinions about allowing alcohol and substance use on the property. The participants felt issues with safety could arise if alcohol and substance use were to be permitted on the property. One participant commented:

> *You shouldn't be able to like do drugs outside. I don't know about drinking, that's a tough call that like I wouldn't want – like if I had a roommate, I wouldn't want to be housed with somebody who drinks. That'll trigger me to drink again.*
>
> *- Former Client*

Survey Results: Supports Related to Housing

Participants were also asked about specific services that could assist clients to find and maintain housing. A summary of their responses is included in Table 7. Almost every participant (97.5%) across staff and client groups would like to see supports that assist clients to access to housing benefits like rent supplements. Similarly, 95% of participants indicated that support to identify potential housing opportunities (e.g., searching on Kijiji or applying to social housing) would be favourable.

The majority of former and current clients indicated that supports to engage with landlords and supports for learning how to budget should be included in a supportive housing program. Specifically, 81% of current clients compared to 75% of former clients

were in favour of having supports to engage with landlords. The responses were mixed for supports to learn how to budget with 81% of current clients in favour this support compared to 50% of former clients.

Table 10: Participant decisions on housing-related supports

Supports Related to Housing	Total (N:42, %)	Staff (N:13, %)	Current Clients (N:21, %)	Former Clients (N:8,%)
Preparing for successful tenancies, including rights under the Residential Tenancies Act				
Strongly Agree/Agree or Yes	35 (83%)	12 (92%)	18 (86%)	5 (62.5%)
Strongly Disagree/Disagree or No	5 (12%)	0	3 (14%)	2 (25%)
Neither Agree nor Disagree	1 (2.5%)	1 (8%)	0	0
Decline to Answer	1 (2.5%)	0	0	1 (12.5%)
Identifying potential housing opportunities (e.g., support to apply for social housing, housing searches via Kijiji)				
Strongly Agree/Agree or Yes	40 (95%)	12 (92%)	21 (100%)	7 (87.5%)
Strongly Disagree/Disagree or No	1 (2.5%)	0	0	1 (12.5%)
Neither Agree nor Disagree	1 (2.5%)	1 (8%)	0	0
Decline to Answer	0	0	0	0
Access to housing benefits (e.g., rent supplements)				
Strongly Agree/Agree or Yes	41 (97.5%)	12 (92%)	21 (100%)	8 (100%)
Strongly Disagree/Disagree or No	0	0	0	0
Neither Agree nor Disagree	1 (2.5%)	1 (8%)	0	0
Decline to Answer	0	0	0	0
Learning how to engage with landlords (N=29)				
Strongly Agree/Agree or Yes	23 (79%)	N/A	17 (81%)	6 (75%)
Strongly Disagree/Disagree or No	5 (17.5%)	N/A	4 (19%)	1 (12.5%)
Neither Agree nor Disagree	0	N/A	0	0
Decline to Answer	1 (3.5%)	N/A	0	1 (12.5%)
Learning how to budget your money (N=29)				
Strongly Agree/Agree or Yes	21 (72%)	N/A	17 (81%)	4 (50%)
Strongly Disagree/Disagree or No	8 (28%)	N/A	4 (19%)	4 (50%)
Neither Agree nor Disagree	0	N/A	0	0
Decline to Answer	0	N/A	0	0

*Staff were asked to respond with Strongly Agree to Strongly Disagree and both client groups were asked to respond with Yes or No.

Survey Results: Producing Positive Outcomes

The staff survey explored opinions about how Blue Door can ensure that a supportive housing program produces positive outcomes for clients. Almost every response centered around assessing the needs of the client and providing supports and guidelines that are realistic for the client given their individual circumstances. One staff commented:

> *Be realistic about people's substance use. Do not plan to serve people who use substances and then create rules that will ultimately lead to their discharge from the program due to their use. Make the housing accessible for people with accessibility needs so that we can broaden the population we can serve. Take on clients who may have an opportunity to increase their income if they can just find a safe space to live for an extended period of time and have support when needed. Also, have a nonpayment of rent plan so we don't have to ask the person to leave in the event they can't pay their rent, find a way to support these individuals with learning that paying rent = housing stability. So many programs in YR [York Region] just kick people out the first time they get behind on rent, but often for people experiencing chronic homelessness, this is a life skill they need to learn.*
>
> *- Staff member at Blue Door*

Other examples included having health resources available onsite (e.g., doctor, mental health worker), more assistance from York Region, and involving residents in the evaluation of the program. One staff member would also like to see more peer support at Blue Door:

> *We need peer support representation, where folks receiving supports can see themselves in the future, giving back, helping others like them, a graduated system of peer lead achievements and guidance. Some very successful substance use treatment programs follow a similar system.*
>
> *- Staff member at Blue Door*

Additionally, a participant explained how important it is to develop Blue Door's program in context of other services available in the sector:

> *The supportive housing program needs to provide a level of support that exists in between the current supportive housing programs formerly known domiciliaries*

(now called Housing with Supports) and independent living. Because there is no in between, too many folks fall through the cracks, and over time develop higher support needs due the absence of supports to address their moderate level of needs for prolonged periods of time.

- Staff member at Blue Door

Survey Results: Exiting Supportive Housing

Staff and clients were asked about what they believed would assist clients to transition out of a supportive housing program and into their own housing in the community. Clients and staff responses were somewhat divided on what was most important in assisting this transition.

Staff. The five supports that received the most support from staff were:

- Improved access to mental health supports (e.g., access to a psychiatrist, access to a community mental health worker)
- Improved access to physical health supports (e.g., access to a physician in the community)
- Effectively managing their substance use
- Attaining employment
- Effectively managing their alcohol use

Clients. Both current and former clients most frequently chose the following five factors that would help them exit the program. Former clients also felt that developing life skills (e.g., cooking and cleaning) were equally as important as having a larger network of supports. Access to social assistance income (e.g., Ontario Works or ODSP)

- Finding employment (part-time or full-time)
- Improvements to their physical health
- Improvement to their mental health
- Having a larger network of supports

During the interviews with former clients, health-related supports were the supports mentioned most frequently and some participants felt that health-related supports should be prioritized over employment supports in a supportive housing program. Former clients also did not indicate the need for any specific financial support to

maintain the housing they were living in after leaving Blue Door. However, on the surveys current and former clients unanimously identified social assistance, a financial support, as the most important support to help them exit the program while improvements to physical and mental health were less important for exiting the program.

Survey Results: Client Readiness for Exit

Clients were asked how they would know they were ready to exit a supportive housing program. There were three common types of responses which revolved around 1) accessing affordable housing, 2) availability of supports, and 3) life stability.

Accessing Affordable Housing. Client participants felt they would be ready to exit the program if they were able to attain their own independent housing. Participants stressed that their exit from the program should depend on having secured safe independent housing. The clients' ability to access affordable housing to be ready to exit the program is dependent upon the availability of accessible housing. Blue Door could assist clients to identify and apply to affordable housing that exists in York Region.

Availability and Accessibility of Supports. Client participants explained that their level of readiness for exiting a program would also be dependent on the availability and accessibility of supports. In particular, clients felt that having access to financial and health-related supports in the community would make them feel ready to exit the program.

Life Stability. Clients suggested that level of readiness of clients in the supportive housing program to exit the program would also depend on their perceived level of stability in their lives. Specifically, when clients feel they are capable of managing major challenges in their lives (e.g., substance use), and when they feel as though they can comfortably live on their own. This would require clients to feel secure in their health, finances, emotions. One client participant explained:

> *I would know I would be ready to leave when everything falls into place that is relating to the individual. Feel comfortable living on your own and are able to stand on your own feet.*
>
> - *Current Client*

Interview Results: Client Readiness to Exit Program

Current Clients. All current clients stated that prior to exiting the supportive housing program, clients should have some support from staff to help plan how and where they will be transitioning to. Participants suggested that support workers and case workers would be helpful in developing a discharge plan for clients who feel like they are ready to exit the program. One participant commented:

> *I think there should be some support around, placing them into the next step of their life. You know like a worker should work with them and then have a plan, upon discharge.*
>
> *- Current Client*

Participants also stressed that clients should not exit the supportive housing program until they have secured their own independent housing:

> *They shouldn't kick people out unless they have their own housing they can move into. They shouldn't kick people out.*
>
> *- Current Client*

Exiting the supportive housing program without having secured independent housing was thought by participants to be a risk of further perpetuating the cycle of homelessness. One participant shared:

> *As long it takes till they get housing. As long as it takes. Everybody wants to get out, but if they don't have housing, what do they do? So, they have to have housing.*
>
> *- Current Client*

Factors influencing former clients' housing decisions

All four former clients found housing in York Region and three explained that they would like to stay in York Region while one participant did not have a preference for where their housing is located. One reason the participants wanted to stay in York Region was because they have built relationships with doctors, mental health workers, psychiatrists

etc., which are located in York Region. Former clients' volunteer or employment (e.g., positions were also located in York Region contributing to their desire to stay in the region. The second reason was because participants felt safer in York Region than in other areas like Toronto. One participant explained that ultimately where he lives is dependent on what area has affordable housing that he can access.

The two former clients living in the group homes were planning to stay in their housing long-term. These two participants want to stay long-term in the group homes because they felt they benefitted from the structure (e.g., planned mealtimes) and environment of the group home. The two participants renting a room in a house were not planning to stay in this housing long-term mainly due to limited privacy when sharing a house with four to five other people. One former client specifically summarized his desire to find independent housing:

> *To have some real privacy.*
> - Former Client

Survey Results: Staff Identified Financial Supports

Staff were asked to identify financial supports that could be offered to help clients overcome income barriers that impact their ability to exit supportive housing and find adequate stable housing. Types of financial supports identified by staff included:

- Ontario Works or ODSP
- Rent subsidies/supplements
- Startup allowances that could be used for food or furniture
- Employment counselling
- Educational resources about budgeting and income stability
- Transit passes or funds for other transportation

Clients Preferred Type of Housing

Current clients were asked what type of housing they would like to move into after exiting a supportive program. The top three responses were:

1. Their own apartment
2. A shared apartment (e.g., apartment with a roommate)
3. Housing with a significant other

However, this contrasts with what most former clients have been able to access. The majority of Blue Door former clients who participated in the survey live in some form of congregate living (e.g., rooming house, permanent supportive housing, group home).

All the former clients lived in York Region at the time of the survey, and all but one of the current clients hoped to attain housing in York Region following their completion of programming.

Survey Results: Sustaining Exits from Homelessness

Blue Door clients and staff were asked what supports are important for preventing re-entry into homelessness. Clients and staff were generally in agreement about what services were necessary, and most often identified health supports as being significant.

Staff*.* The three supports that almost every participant strongly agreed with were:

1. Access to mental health supports in the community not attached to Blue Door (e.g., psychiatrist, psychologist, therapist)
2. Access to substance use supports not attached to Blue Door (e.g., detox, counselling) and
3. Access to alcohol use supports not attached to Blue Door (e.g., detox, counselling) and access to physical health supports in the community not attached to Blue Door (e.g., family doctor, nurse practitioner)

Blue Door staff also provided additional suggestions of community-based supports that clients should be connected to before exiting the supportive housing program to help them retain their housing. Access to case management workers, housing retention workers, crisis intervention teams, peer support workers, and harm reduction services were commonly mentioned by participants. A staff member stressed how important it is that services be available at all times and that clients have access to technology to contact workers who can help them to maintain their housing:

> *Also access to technology so clients can reach out for support before they lose their housing. As well as a community program that people can call to get real time support to show up at their door when they are in crisis (not the police and increased access outside of Monday-Friday 9-5).*

- Staff member at Blue Door

Clients. Current and former clients emphasized the need for:

1. Ongoing case management,
2. Employment and financial supports and
3. Health supports

Clients suggested that in-person follow-ups are needed after they exit a supportive housing program. This is reflected in the comment from one client:

> *A few follow up check-ins to make sure that I am still okay. To make sure I am still on track. Reminders about budget or other connections.*
>
> *- Current Client*

Financial supports were also high priorities for clients to prevent re-entry into homelessness. Specific examples of financial supports included ODSP, rent supplements, and employment support to attain income. In terms of health supports, alcohol and drug use services, mental health services, and access to family physicians were highlighted as important resources to sustain their exit from homelessness.

Interview Results: Sustained Exits from the Program

Supports that Should be Made Available for Clients Who Have Exited the Program

Current Clients. When asked what supports clients should have access to after exiting the supportive housing program common suggestions made by current clients included mental health supports, social supports, and case management supports. All current clients stated that it would be important to have continued support from case managers after exiting the supportive housing program and transitioning into independent housing. Participants stated that having regular check-ins every week would be helpful to ensure that clients continue to work towards their personal goals and to help clients to maintain their well-being. One participant commented:

> *Yea you know, it's really important to have a follow-up or you can slip right, and it doesn't work out, and support, support is still there, you can get right back up.*

- Current Client

Having continued support from case workers after exiting the program was suggested to be helpful in connecting clients to supports, should the need arise, as one participant shared:

> *I think I would want some kind of worker to be able to check in with afterwards like once I'm in the community. And I would want the staff that worked with me to help me find places in the community that can help me.*
>
> *- Current Client*

Regular check-ins from case workers and personal support workers would be especially helpful for clients who have accessibility needs and may need support performing regular activities in the home. Regular check-ins were also seen as valuable by participants because they can provide an added level of social support and someone available that clients can talk to, as one participant stated: *"I don't really have any friends around here I don't know anyone around here, so just someone to talk every once and a while."* Overall, current clients strongly suggested that clients should have semi-frequent check-ins from case workers after exiting the supportive housing program.

Survey Results: Practices to Avoid

Based on their experiences Blue Door staff were also asked what types of practices should not be incorporated into a new supportive housing program. Participants felt that this supportive housing program should not be offered to:

1. People experiencing isolated incidents of homelessness and
2. People whose housing challenges can be addressed more rapidly through other resources (e.g., landlord mediation).

Two staff members also emphasized the need to ensure that there has adequate funding to sustain this new program. For this program to be successful one staff member emphasized:

> *We should not be filling a unit with 4 to 5 chronically homeless individuals with a once-a-week support and expect it to be successful. People experiencing chronic*

homelessness need their own unit found for them (or with little interaction with the landlord to begin with) and supports checking on them frequently until they begin to learn skills that can support their own housing, then supports can be reduced. If we cannot do this, then we should focus on our clients with mid-low acuity who have a potential to increase their income [and] eventually be able to afford their own housing.

- Staff member at Blue Door

Interview Results: Practices to Avoid

Ensure Accessibility

Current Clients. When asked what Blue Door's supportive housing program should avoid doing one current client reflected on their experience of residing in shelters and how these spaces are not fully accessible. This participant stated that to fully accommodate all clients, Blue Door should make the supportive housing residences accessible to individuals who may have disabilities. Moreover, this participant suggested that when clients exit the supportive housing program that they should have the option of attaining independent housing that is accessible if so needed. This participant commented:

Accessibility is sometimes not there; residences are not accessible. They should help people have housing that is accessible. And they should help people find their own housing. Make sure the housing is safe and appropriate and accessible.

- *Current Client*

Recommendations

The recommendations are informed by the report from Endeavour Consulting, the surveys completed by Blue Door staff and clients, and the interviews completed with current and former Blue Door clients. This evaluation centered around determining best practices to guide the development of a new supportive housing program at Blue Door. The Hub Solutions team did not evaluate any other programs offered by Blue Door,

therefore these recommendations relate only to the design and implementation of Blue Door's supportive housing program and not to Blue Door programs as a whole :

- Short-term recommendations: Focus on internal processes and protocols that Blue Door should develop and design prior to the implementation of the supportive housing program. The timeline for Blue Door to carry out short-term recommendations is six to 12 months
- Medium-term recommendations: Identify community resources, supports, and connections that will be needed to meet the needs of clients. The timeline for Blue Door to carry out medium-term recommendations is 12 to 18 months
- Long-term Recommendations: Demonstrate how Blue Door can monitor and improve the supportive housing program over time. The timeline for Blue Door to carry out long-term recommendations is 18 to 24 months.

Short-Term Recommendations

1. **Identify whether the necessary resources and space (e.g., financial, physical, and human) are available for Blue Door to undertake the design and development of a new supportive housing program within their existing emergency housing**. The guide from Oudshoorn et al., (2019) describes the need for physical separations of new units that are based at emergency shelters, thus the rooms in a new supportive housing program at Blue Door should be on a separate floor or have separate entrances from the emergency shelter units. Blue Door will also need to determine the staffing requirements for this new supportive housing program. New staff may be needed to create a dedicated team for the supportive housing program or existing staff will need to integrate the responsibilities of the supportive housing program into their existing roles (Oudshoorn et al, 2019). As mentioned by participants in the interviews, Blue Door should assess the availability of funding to design, implement and sustain this new supportive housing program. Once Blue Door has identified the available resources required to create a new supportive housing program onsite of their traditional emergency housing the remaining recommendations should be considered in the development and implementation of this program.

2. **Develop eligibility criteria for the supportive program housed within existing emergency housing so that individuals who self-identify as needing intensive supports are enrolled.** The literature review demonstrated

that transitional supportive housing is best suited for individuals who could benefit from intensive supports prior to finding independent housing (Nova et al., 2004). Results from the staff survey also supported this. Therefore, Blue Door should develop program eligibility criteria that targets individuals experiencing chronic or episodic homelessness who have self-identify as requiring intensive supports.

3. **Develop a length of stay policy for the new supportive housing program based on the needs of each client.** While the supportive housing program may be built within Blue Door's existing emergency shelter the supportive housing program may require separate policies from the existing emergency shelter policies. As described in the literature review, emergency shelters that have moved to a housing-focused orientation often require more flexible timelines (Regional Municipality of Waterloo, 2017; Oudshoorn et al, 2019). While 38% of participants felt that the length of stay should be zero to six months and 26% felt it should be six to 12 months many current clients also felt that the length of stay should be set according to their needs. Having a strict timeline where clients must exit the program, with or without housing, risks further experiences of homelessness for clients. Both clients and staff identified that there is a lack of affordable housing within York Region and the difficulties that can delay the attainment of independent housing. Therefore, results express the need for the supportive housing program to allow clients to remain in the program until they are fully prepared for independent living.

4. **Ensure that the supportive housing program is strength-based, and harm reduction focused.** To facilitate positive housing outcomes, Blue Door should apply strength-based practices that focus on collaboratively identifying personal and social resources of clients. This will help to foster personal growth, support the achievement of personal goals, and strengthen resiliency. Policies following a harm reduction approach, will help clients to remain in the program, to have access to supports, and to attain independent housing after exiting the program. Therefore, the program should aim to be as low barrier as possible and develop policies to address non-compliance to program rules.

   Blue Door staff, current and former clients expressed in both the interviews and surveys that Blue Door policies and practices need to acknowledge that many of their clients may be coping with substance use challenges. Therefore, Blue Door should ensure their new supportive housing program is harm-reduction focused. In 2013, CATIE (Canadian AIDS Treatment Information Exchange) released a

synthesis of best practices for harm reduction programs that serve people who use substances followed by a guide for Indigenous centered approaches for harm reduction (Canadian AIDS Treatment Information Exchange, 2020; Strike et al., 2013). These documents can begin to inform the harm-reduction strategies implemented by Blue Door in their new supportive housing program. A sample of the recommendations from CATIE's reports are included here:

a. For needle and syringe distribution: Client should be educated about the risks of using non-sterile needles. Clients should also be provided with pre-packaged safe injection kits (needles/syringes, sterile water for injection, alcohol swabs, and tourniquets).

b. For opioid overdose prevention: Organizations should assess the accessibility and feasibility of a naloxone distribution program. If naloxone distribution is a viable option, clients who use substances or are at risk of overdosing should receive training on how to properly use naloxone.

c. For safer drug use education: Clients should receive educational sessions/interventions about reducing the transmission of HIV/Hepatitis C and B and about safer substance use behaviours (e.g., pipe reuse and sharing). These educational sessions should be delivered in a variety of different formats including one-to-one, group workshops, pamphlets, and instructional videos.

5. **Identify the goals of the clients early and regularly, but flexibly, monitor these goals with the clients.** Self-directed goal identification was stressed as an important feature of supportive housing by staff members. The surveys from clients also reinforced the importance of reviewing clients' perceptions of their progress toward their goals and their perceived readiness to exit the program. Therefore, Blue Door staff should begin collaboratively identifying service users' goals upon their entry into the program. As stated in the literature review, supportive housing services should be provided using a flexible, person-centered approach to foster independence and support recovery (Dorozenko, et al., 2018). In applying this approach, Blue Door should assess the needs of clients early and monitor them regularly. This will ensure that staff understand the types of services clients need, when clients would like to exit the program, and what housing considerations clients may have. In doing so, staff and clients can work

together to create realistic timelines for exiting the program and for attaining appropriate independent housing for clients.

6. **Create a transition plan for clients who are nearing a time when they will exit the program.** Client responses to the surveys emphasized their desire to have support from Blue Door staff to develop a plan for exiting the program and beginning the next phase in their life. Ensuring that clients have access to supports, have secured their own housing, and feel ready for independent living will be needed when clients near an appropriate time to exit the program. Regular assessments by case workers will be needed to determine level of preparedness of clients prior to their planned exit from the program.

7. **Limit guests during the on-going pandemic but reassess guest policies when public health measures are less restrictive.** While there was almost equal support for (55%) and against (41%) allowing guests to visit clients in a supportive housing program it may be best to limit or prevent guests from visiting altogether during the COVID-19 pandemic. During the COVID-19 pandemic additional measures (e.g., sanitation and screening) would need to be implemented to by Blue Door staff to ensure the safety of all residents at Blue Door which may exacerbate Blue Door staff and resources. Some participants were also concerned about privacy and confidentiality if guests were allowed to visit clients in the supportive housing program especially if they do not have a private room. Participants did recognize that interactions with family and friends are an important form of emotional and social support, therefore Blue Door could identify ways to offer virtual visiting within the supportive housing program. Once the COVID-19 outbreak has ended and the possibility of viral transmission is no longer present, Blue Door should re-assess the needs of service users and the possibility of allowing guests to visit.

8. **Monitor the need for a curfew**. There were also mixed responses about the need for a curfew in the supportive housing program. Specifically, 48% of current and former clients were in favour of a curfew while 52% were against a curfew in a supportive housing program. As suggested by one participant it may be helpful for Blue Door to revisit the need for a curfew once they have decided who will be admitted to the supportive housing program. If this program is offered to youth experiencing homelessness or is comprised of clients that feel they benefit from structure, then the adoption of a curfew may be necessary/beneficial.

Medium-term Recommendations

9. **Ensure that supports available in the program are person-centered and based on the needs of each unique client.** A wide variety of supports including case management, mental health supports, life skills development, and preparing clients for independent living were suggested by staff. Whereas among current and former clients, the most important supports were mental and physical health supports, and financial supports. Therefore, both the data collected in this evaluation and the existing literature support the inclusion of a range of different supports in the supportive housing program (Dorozenko et al, 2018; Novac et al., 2004). In the delivery of these supports, they need to be person-centered to meet clients where they are at in their lives and to appropriately respond to each individual's needs.

10. **Provide access to physical and mental health supports across Blue Door. This includes in-house services and referrals to community-based services.** Clients and staff identified the need for enhanced physical and mental health supports at Blue Door, and particularly within the supportive housing residences. Clients and staff also described the importance of connecting residents with supports that are available in the community before residents leave the supportive housing program. As described in the literature review, by ensuring increased access to medical services, other transitional supportive housing programs have made improvements to the use of emergency room visits and the overall well-being of their clients (Ciaranello et al., 2006). Potential health services that can be provided on-site include medical, dental, and social services. Moreover, referrals to other health care sites in the community providing diagnostic testing and specialty care may be needed.

11. **Offer transportation options.** To foster independence among clients in the supportive housing program and to ensure that clients can access community-based supports Blue Door should provide different options for transportation. This may involve Blue Door staff driving clients to healthcare appointments or to view housing. Alternatively, current and former clients expressed interest in having Blue Door provide transit passes or presto cards to assist them in accessing public transit to attend appointments or get groceries on their own. Increasing access to community services and supports in this way can help foster independence and connection to the community. This aligns with the literature that encourages opportunities for individuals residing at emergency

shelters to build independence and community connections (Ciaranello et al., 2006).

12. **Facilitate access to financial supports, including housing benefits and social assistance.** Blue Door can assist clients to receive financial supports such as rent subsidies, Ontario Works, and ODSP. Specifically,100% of both current and former clients, and 92% of staff would like there to be access to housing benefits (e.g., rent supplements) through the supportive housing program. Likewise, 86% of current clients and 100% of former clients would like help getting social assistance and 85% of staff supported including this service as well. Residents of the supportive housing program should receive assistance to access financial supports that they can continue to receive after they have exited the program. As was identified by several clients, barriers like not having valid personal identification documents (e.g., Driver's license, tax return) can prevent clients from gaining access to these financial supports. Therefore, Blue Door should have a dedicated staff member who ensures that supportive housing clients have all the needed documentation to attain all the financial supports that clients are eligible for and to help clients navigate this system.

13. **Assist clients to secure independent housing prior to exiting the program.** Supportive housing programs must consider housing options for clients once they exit the program (Dorozenko, Gillieatt, Martin, Milbourn, & Jennings, 2018; Novac et al., 2004). Current and former clients and staff all strongly responded to the need of clients to have secured independent housing prior to their exit from the program. Current and former clients also expressed their desire to remain in York Region, which should also be a priority when searching for client housing. The most desirable form of housing for 76% of Blue Door clients was their own apartment followed by a shared apartment However, attaining affordable independent housing can be difficult with affordable housing being in such high demand. As part of creating an exit plan, Blue Door staff and their clients should collaborate in identifying a range of acceptable forms of housing for clients upon their exit from the program.

14. **Continue to provide supports to clients after they have exited the program. Warm transfers should occur when referring clients to community-based supports.** Clients and staff agreed that providing continued supports to clients after they exit the program will be needed to prevent a return to the program or re-entry into homelessness. Semi-regular check-ins from case workers should be continued after a client exits the program to provide social support and to

continually assess the needs of clients to prevent a fall back into homelessness. Connections to available and desirable community-based supports should also be established for clients who have moved into their own housing. In supporting clients to access community-based supports, a warm transfer between Blue Door and the community agency should be prioritized.

15. **Incorporate peer support and community development opportunities.** It was mentioned multiple times by Blue Door Staff that clients could benefit from having peer support workers employed in the program. Staff felt that by working with peer support workers, clients in the new program can see that people who have had similar trauma (e.g., substance use, domestic violence, homelessness) were able to achieve their goals despite complex challenges in their lives. Other peer support options may include creating a network of peers who have graduated from the program who would like to offer support to others in the program and who successfully exited the program. Former clients also suggested that service users who exit the supportive housing program may require weekly support from case managers and personal support workers while living independently. The literature review discussed how other supportive housing programs benefited from creating a sense of community within the program, which fostered relationships between clients and created an environment where clients felt comfortable to voice their concerns (Oudshoorn et al., 2019). Therefore, Blue Door should establish a variety of supports that clients can access that can provide social and emotional support within the program and in the community. One suggestion mentioned in the literature review was to have regular community meetings for clients in the program (Novac et al., 2004).

Long-term Recommendations

16. **Consistently assess the support needs of each client to determine what specific supports should be prioritized.** Since clients and staff suggested that supports should be based on the needs of each client, continued assessments will be needed to provide a full picture of what supports are needed. Health supports and financial supports were stated by current and former clients to be a priority, and staff believed case management supports and independent living skill development were also crucial. Other research has shown that a wide variety of supports are important to support clients' health and well-being in supportive housing (Oudshoorn et al, 2019).

17. **Continue to expand the number of community connections and partnerships.** To further increase the number of supports that are accessible to clients, Blue Door should continue to coordinate and connect with services within York Region. This is particularly important for clients who have exited the program and are living independently, since they may have less access to supports compared to when they were in the supportive housing program. Ensuring a consistent level of supports for clients who have exited the program will help to decrease a potential return to homelessness and can improve one's connection to the community. Moreover, as Blue Door continues to monitor the needs of clients in the supportive housing program, it may be discovered that new or additional health supports are needed by clients. Therefore, it will be beneficial to continually expand the number of partnerships Blue Door has, to have the capacity to respond to changing needs of service users.

18. **Increase access to needed health supports.** As described throughout all stages of the recommendations, access to health supports is critical. However, the extent to which Blue Door can implement the following four recommendations may depend on the resources available to them (e.g., financial, physical, staff).
    - **a.** One strategy Blue Door can take to ensure clients are connected to needed health supports Blue Door is to seek out and engage with mental and physical healthcare service providers. This will be an on-going process as more connections are made with different services and the number of connections with health services can be increased.
    - **b.** If possible, Blue Door should offer healthcare services onsite of the supportive housing program. This strategy could help remove major barriers that people experiencing homelessness encounter when trying to access health care facilities. These barriers include a lack of transportation and previous experiences with discrimination at healthcare facilities (Fokuo et al., 2020; Campbell et al., 2015).
    - **c.** Blue Door can also facilitate the development of a long-term and trusting relationship between clients and family doctors. Many people experiencing homelessness lack access to a family doctor which contributes to higher rates of emergency department use among this population or avoidance of healthcare altogether (Fleury et al., 2021; Hoshide et al., 2011). Blue Door can do so by connecting clients to family doctors and ensuring they attend regular appointments with their family doctors while in the program thereby helping to form and sustain this important relationship.
    - **d.** A critical service that Blue Door should also consider including in their supportive housing program is one that helps clients receive government

identification. Given that the lack of a health card (and other identification) is a recognized barrier to access healthcare services by participants in this evaluation and in previous studies this should be a key focus area for Blue Door.

19. **Assess the use of a Collaborative Care model at Blue Door.** In this evaluation, staff emphasized the importance of involving the clients in their care planning while at Blue Door. Therefore, the Collaborative Care model described in the literature review may be the most appropriate model of care for a supportive housing program (Stergiopoulos et al., 2008; Stergiopoulos & Yoder, 2007). Collaborative Care models are designed to involve the client, their family, and a multidisciplinary care team (both onsite at the shelter and in the community) to ensure that the client receives care that meets their needs. The evaluations of Collaborative Care models that deliver mental health services to people experiencing homelessness show promising results related to client functioning and housing stability. Therefore, utilizing this type of care model at Blue Door would align with staff and clients' desire to have mental health services available in the supportive housing program. As described in the literature review, specific programs that use a Collaborative Care model include Fusion of Care at Seaton House in Toronto. One of the physicians in the Inner City Health Associates (ICHA) group also used the collaborative mental health care model to establish outreach services at a community drop-in center (Tam, 2010). A jurisdictional scan of organizations and programs that apply a Collaborative Care model within a congregate housing setting may also be a useful to gain a better understanding of how to apply this model within Blue Door.

20. **Further investigate the needs of different identity groups and clients with different levels of need (low vs. high support needs).** The sample of participants who took part in surveys and interview werelargely white/Caucasian (79%), heterosexual (89%) and male (97%). . Therefore, further investigation will be needed to identify support that meet the needs of marginalized populations such as individual who access Blue Door and identify as Black, Indigenous, POC, and/or 2SLGBTQIA+. Moreover, this evaluation did not investigate the difference between community members with differing levels of support need (i.e., low, medium, high).

21. **Ensure continuous monitoring of the supportive housing program.** Blue Door should continually monitor and evaluate the success of the supportive housing program. This will ensure that client needs are being met, that clients are

achieving their housing and life goals, and that staff feel they are operating the program successfully. Needs assessments, surveys, and regular check-ins between case managers and clients can all be applied to ensure that clients' needs are being met, and for the program to adapt where needed. Blue Door should also regularly monitor staff opinions on their abilities to provide strength-based and harm reduction approaches within the program, and when additional staff training is needed.

System Level Recommendations

22. **Advocate for more affordable housing in York Region.** The need for additional affordable housing stock in York Region was identified within Endeavour's evaluation as well as from the survey and interview results in this evaluation project. Lack of affordable housing was identified by 92% of Blue Door staff as the most significant barrier to housing that their clients face. Likewise, former and current clients all agreed that there is a major need for more affordable housing in York Region. These results can be leveraged to advocate for more affordable housing thereby ensuring the success of the supportive housing program, meeting the needs of clients, and preventing community members from ever experiencing homelessness.

23. **Advocate for coordinated onsite healthcare services at homeless serving organizations in York Region.** The literature review highlighted common obstacles to accessing healthcare among people experiencing homelessness which included a lack of transportation to and from healthcare facilities, long wait times at clinics and on waitlists as well as lack of knowledge of available health services in the community (Fokuo et al., 2020; Hauff & Secor-Turner, 2014; Weber et al., 2013). People experiencing homelessness are also five times more likely to use emergency departments than the general population (Fleury et al., 2021). These obstacles can be mitigated if Blue Door and other homeless serving organizations in York Region have the resources and capacity to offer onsite healthcare services**.** The need to have onsite healthcare services was also frequently emphasized by Blue Door staff and clients throughout this evaluation. Blue Door can draw upon the evidence produced through this evaluation to advocate for coordinated healthcare at their sites and onsite of other homeless serving organization in York Region. Although healthcare should be offered onsite, the focus should also be to connect clients with longer-term healtcare supports in the community.

24. **Advocate for additional mental health and substance use supports in York Region.** Clients explained that they are experiencing long wait times to access mental health resources particularly during the pandemic. Staff also described the limited availability of detox and treatment programs in York Region for clients coping with substance and alcohol use challenges. While increasing the number of support available to clients in the community is beyond the scope of Blue Door Shelters, they can utilize the information collected in this evaluation to raise awareness about the lack of these much-needed supports and advocate for additional supports to be implemented in York Region.

Next Steps and Future Research

1. Blue Door can extend an opportunity to local service providers to be involved in different capacities in the design and implementation of this new supportive housing program. This can be done to better understand and coordinate services between Blue Door and service providers to ensure that service users have access to the supports they need.

2. A comprehensive literature review of best practices for harm reduction programs that serve people experiencing homelessness who use substances was beyond the scope of this evaluation. However, this evaluation demonstrated that Blue Door should design their supportive housing program to be harm-reduction focused. Therefore, an in-depth review of current best practice guidelines for harm reduction as well as a jurisdictional scan particularly in the context of supportive housing is needed.

3. Given that the participants in this evaluation were primarily people who identified as heterosexual, Caucasian, and male, additional research is needed to identify the needs of people with different racial/ethnic and sexual identities (e.g., Indigenous, POC, 2SLGBTQIA+). Similarly, to ensure that Blue Door is assessing the needs of their diverse client population as well as monitoring and evaluating their new supportive housing program further investigation is necessary to identify culturally competent assessment, monitoring, and evaluation instruments. For example, a recent study suggests that there is evidence of racial and gender bias in the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) (Cronley, 2020). Given that Blue Door serves clients with different racial/ethnic, gender, and sexual identities it is important to use instruments that accurately record and reflect their needs.

Limitations

As mentioned throughout this report, the sample of participants that took part in the surveys and interviews largely included individual identifying as white/Caucasian, heterosexual, adult males. There were similarities among this sample and the larger population experiencing homelessness in York Region, however, our sample did not include youths (aged 24 and under) and included only a small proportion of individuals with different identities (e.g., gender, sexual orientation, ethnicity). Thus, the extent to which these results can be applied to all individuals experiencing homelessness in York Region is limited. Additionally, some current and former clients had a limited understanding of the meaning of supportive housing therefore their recommendations about the supports, practices and protocols that should be implemented in a new supportive housing program may not align with traditional models of supportive housing.

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