Models for Sustainable Partnerships Between Housing Providers and Community Agencies To Address Homelessness

APPENDICES

Appendix A

Models for Sustainable Partnerships Between Housing Providers and Community Agencies To Address Homelessness

Profiles of 8 initiatives in Canada and the United States

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#1 Special Needs Housing Program, Victoria BC

Introduction

The Special Needs Housing Program of the Vancouver Island Health Authority (VIHA) provides a variety of housing options for individuals with complex needs who have a serious and persistent mental illness and/or substance use. Many have a history of homelessness. Through this program, the individuals live in their own apartments with access to a range of support services designed to maintain their tenancy. Housing units connected to this program are located in both non-profit and private rental buildings.

The guiding principle of the Special Needs Housing Program is to assist individuals to live as independently as possible in housing that is safe, adequate, affordable and appropriate. The housing and supports are client-centred (i.e. *based on what the client wants*) and the program promotes creative approaches. Supports are implemented in a flexible manner using the principles of Psychosocial Rehabilitation and Harm Reduction.

The Program actively fosters partnerships for the provision of housing and support. VIHA partners with four non-profit housing societies to house and support people identified as having complex needs. These non-profits manage their own buildings where they house clients from the Special Needs Housing Program as well as others. One housing provider, Pacifica Housing Services, provides support to tenants in their own building and also supports tenants in private rental units who have been referred through the Program.

This case study looks at the overall Special Needs Housing Program and at how it operates at Pacifica Housing Services (PHS).

Partnership at a glance	
Description	The Vancouver Island Health Authority partners with non-profit housing providers to provide housing and a range of support services designed to maintain the tenancy of individuals with complex needs in both non-profit and private market rental buildings.
Partners	• Vancouver Island Health Authority • Pacifica Housing Services • Other non-profit housing providers/Coordinated Housing Registry • Private landlords
Goals	To help individuals with complex needs live as independently as possible in housing that is safe, adequate, affordable and appropriate.
Target Population	Individuals with a mental illness and/or an addiction
Number of Units [1]	550
Factors for success	• Flexibility to meet client's needs • The support for tenants - even those not in the program, as well as support to landlords • Staff who are dedicated and knowledgeable • Cooperation and coordination among agencies
Location	Victoria, BC
Date implemented	1996

[1] Total number of units in the program, including housing for tenants who are supported by VIHA's own staff in private market units.

Background

The Special Needs Housing Program was established in 1996 by the former Capital Region Health Authority. The health authority had conducted a survey of licensed residential care facilities (24-hour care for people with severe and persistent mental illness). Findings indicated that many residents did not need this level of expensive residential care ($130/diem), but could function well under more independent conditions.

As well, the survey found that:

- Individuals who needed the most help were ending up on the street where they received no services; and
- Individuals with a mental illness, including the individuals with complex needs and particularly those with concurrent disorders (i.e. a mental illness plus one or more addictions) needed a broader range of housing options.

As a result of the survey, the health authority established new programs to encourage independent living for individuals with a mental illness and to assist the tenant to maintain this independent housing. One of these was the Special Needs Housing Program.

Pacifica Housing Services is a division of one of Victoria's non-profit housing providers, Pacifica Housing Advisory Association. It was created to house and support individuals who had more complex needs than Pacifica's usual tenants. This shift to serve people with more complex needs came about in part as a result of Pacifica's parallel involvement in another program funded by VIHA. Pacifica was assisting individuals who had rented apartments but for one reason or another could not establish their tenancy (e.g. they lacked the damage deposit, or the first month's rent while waiting for disability benefits to begin). Pacifica helped these individuals establish a tenancy and then provided some support. Pacifica staff noticed that individuals with a mental illness who were being supported while waiting for disability benefits showed a marked improvement, needing no hospitalization during the waiting period.

Pacifica wanted to find a way to increase the supply of housing for those with a mental illness. Because average rents in Victoria, even for bachelor units, were greater than the BC Benefits shelter allowance, Pacifica approached BC Housing and suggested that it could place individuals with private landlords if BC Housing provided rent supplements to top up the shelter allowance. Pacifica pointed out that this would be cheaper than building new purpose-built accommodation. As well, they noted that a significant number of people did not want to live in purpose-built "supported" buildings for mental health consumers. With rent supplements in place, two private landlords in Victoria who had been using the Coordinated Housing Registry (see below) to access tenants for their buildings agreed to take Special Needs clients.

Partnerships

Partners

Vancouver Island Health Authority (VIHA)

The Vancouver Island Health Authority provides a full range of health care services to approximately 706,000 people living on Vancouver Island, the Gulf and Discovery Islands and to residents of the mainland located adjacent to the Mt. Waddington and Campbell River areas.[2]

Pacifica Housing Services (PHS)

PHS is a division of Pacifica Housing Advisory Association (PHAA) of Victoria, a non-profit housing organization that manages 500 units in more than 20 developments, providing affordable housing for families with modest incomes and people with mental illness or physical disabilities.[3] PHS was created to administer the Coordinated Housing Registry and, among other functions, to house and support PHS clients with complex needs. It owns and manages a converted motel, Medewiwin, which houses tenants from the Special Needs Program, and it manages the intake and provides support to Special Needs clients in two private rental buildings, the Saunders and Yates buildings.

Other non-profit housing providers

These include:

Other non-profit housing providers

These include:

- The Capital Mental Health Association (CMHA) which manages two buildings with 20 and 17 units respectively offering light support to mental health clients;
- The Society of St. Vincent de Paul operating a 43 bachelor suite building for adults living on an income of less than $20,000/yr. (There is no maximum length of stay but tenants must sign an agreement and be free of alcohol/drug use for one year before entering.); and
- Victoria Cool-Aid Society with 5 buildings (120 units) offering different levels of support to people who are marginalized, previously homeless and/or having complex needs.

Along with Pacifica Housing Services, these non-profit societies are partners in the Coordinated Housing Registry. The Coordinated Housing Registry provides tenant referrals to the portion of the Special Needs Housing Program operated by PHS and these non-profit providers.

Private landlords

PHS currently has formal arrangements with two private landlords to house a total of 19 individuals.

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[2] www.viha.ca/
[3] From: www.bchousing.org/Whats_New/News_Releases_2002/news12190201.asp

In addition, VIHA has arrangements with a number of private landlords who make about 300 units available to special needs clients. VIHA provides support directly to these clients.

Implementation

The Special Needs Housing Program provides support services to tenants in non-profit and private market rental buildings. The arrangement is similar to the Supported Independent Living Program (SILP),[4] though more flexible. Individuals who do not meet SILP's criteria, such as non-compliance, can still be housed in the Special Needs Housing Program. As well, the health authority offers landlords education regarding managing mental health issues.

Staff at PHS support tenants in the three buildings for which PHS manages the intake, and administers the Coordinated Housing Registry. Staff include:

- One Housing Outreach Worker, (this is 1 FTE position consisting of a half-time position and half of the Coordinator's time).
- The Coordinator of the registry who also does intake and manages programs and the data base;
- The half-time Housing Outreach Worker also serves as administrator and manager of the hiring process, and handles the payroll and invoices;
- One front desk intake worker who connects with people coming to the registry looking for housing and/or trying to see financial worker;
- One Community Support Worker for 28 hrs/week primarily at the privately owned Saunders and Yates building;
- One Community Support Worker at Medewiwin (owned and operated by PHS) for 35 hrs/week;
- One coordinator of Medewiwin at 35 hrs/week; and
- One coordinator for the Coordinated Housing Registry

Rent supplements for the tenants are provided by BC Housing. Landlords sign written agreements with BC Housing that address the selection of units, occupancy agreements, the nature of the assistance, obligations of the parties, and termination of the contract.

The client to staff ratio for Medewiwin, Saunders and Yates is 26:1.

Initiative

Who is served

The entire Special Needs Housing Program supports individuals in approximately 550 units occupied mainly by single men and women, but also a few couples. All have serious mental and/or physical health issues.

[4] The Supported Independent Living Program (SILP) is a partnership between BC Housing, the Ministry of Health and the health regions. SILP is a supported housing program that enables people with severe and persistent mental illness to live independently in affordable, self-contained housing. The Adult Mental Health Division of the Ministry of Health funds the shelter component of SILP. BC Housing administers the program.

Pacifica Housing Services currently supports 45 tenants in three buildings, Medewiwin, which it owns and manages, and two private market rental buildings, Saunders and Yates.

Of the special needs tenants in these buildings:

- 49% are men, 49% women and 1% couples.
- 90% have multiple issues.
- Approximately 40% of clients in Medewiwin and 50% in the Saunders and Yates buildings have a formal diagnosis of serious and persistent mental health issues and are connected to mental health team.
- 75% have a substance use issue and many have a concurrent disorder.
- Less than 1% have HIV/AIDS.
- A number of tenants have been involved in the criminal justice system.
- A number have brain injuries resulting from addiction, mental illness, or car accidents.
- Most of the women have experienced domestic violence in their past. However, there is no formal agreement to use this program to house women out of transition houses.

Housing and services

All units at Medewiwin, Saunders and Yates are self-contained and considered permanent housing.

Building	**# of units for Special Needs Tenants**	**Support Services**
Medewiwin (Non-profit)	26 – the entire building	Full time Community Support Worker (CSW) 5 days/wk, funded by VIHA. Provides tenant support, mediation, between tenants, support with appointments, shopping, crisis management, etc. Focus of program is to build strong relationship between support worker and tenants.
Saunders (Private)	10 scattered units in a 28-unit bldg; 3 bachelor; 7 1-BR*	Outreach Mental Health Community Support Worker provides primary services on an "as needed" basis. CSW is employed by PHS paid for by VIHA; covers both Saunders and Yates
Yates (Private)	9 scattered units in 2 bldgs.	

*Reaching ten units came about gradually, through surveying how well the program worked.

Some tenants at Medewiwin, Saunders and Yates are connected to the Mental Health Team and have case managers. None receive Assertive Community Treatment. Some receive support services such as Meals on Wheels. Community services are available to the tenants as they are for any member of the community. Home support is undertaken by Community Support Workers (CSWs). Some case managers will undertake home visits.

Other services provided at buildings where PHS manages the intake of Special needs tenants are:

Services	Provided by	Available on-site?	Source of funding
Medical care	Swift Clinic attached to Cool Aid Society – or use own GP.	No	MSP
Mental health	• Case management • Emergency MH services • Direct referrals to hospital system • Contact GP • Downtown Team of MH workers. • Some attend clinics related to particular disorder After Hours Emergency Service[5]	Generally no No	VIHA VIHA
Substance use	• No formal services. • Community Support Worker (CSW) is there to support tenant who want to enter treatment. • CSW will visit the tenant in treatment.	No	VIHA
Employment assistance	Tenants may be referred to another agency that provides this services. Fairly rare. Majority of clients are unemployable.	No	
Money management	• Connected with financial worker in PHS office. • CSW takes people grocery shopping	No	PHS
Assistance with life skills, food, transportation, clothing etc.	CSW Meals on Wheels, etc.	Yes, in tenant's unit	PHS Community organizations

There are rooms allocated at Medewiwin for tenant and other meetings, and there is an office for the Community Support Worker. At Saunders and Yates, the CSW meets with tenants in the tenant's own unit.

Access to housing

Tenants in the Special Needs Housing Program are referred through two sources:

1. The Coordinated Housing Registry**:** This registry includes individuals who are not connected to the mental health system. It began as a small partnership of non-profit housing providers that posted information on vacant units supplied by landlords. It was funded by BC Housing. Later, additional funding from the City of Victoria and Ministry of Human Resources enabled the registry to hire an outreach worker who brought landlords and clients together to find and match appropriate housing. When BC Housing declined to continue funding the registry, Pacifica Housing Advisory

[5] In private rental buildings, PHS trains the landlords in the appropriate use of this service. Staff of housing providers are similarly trained.

Association took over administration. In 2002, funding from Supported Community Partnerships Initiative (SCPI), created the Coordinated Housing Registry (CHR) and the old registry ceased to exist. PHS, Victoria Cool-Aid Society, the Society of St. Vincent de Paul and VIHA remain as partners in the new registry.

The registry seeks to provide affordable housing to persons with mental health issues, chemical dependencies, and/or dual diagnoses, who have been homeless or living in sub-standard accommodation for at least six months. It provides a one-stop service for intake into the ten buildings that house Special Needs clients. The quantity of buildings in the registry contributes to the efficiency of supportive housing by making possible a "best placement" for both the client and the other tenants in the building. As well, the coordinating function of the registry allows for the possibility of swapping units between buildings if a tenant is having difficulties in one building related to the culture of that building or its location.

A committee of the partners deals with issues such as the budget, applying for funding, and the functioning of the Special Needs Housing Program, but PHS handles the day-to-day administration of the registry.

2. Residential Housing Access Committee: This committee, which has been meeting weekly for three years, supplies referrals through the mental health system. At the meetings, the committee discusses and makes recommendations to managers of residential care and housing facilities. It includes representatives from the hospital, Community Outreach, Tertiary Care, Mental Health and Addiction Services, the Coordinated Housing Registry, and Housing and Community Development. Criteria exist to establish priority for placement and the committee aims for consensus on the priority of a particular client. If this is not possible, a vote is taken. The case manager or another health professional such as a psychiatrist is responsible for moving the selected tenant into a unit.

   The weekly meetings are labour intensive because of the number of people involved, (between seven and twelve). However, the committee members know the available resources and the individuals and are able to make a match between vacancy and prospective tenant. Never has a week gone by where there was no vacancy or no potential vacancy, although it should be noted that this committee fills vacancies in VIHA housing beyond what is available through the Special Needs Housing Program.

When there is a vacancy in one of the three buildings where PHS manages the intake of Special Needs tenants, PHS notifies the registry. The registry then notifies the Residential Housing Access Committee. The Committee and the registry each identify three individuals from their lists who are of highest need and who would make the best fit with the level of support and tenant culture of the building. Working with all the recommendations, the registry provides up to four prospective tenants to managers of the housing resources. Managers are either the coordinator/manager of the building or the Community Service Worker and Housing Outreach Worker depending on the building where the vacancy occurs. These managers make the final decision. PHS will then bring the client to view the unit and meet the landlord, who has a right to reject the person, though this has not happened.

The Coordinated Housing Registry is the wait list for the Special Needs Program. The list has been growing steadily. It presently contains 270 individuals. VIHA does not maintain a wait list for the program.

Eligibility

For the Special Needs Housing Program, clients must be 19 years or older, have a serious and persistent mental illness and/or substance use and are either homeless or living in substandard conditions and spending more than 40% of gross monthly income for housing. Individuals who are too high functioning will be referred to conventional housing opportunities. Eligibility is based on the degree of need of the tenant and whether the facility has the capacity to take that particular tenant with his/her needs at that time. Limitations are few. Examples are:

- The physical nature of some of the housing; e.g. housing without an elevator requires tenants who can negotiate stairs.
- Housing that is located near a schoolyard may not accept tenants with certain criminal records.
- The Residential Housing Access Committee will take into consideration clients who have been victimized and will not place them in a neighbourhood known to have bullies.
- Individuals who are too ill, too active in their drug use, or who have too long a history of evictions, may be better served in a more pro-active treatment program. These individuals will likely be brought up at the network meeting between agencies, where attempts will be made to encourage them into detox or treatment. Often such individuals have their names brought up weekly. If there is one week where they seem to have improved, a concerted attempt will be made to find them housing in the hopes that the housing will contribute to sustained improvement.

Expectations

Expectations at the three buildings where PHS manages the intake are:

Building	Expectations
Medewiwin	Tenants able to function with some independence, but have complex needs that require daily support. Tenants are responsible for activities of their daily living and involved in housekeeping duties, social events, gardening, and basic maintenance like painting.
Saunders	Tenants required to have a high level of independence and to need only light support. The private landlords are not involved in process of recommendation or assessment of capability.
Yates	

Every individual referred by the Residential Housing Access Committee has a needs assessment that includes an assessment by an occupational therapist (OT). Some clients on the Coordinated Housing Registry receive a needs assessment by the OT, but others do not.

Policies and issues

Tenants housed through the Special Needs Housing Program are not required to participate in any programs to be eligible for housing. However, the goal is to have the tenant develop a trusting relationship with the support worker and that this, combined with stable housing, will lead to eventual participation.

Drug use is tolerated in a person's apartment so long as it does not interfere with other tenants. If there is violence or any attempt to get others in the building involved in drugs, staff will intervene. If dealing is occurring by visitors, the housing outreach worker will attempt to gain mutual respect with the dealers and reason with them about not disturbing the other tenants with their activities, and about not selling to the most vulnerable residents. Sometimes a "visitor" will be banned or legal action taken to restrict access.

Staff make sure that registry applicants are properly informed that there will be people in the buildings who are using drugs.

Termination of tenancies

When an individual with complex needs is finally placed in accommodation, every attempt is made to keep the tenant housed. Such attempts include mediation between landlord and tenant, a "peers" cleaning crew to clean up a messy apartment, facilitating a referral to detox or seeing a doctor for medication. Sometimes the situation can be addressed by moving the tenant out for a few days, but it is not always possible to find alternative accommodations.

Eviction might occur:

- If a person is violent and shows no desire to change.
- If dealers come in and take over the tenant's apartment and start dealing in the building.
- If repeatedly, over long time, a tenant allows guests into the apartments who threaten abuse or are violent to other tenants

There are no formal written policies concerning eviction in the Special Needs Housing Program. Eviction is covered in the *Residential Tenancy Act* and applies to clients of this program the same as the general population. In the years with the program, the landlord of the Saunders Apartments has had to evict only two tenants. One was involved with drugs and playing music to loud for the other tenants, and the other brought inappropriate people to the apartment. From time to time, Pacifica will set up a contract with a tenant that will include possible reasons for eviction and/or outline possible concerns specifically related to an individual's behaviours and an agreement on limiting those negative behaviours.

If a tenant must leave the unit to seek treatment, staff will contact the hospital social worker to ensure the rent continues to be paid. If the tenant's psychiatric level deteriorates to the point where they need a long period of a higher level of supported housing, the social worker will inform the housing coordinator and a month's notice is processed on the tenant's apartment.

Costs and funding

Landlords receive rent supplements for Special Needs Housing tenants through BC Housing to cover the difference between the shelter portion of the tenant's disability allowance, or 30% of their income, and the rent.

There is a crisis fund that covers unforeseen damage to the unit or something needed for the individual.

The Coordinated Housing Registry is currently funded through a Supported Communities Partnership Initiatives grant from the federal government.

Lessons Learned

Outcomes

All the partners consider the program successful. It has created the ability to house individuals with complex needs, and have them remain in housing rather than fall back into homelessness. A majority of tenants provide PHS with positive feedback. Some of the tenants have made remarkable progress recovering from major mental illness and/or drug and alcohol use.

Outcomes for the buildings where Pacifica manages the Special Needs Housing Program intake are:

Outcomes	**Examples of changes since resident housed**
Residential stability	Between 1999 and 2004, there was turnover in 9 of the 45 units. In 3 of the units, the tenants died of natural causes.
Substance use	Generally decreased but mostly "harm reduction" (Medewiwin)
Mental health	2 hospitalizations in 5 years - medication reminders are given by the Community Support Worker, therefore better compliance (Saunders Yates)
Education	2 people have completed courses (Saunders Yates)
Employment	1 person is working part time (Saunders Yates)
Income	All tenants are on permanent disability. They are able to top up their support benefits by being a "peer" worker on cleaning apts.
Personal networks	A community has developed; generally good respect and tolerance for each other. A few tenants re-connect with family.

The community response has been very supportive for the three buildings where PHS manages the intake of Special Needs Housing tenants. As well, some friendships have developed between non-supported and supported tenants. Housing partners work as a team to resolve any issues that come up. Complaints by tenants are taken seriously and attempts are made to resolve concerns. In the two private buildings, complaints about noise, etc. were resolved by moving the tenant or complainant or by providing mental health education.

Evaluations

VIHA spent $60,000 trying to identify a functioning evaluation tool for the Special Needs Housing Program. Eventually, it determined that the tool was not sophisticated enough. It could not measure outcomes such as: *In the beginning the tenant did not make eye contact and did not know how to make a cup of coffee, but after six months, they were able to accomplish both.* The health authority is now researching another evaluation tool.

VIHA conducts satisfaction surveys with tenants pre- and post-usage of health services. As well, anecdotal evidence from agencies, practitioners, and family members suggest that initiatives such as the Special Needs Housing Program have positive outcomes.

Challenges

- NIMBY and zoning;
- Not enough housing to refer people to. It is frustrating to see people on the Registry wait list remain there for a long period of time;
- Prejudice by other tenants against those with mental illness. (This was more of a problem early on. Landlords and PHS staff have calmed the situation by explaining the program and offering education to the other tenants in issues of mental illness.)
- The inability to know beforehand if a tenant may be violent; and
- When arranging priorities, some Residential Housing Access Committee members may advocate for a client, rather than remain neutral and consider the established criteria.

Reasons for success

VIHA believes that the Special Needs Housing Program is successful due to:

- The flexibility built into the program to adapt to an individual's needs; and
- The support it offers to clients, landlords and other tenants in a building who may need assistance.
- Landlords are assured that they will receive their rent each month and in some buildings, VIHA collects the rent and pays the landlord directly, which is a cost savings.
- The health authority is available immediately when there is an issue. This not only assists the tenant, but engenders confidence in the program on the part of the landlords.

PHS attributes the program's success to:

- The Coordinated Housing Registry, which provides excellent service for tenants, as a one-stop shop and fair process;
- The coordination with various agency participants fosters cooperation rather than competition; and
- The system of housing and supports enables tenants to improve their lives.

As well, success depends on:

- The program being client-focused and geared to the needs of each individual. "*These are people with a mental illness or a brain injury and as citizens, deserve housing as much as anyone else.*"
- The staff: dedicated housing-related workers with a wide range of background and education and an understanding of the multiple issues facing their clients.

It is important to be well organized and expect that there will be complications when developing such a program. The first few months are the worst, and then things settle down. A program like this takes careful planning and one should expect that it will take, on average, two to three years to become operational.

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Additional Sources

www.viha.ca/

www.bchousing.org/Whats_New/News_Releases_2002/news12190201.asp

#2 BC Housing Health Services Program, Province Wide

Introduction

The Health Services Program (HSP) is a partnership between BC Housing, the Ministry of Health, Adult Mental Health Division, and housing providers. It offers increased accessibility to housing for individuals with a mental or physically disabling illness, along with support services. Applicants who meet the program's criteria are housed in developments managed by BC Housing, non-profit housing societies, and private landlords. Subsidies are applied where needed to fully cover rent.

Coordinators for the program are registered psychiatric nurses and registered nurses. They are based at BC Housing regional offices throughout the province. In addition to serving individuals who have been specifically referred to housing through this program, the HSP also offers help to other tenants in a building served by the program who may need support. Housing providers have found this part of the program to be of great value, in that it helps to maintain other vulnerable tenants.

This profile describes the HSP generally and focuses on one of the first housing providers to participate, Rainbow Lodge in Langley.

Goals

The goals and objectives of the HSP are to:

- Ensure that individuals with various health issues can maintain a successful tenancy and that the necessary supports are available; and
- Provide training to housing providers to enable them to become better equipped in assisting these tenants.

Partnership at a glance	
Description	BC Housing partners with non-profit housing providers, mental health and other support services to maintain successful tenancies for adult mental health clients or people with health-related disabilities. Health Services Coordinators in each region ensure appropriate supports are in place.
Partners	• BC Housing • Non-profit housing providers • Private landlords • Mental Health Teams/ Other support services
Goals	• Ensure that individuals with health issues can maintain a successful tenancy and that necessary supports are available • Provide training to housing providers to enable them to become better equipped to assist these tenants.
Target Population	Adults with mental and physical health issues
# of Units in BC	1,256 as of June 2004
Factors for success	• Fulfils a need for support services as well as decent affordable housing • Good relationship between partners • Flexibility and adaptability • Serves tenants other than those it places
Location	Throughout BC
Date implemented	1991

Background

Two factors led to the Health Services Program, which began in 1991.

1. BC Housing recognized that there were tenants in the directly-managed portfolio experiencing difficult life situations and that the organization lacked the expertise to properly support them.
2. BC Housing wanted assistance in placing people with mental illness in BC Housing units to ensure that the placement enabled these individuals to maintain their contact with case managers, home support, family, friends, etc.

At its inception, the Health Services Program had access only to units in BC Housing directly-managed buildings. Two Health Services Coordinators, working out of Lower Mainland regional offices, selected and supported these tenants.

In 1998, staffing increased and the Program was able to expand to place eligible clients with non-profit housing providers. As well, Health Services Coordinators were placed in other regions of the province. At present, there are 6 Health Services Coordinators. Two are located in the Lower Mainland West region, two in Lower Mainland East, one in Victoria and one in Penticton.

In first implementing the HSP, the program established which health care providers were needed in a particular BC Housing building. Program staff then facilitated the necessary partnerships with agencies such as mental health teams, mental health housing providers, and continuing care providers. BC Housing also consulted with non-profit housing providers.

Rainbow Lodge became involved through a workshop at a BC Non-Profit Housing Association conference. At the time, some seniors housed at Rainbow Lodge had mental health issues and/or exhibited unusual behaviours, but the Lodge did not have support services to offer them. As well, Rainbow Lodge was having difficulty renting its bachelor suites to seniors, many of whom now preferred to rent one-bedroom units. The HSP enabled Rainbow Lodge to fill vacant units, as well as receive support and services for tenants already living in its buildings.

Partnerships

Partners

In general, partners involved in the HSP consist of BC Housing, a housing provider (non-profit or private landlord) and a local mental health team.[6] The following is a description of the partners involved in providing services at Rainbow Lodge, one of the partnerships operating under the HSP.

[6] Where an HSP client has a physical disability, the partnership would include BC Housing, the housing provider and whatever agencies are necessary to support that person's disability.

BC Housing, Health Services Program

BC Housing is a provincial crown agency that develops, manages and administers a wide range of subsidized housing options across the province. It provides housing subsidies for more than 82,000 families, seniors, and individuals with disabilities in 33,200 units of social housing managed by non-profit societies and co-operatives.[7] The Health Services Program is one of the programs delivered by BC Housing.

Rainbow Lodge, Langley

Rainbow Lodge opened in 1972. It now has 595 units in six buildings. Its mission is to house seniors and persons with disabilities with low and moderate incomes who can live independently. It joined the Health Services Program in 1998.

Langley Mental Health (and other support services)

Langley Mental Health (LMH) is a division of the Fraser Health Authority, which serves 1.44 million people living between Burnaby and Boston Bar.

Private landlords

Several private landlords participate in this initiative.

Implementation

The Health Services Program generally serves as an intermediary between Mental Health Centres and participating housing providers. HSP-placed tenants come to their housing with supports. In the case of private market rental housing, the local mental health team places the client and either provides services itself or contracts with another agency for ongoing support. The role of the HSP is to act as a facilitator and bringing the interested parties together. Through BC Housing, the HSP is able to provide a rent subsidy for tenants involved in the program.

Coordination/management

A formal agreement is signed between the Health Services Program and a non-profit housing provider, such as Rainbow Lodge. The agreement stipulates the number of units to be rented to clients of the HSP and the number of clients to be pre-screened by the HSP. As well it specifies that the HSP agrees to:

- Maintain a wait list of eligible applicants to be able to refer promptly;
- Provide follow-up and on-going monitoring and support for the tenants referred by the HSP;
- Dedicate a staff member to provide consultation and support to assist Site Managers in addressing tenant and staff concerns;
- Accept and follow-up as required regarding any problematic tenant situations; and
- Provide an agreed upon number of in-service training sessions for housing provider staff.

[7] From: www.bchousing.org

There are no formal agreements between housing providers and service agencies. Rather, support services to the tenant are handled between the HSP coordinator and the service agencies. The HSP tenant comes to the unit with a case manager, GP or psychiatrist already in place.

There is an informal arrangement between Rainbow Lodge and Langley Mental Health facilitated by monthly meetings. Lodge staff will contact Langley Mental Health with concerns either about HSP tenants or other tenants not connected to the Team on an as needed basis.[8] Langley Mental Health will inform Rainbow Lodge if a tenant has been taken to hospital.

When the program began at Rainbow Lodge, there was some conflict with Langley Mental Health about the complexity of needs concerning a tenant that Rainbow Lodge could manage as a seniors housing provider. As well, privacy issues precluded LMH from sharing the type of information about clients that Rainbow Lodge considered necessary to assist the tenant. These conflicts have been resolved. There is now a delegated LMH case manager who acts as a liaison, and the two organizations enjoy a good working relationship that continues to improve. Every other month Rainbow Lodge staff and the LMH liaison are joined at the meeting by the psychiatric nurse from the East Region of the HSP. From these meetings, concerns about LMH clients are taken back to the Mental Health Team and to clients' case managers.

Where appropriate, the HSP has organized service provider meetings at BC Housing's directly-managed buildings, attended by health care providers (mental health workers, addictions counsellors, and continuing care staff) and the building manager, the property portfolio manager and the Health Services Coordinator. A non-profit could do this as well.

Initiative

Who is served

In June 2003, a total of 1,256 clients were served by the HSP. These included single persons, couples, families with children, people who are transgendered, seniors, and individuals with addictions.

- Approximately 90% of individuals served have a serious and persistent mental illness with a formal diagnosis. They are connected to a mental health team**,** GP or private psychiatrist. Some have concurrent disorders and some are/were involved with the criminal justice system;
- The remaining 10% are individuals with a brain injury and most recently, the developmentally disabled and those with multiple sclerosis (MS).

Rainbow Lodge houses 29 people through the HSP program, integrated throughout its six buildings. Sixty-five percent are single men. Couples are housed occasionally. Only two HSP clients at Rainbow Lodge are over 55.

[8] While LMH will attempt to assist in such cases, it must be recognized that there are privacy concerns that may affect their ability to intervene.

Housing and Services

All of the units available through the HSP program are permanent, and most of the 1,256 units are directly managed by BC Housing.

Type of Housing	Number
Directly-managed by BC Housing	767
Non-Profit	181
Rent Supplement (private landlords)	308
Total	1,256

Twenty-six (26) non-profit housing providers have formal agreements with the HSP, mostly in the Lower Mainland, but also in other parts of the province. All units in the non-profits are self-contained. Typically, a non-profit offers a specific number of units for the HSP's target population integrated throughout its building(s). Units are not designated for an HSP tenant, but rather an applicant will be housed in the next available, suitable unit.

Private landlords also house HSP tenants, predominately in BC Housing's Southern Interior Region where there is a limited number of directly-managed housing units. Private landlords housing HSP tenants are generally tolerant and accepting of people with mental illness. The housing is often for five or less individuals and there is usually some shared common space, although some units are self-contained.

Services

The HSP does not provide direct service. Rather it liaises with health care providers and relevant community resources to ensure the necessary supports are in place.

The Health Service Coordinators provide the following services:

- **Housing** to tenants who have met the program's criteria;
- **Consultation** to assist tenants who are not placed by the HSP who exhibit signs and symptoms of mental illness, behavioural problems and other health issues and to ensure that adequate support services are provided for tenants to maintain their tenancy. (If a non-HSP tenant in need of support has a case manager, the HSP will relay concerns about the tenant to the case manager who then assumes responsibility for follow up. If that tenant has no case manager, the Health Services Coordinator meets with the tenant to determine the cause of the behaviour and connect the person to appropriate community resources needed to maintain their tenancy.
- **Education** to assist housing staff in understanding mental illness and related issues, and to provide specific skill training to enhance staff effectiveness in relating to tenants who may have a mental illness and/or behavioural problems;
- **Support** during traumatic events to housing staff and assessing the need for further intervention to staff who have been exposed to traumatic events; and
- **Facilitation** of community partnerships programs with health authorities to enhance service delivery to tenants and to increase the sense of community within the building.

Cumulative Activity by the HSP to June 2004

Type	Number
Consultations	4229
Education	97
Critical Incident Stress Management	32

Tenants housed at **Rainbow Lodge** through the HSP program have case management services from a mental health provider (mental health team, private psychiatrist, or GP) who is responsible for their medications. There are also other support services like Meals on Wheels and Cluster Care[9]. A Community Living Support worker from Langley Stepping Stone Rehabilitative Society offers services such as employment assistance, money management and assistance with life skills[10] A counsellor attached to the Langley Mental Health unit runs a monthly substance use group at Stepping Stone.

HSP tenants connected to **Langley Mental Health** develop a Care Plan like all LMH clients. Case managers monitor the tenant's medications, physical health, and visits to the psychiatrist. LMH also offers:

- A leisure access counsellor (recreation therapist);
- An occupational therapist who conducts a life skills assessment;
- Janitorial staff to clean suites should the suite become disorderly; and
- A training apartment for clients where they can spend 1-2 weeks in a very structured situation to assess life skills before placement and prepare them for being housed independently. Funding for the apartment is through SIL program, but it can be used for someone who is going into Rainbow Lodge.

If a client is also physically disabled, the Mental Health Team can arrange for home support. A few clients who began receiving home supports when it was offered to those with a mental illness but no physical disabilities now continue receive this support, but new clients are now unable to access the service.

LMH also offers Assertive Community Treatment (ACT). Only 2-3 people at Rainbow Lodge receive ACT.[11] If a LMH client is exhibiting behaviours that might make intervention necessary, case managers will prepare staff at After Hours Emergency Services. Staff at Rainbow Lodge will also be notified.

There are no specific services delivered in public areas at Rainbow Lodge, although this may change in the near future.

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[9] Due to the concentrated numbers of units housing seniors, two buildings at Rainbow Lodge were chosen as a pilot project to have full time home support staff on site. This saved on travel time and allowed fewer staff to support more persons in need of care. The most important feature of this pilot project is that the worker can vary time spent with a resident, allotting the most time with those who are the most ill. The project proved so successful it has now been made available to all the buildings at Rainbow Lodge.

[10] Approximately half of Rainbow Lodge HSP residents are connected to Stepping Stone. The organization provides a psychosocial rehabilitative program to adults recovering from a mental illness.

[11] ACT is a program of Mental Health Services that provides flexible, comprehensive and intensive services to individuals with complex needs, including mental illness.

Access to housing

Tenants are referred to the HSP from Mental Health teams, affordable housing providers, and/or BC Housing's applicant registry. If an applicant to BC Housing indicates a mental illness or a disability that may impact level of functioning, he/she will be interviewed for housing by staff of the HSP.

The HSP provides a four-page client referral document to be completed by the case manager, GP or private psychiatrist, containing the person's medical history, supports, and medications. (The client signs an authorization for release of information so that the case manager can forward the information to HSP).

The Health Services Coordinator then meets with the client to complete an assessment of the individual's activities in daily living (cooking, shopping, budgeting skills, etc.) and determines if the unit is suitable for the client. If not, if, for example, the client needs a higher level of support, HSP will work with the case manager to find alternative housing.

Rainbow Lodge will notify the HSP if they have a vacancy in one of their units that they would like to fill through a referral. The HSP contacts Langley Mental Health, and they will suggest two clients to be interviewed for the vacancy, chosen on a needs basis from their wait list. The HSP then contacts the clients' Case Managers to arrange the interviews. After the assessment indicates the applicant is qualified, Rainbow Lodge conducts an informal interview while showing the applicant the unit. The final decision is made by the HSP and the client, with input from LMH and Rainbow Lodge.

Rainbow Lodge is not required to house HSP residents strictly from the LMH wait list. People under 55 with mental health challenges who are not connected to LMH may also be housed. They may be patients of a private psychiatrist or GP and may be referred to Rainbow Lodge through other channels.

Eligibility

To be eligible for housing through the HSP, clients must:

- Meet the eligibility requirements of BC Housing (if below the age of 55 years, must be in receipt of a disability income);
- Be diagnosed with a mental illness, or health related disability that impacts their level of functioning;
- Have clearly demonstrated the ability to live independently (may require minimal supports to do so);
- Be involved in a constructive activity on a regular basis;
- Agree to maintain regular contact with health services provider, if appropriate; and
- Agree to accept community support services, if required and available, to maintain a successful tenancy.

To be placed in the unit of a non-profit housing provider, the applicant must also meet that organization's criteria. Those that are deemed to be insufficiently housing ready may be asked to enrol in life skills training or referred to other agencies that provide a more supported housing environment.

Expectations

There is no formal agreement between HSP and the tenants it houses, but there are expectations that:

- The tenant is supported by Mental Health services or other community health services and that they are accepting of these supports; and
- If these supports are discontinued, it is by mutual consent of all parties.

Wait list

BC Housing maintains a registry for all its housing, but there is no specific waiting list for the HSP. Mental health teams maintain their own wait lists and they make referrals directly to the HSP.

Rainbow Lodge has a wait list of over 300 persons under 55 with disabilities who require housing. When a unit becomes available, they fill it either through the LMH wait list or their own.

Policies and issues

Living in a non-profit housing unit is no different than living in an apartment in the private rental market regulated by the *Residential Tenancy Act*. Units are mainly self-contained. As such residents are entitled to privacy and freedom to make their own choices. All tenants housed by BC Housing sign a crime free addendum.

If an HSP's tenant's behaviour becomes problematic and disruptive to other tenants, and this cannot be resolved, then steps are taken to end the tenancy. If the health and safety of other tenants is jeopardized then the landlord may have no option but to move to evict the individual. Rainbow Lodge does not permit drug dealing on the premises. In some cases they have had to evict or call in the police.

Termination

To avoid an eviction, attempts are made for early intervention before the situation escalates and reaches a crisis. Current community health service providers are informed and enlisted to assist the tenant. Tenants are involved in the process, to make them aware of the consequences of their actions. If a tenant needs to enter a residential treatment facility or a hospital, the housing provider will hold the unit for a reasonable period of time so long as the rent is paid. Rents are often paid directly from the Ministry of Human Resources to BC Housing or the non-profit. In such cases, the Health Service Coordinator connects with the tenant's case manager or hospital social worker to ensure that rent payment continues. The Health Service Coordinator will also liaise with the building manager to ensure he/she understands that the individual is still a tenant.

Evictions are handled on a case-by-case basis. The HSP will support the arbitration procedure when it is necessary to evict, but LMH will most likely intervene to help avoid eviction.

Costs and Funding

The Adult Mental Health Division of the Ministry of Health funds the Health Services Program through an annual budget. The funds pay for staff, travel costs, and education.

Most tenants of the HSP pay 30% of income. Those receiving BC Benefits pay the shelter allowance. If necessary, BC Housing provides a subsidy to cover the difference between what the tenant can pay and the unit's rent.

Lessons learned

Outcomes

BC Housing measures success of the HSP program by:

- Longevity of tenancy;
- People maintaining their housing; and
- The total number housed over the life of the program and those remaining in housing.

HSP residents have left their tenancy for reasons that include: marriage, receiving unexpected funds, and re-entry into the work force enabling the tenant to afford accommodation in the private market.

While there has not been a formal evaluation of outcomes, a service delivery review of the HSP was completed in January 2003.[12] The review involved interviews with non-profit housing providers and health authorities. Results indicated a high level of satisfaction.

Among the non-profits, the greatest area of satisfaction focussed on the HSP staff's willingness to listen, and their ability to resolve issues. Staff were cited as knowledgeable, informed, reliable and resourceful. The areas of least satisfaction indicated a greater need for consistency of treatment among different groups, a clearer mandate on priorities and a desire for more training and education. Stakeholders perceived that a lack of resources were a barrier preventing well-meaning staff from fully delivering the program.

Rainbow Lodge measures success as the ability to provide Langley with affordable housing for local residents. Many residents housed under the HSP are thankful to live affordably in their own unit yet still participate in the community. Long-lasting friendships have been formed and many of those who tended to live in isolation have begun to socialize. A number of residents whose previous tenancies tended to be short-term have lived at Rainbow Lodge for many years because of the supports, the tolerance of odd behaviour, the payment programs for missed rent etc., and the camaraderie formed between themselves and many of the staff.

At **Rainbow Lodge** Tenants who have come in through the HSP are thankful for an apartment of their own and their own improvement. When other tenants raise concerns

[12] *BC Housing Health Services Program: Service Delivery Review, Assessment Report,* January 2003

about HSP tenants, Rainbow Lodge attempts to diffuse the situation. Some staff do not support putting mental health clients into the tenant population.

Challenges

The HSP faces several challenges.

- Limited participation by non-profit housing societies. The program has not reached original targets for participation.
- The stigma associated with mental illness.
- Placing younger mental health clients in what is mainly a seniors complex is not a perfect fit.
- The difficulty in finding units for single young people.
- The number of individuals with a mental illness requiring housing is increasing.
- Community support services are being curtailed – e.g. housekeeping and laundry services for individuals with a mental illness have been reduced.
- Strange behaviours from some mental health clients can be unsettling for other residents, making it difficult to integrate them into general population. The mental health team must be attentive that clients are taking their medications and that other aspects of the client's care plan are being met.
- The need for post-placement follow-up care is increasing.
- Housing providers require more training to be able to effectively deal with the increasing number of tenants with a mental illness.

At **Rainbow Lodge** the following challenges were identified:

- The initial mandate of Rainbow Lodge was to house seniors. Many seniors can now afford better accommodations and prefer units larger than a bachelor. This leaves Rainbow Lodge with an increasing number of units filled with people under age 55 with either mental or physical difficulties. Rainbow Lodge finds itself evolving into a provider of housing for individuals with complex needs and this can cause conflict with other tenants.
- There is a question of saturation, i.e. how many mental health clients can Rainbow Lodge absorb?
- While the Board of Rainbow Lodge now generally supports the change in direction to house individuals with complex needs, some staff members are still uncomfortable with the new mix of tenants.
- By having its own wait list, Rainbow Lodge sometimes finds itself in conflict with Langley Mental Health as to which client has the highest need for housing. People seeking housing at Rainbow Lodge can apply with the staff member responsible for Tenant Relations. This contact can create the compassion that then becomes the deciding factor in selecting which applicant fills the vacancy.
- Tenants who stop taking their medication or refuse to become connected to a mental health team.

Reasons for success

According to those interviewed, there are several reasons for the success of the HSP partnership:

- The program fulfils a need of the clients for support services as well as housing;
- The established relationship with external partners like Community Health and other agencies to provide ongoing support to the client;

- Housing providers prefer clients referred by the HSP because support services are in place;
- Flexibility and adaptability, i.e. the ability to be creative to come up with innovative housing solutions. *"Never be surprised about what comes up."*

Rainbow Lodge offered these reasons for success as specific to its participation in the program:

- The support given to Rainbow Lodge by BC Housing and the LMH Team. *"Couldn't do it without them."*
- There are regular meetings between partners.
- The program successfully houses people who previously were forced by financial circumstances to live with unacceptable roommates, such as a substance user.
- That Rainbow Lodge, which was housing people over 55 through its own intake who were not revealing their mental health problems, now has a program that can support these tenants as well as the HSP-placed tenants.

Langley Mental Health identified Rainbow Lodge being close to the LMH Centre and amenities in Langley City as a success factor.

For the HSP to succeed, housing providers need to have a good working relationship with their Board and with the Mental Health Team and need to seek 100% support of staff by ongoing formal training and in-house workshops. As well, the program benefits from having a single liaison person from the Mental Health Team.

Contacts

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Additional Sources

- *BC Housing Health Services Program: Service Delivery Review, Assessment Report,* January 2003
- Brochures:
  - *Health Services Program*, BC Housing,
  - *Addiction Recovery Program*
  - *Rosewood Outreach Service Enrichment Project*
  - *Grandview Community Program*
  - *Star Office: Providing Outreach Services to the Tenants of Sunset Towers*
- Agreement Form between the Program and the non-profit society
- BC Housing Health Services Referral List form
- Client Referral form
- Tenant Referral form, for listing reason for referral, action taken, etc.
- ADL Assessment form for assessing applicant or tenant's functional abilities
- Form for Authorization for Release of Information on an applicant or tenant, to be signed by the individual
- Websites:
  - www.bchousing.org

#3 Seymour Place, Vancouver, BC

Introduction

Seymour Place is a 136 unit, twelve-storey apartment tower in the Downtown South area of Vancouver providing housing to low income urban single individuals. It was developed by the Affordable Housing Non-Profit Rental Association (Affordable), which manages the building.

Seventy supported units are reserved for individuals with complex needs who are living with a mental illness or HIV/AIDS. Located at ground level is a two-storey drop-in Resource Centre, managed by the Coast Foundation Society (Coast) for people living with a mental illness in the Downtown South area.

The building is on land owned by the City of Vancouver that was leased to Affordable. It was built with funding from a component of the provincial HOMES BC program called Low Income Urban Singles (LIUS). Vancouver Coastal Health is another funding partner. The building opened in 2000.[13]

Seymour Place was the first LIUS partnership that involved a housing provider (Affordable), service agencies (Coast and McLaren Housing Society) and Vancouver Coastal Health. Vancouver Coastal Health currently has partnerships similar to the one at Seymour Place with four other buildings.[14]

Partnership at a glance	
Description	Non-profit housing and service providers house low income single people in a 136 unit building. Seventy of the units are reserved for individuals with a mental illness or HIV/AIDS who receive support. A mental health Resource Centre is on site.
Partners at Seymour Place	• Affordable Housing Non-profit Rental Association • Coast Foundation Society • McLaren Housing Society • BC Housing • Vancouver Coastal Health • City of Vancouver
Goals	Provide safe, decent, affordable, housing for low-income urban single individuals; and provide housing and support to single individuals with challenges such as mental illness and HIV/AIDS.
Target Population	Low income urban singles: Some with mental illness Some with HIV/AIDS
Number of Units	136 (70 reserved for individuals requiring support).
Factors for success	• A relationship of mutual trust between partners • Having project champions • BC Housing included the outstanding mortgage of the Resource Centre in with the residential building and the City agreed to step in if Coast is forced to default on the mortgage for the Centre.
Location	Vancouver, BC
Date implemented	2000

[13] Low income singles account for almost half of households that pay 50% or more of their income for rent, putting them at risk of homelessness. LIUS developments provide affordable housing for this group. www.bchousing.org/

[14] These include Powell Street and 40 East Hastings St, with Triage Emergency Services and Care Society (service provider) and the Main and Hastings Housing Society; Candela Place, with More Than a Roof Society (housing provider) and Coast (service provider), and Veteran's Manor, with Triage.

Goals

The goal of Seymour Place is to house low income urban single individuals, especially those being displaced from SROs and rooming houses in the Downtown South area, in safe, affordable, decent housing. The goals of the supportive program at Seymour Place are to increase housing stability, reduce hospitalization and emergency room visits, support patients to maintain treatment connections, support other tenants in the building and help the housing provider feel more comfortable in providing housing for this target population.

Background

For many years social housing development in the Greater Vancouver Regional District focused on serving families, seniors and the physically disabled. Few developments were designed for low-income single individuals. BC Housing and other agencies realized that there was a great need for this population. Many had been homeless one or more times in their lives and transience was common. As well, many low-income urban single people were paying rent that was higher than their BC Benefits shelter allowance, leaving them inadequate funds for other needs. It was also determined that to effectively respond to the lack of affordable housing for this population, a range of support services must be offered in addition to housing units.

The City of Vancouver purchased the site of Seymour Place in 1996 to develop housing for low income urban single people who were being displaced by the redevelopment of Single Room Occupancy (SRO) hotels and rooming houses in the Downtown South.[15] The City selected Affordable to sponsor the project.

The 1999-2000 Homes BC program authorized the construction of 700 LIUS units However, this was strictly a housing program and did not include support services. Services would have to be provided through partnerships.

Vancouver Coastal Health had noticed that housing providers tended to choose the most stable clients for their units and passed over those with more complex needs. Seymour Place, and other projects like it, allowed a housing provider to dedicate units to this population and the Health Authority to assist by providing funds for support services in the form of a Community Support Worker. Coast joined the partnership because it was looking for a permanent site for its Resource Centre. The Centre had been having difficulty finding a location in downtown Vancouver and at the time of the development of Seymour Place was temporarily operating from an interim site, in another city-owned property.

[15] A 1998 survey by the city's Housing Centre found that, in the previous two years, the Downtown South had the largest decline in low-income housing stock of all downtown neighbourhoods. Seymour Place was designed to replace *all* SRO and rooming house stock in the area lost between 1991and 1998.

Partnership

Partners

Affordable Housing Non-Profit Rental Association

Affordable Housing Society was founded in 1982 and is one of BC's largest non-profit housing providers.

Coast Foundation

Coast Foundation Society was founded in 1974. It seeks to promote the restoration of health, personal growth and a return to society for consumers of mental health services and provides practical and pragmatic help such as housing, jobs, community, rehabilitative social and recreational opportunities, food, clothing and basic life skills training.

McLaren Housing Society

McLaren Housing Society is a non-profit organization providing safe, affordable housing to men, women and families who live with HIV/AIDS and are in financial need but able to live independently.[16]

BC Housing

BC Housing is a provincial crown agency that develops, manages and administers a wide range of subsidized housing options across the province. By March 2002, six developments (497 units) of LIUS housing had been completed in Vancouver through the HOMES BC program, managed by different housing providers.

Vancouver Coastal Health

Vancouver Coast Health serves over one million people, (25% of BC residents) and covers the North Shore/Coast Garibaldi, Vancouver and Richmond.

City of Vancouver

The Housing Centre of the City of Vancouver is responsible for housing programs, policy and research. Its focus has been on the provision of social and rental housing to meet the needs of lower income households in the City.

Planning

During the development phase of Seymour Place, Affordable submitted a proposal to BC Housing for 100 units of which 50% were to be bachelor units. At the time, BC Housing was not supporting the development of bachelor units due to vacancies in seniors' buildings with such units. However, Affordable eventually convinced BC Housing that people being displaced from SRO hotels would find bachelor units accommodating. BC Housing then agreed to allocate funding based on a project with 50 bachelor and 50 one-bedroom units, but to allow Affordable to provide a greater percentage of bachelor units if Affordable remained within the allocated annual subsidy budget and if the bachelor units were well designed for liveability.

[16] www.mclarenhousing.com/

During negotiations, the City of Vancouver suggested that Coast move its Resource Centre to Seymour Place. Once Affordable accepted the idea of the Resource Centre in its building, it was decided that a certain number of units should be reserved for Coast clients supported by the Resource Centre.

Affordable and the City continued to explore replacing one-bedroom units at Seymour Place with bachelor units to provide housing for as many people as possible being displaced from area SROs. Based on the annual subsidy budget allocated by BC Housing, Affordable determined that 122 mostly bachelor units could be built at Seymour Place. However, zoning for the site allowed for an additional floor of 14 more units. Because the structural and mechanical systems were much the same whether 122 or 136 units were built, the cost of the extra floor was about half of what it would otherwise have been. Affordable then pursued funding through the Vancouver Health Board (now Vancouver Coastal Health), for subsidies for an additional 15 units for individuals who would receive Supported Independent Living Program (SILP) funding.[17] With SILP funding, Affordable was able to add the final floor, increasing the number of bachelor units to 126, and the total number of units to 136. A total of 30 units were assigned to Coast for mental health clients. An additional 20 units at Seymour Place were designated for people living with HIV/AIDS referred and supported by the McLaren Housing Society.

Implementation

The relationship of the partners to Seymour Place is:

Partners	**Nature of the partnership**
Affordable	Housing developer, building owner, landlord
Coast	Design input, development of Resource Centre, select and support 30 tenants who are mental health consumers
McLaren	Design input, select and support 20 tenants who are living with HIV/AIDS
BC Housing	Funder • Capital costs of the project • Monthly ongoing operating rent subsidies for 121 units
VCHA	Funder • Monthly rent supplements for 15 units (SILP), • Resource Centre's share of mortgage and operating expenses
City of Vancouver	Provided the land at no cost through a 60-year lease

[17] "The Supported Independent Living Program (SILP) is a partnership between BC Housing, the Ministry of Health and the health regions. SILP is a supported housing program that enables people with severe and persistent mental illness to live independently in affordable, self-contained housing. The Adult Mental Health Division of the Ministry of Health funds the shelter component of SILP. Vancouver Coastal Health and the Vancouver Island Health Authority are responsible for administering the Rent Supplement portion of the SIL program in their regions. Staff from mental health centres, located across the province, select participants for the SILP program." www.bchousing.org/Applicants/Rent_Supplements.asp#T3

There are a number of formal agreements between partners at Seymour Place. These include agreements between:

- Affordable and BC Housing for 35 years of monthly rent subsidies for 121 units;
- Affordable and Vancouver Coastal Health for monthly rent supplements for 15 SILP units; and
- Coast and Vancouver Coastal Health whereby the health authority will cover the Resource Centre's share of the mortgage and common operating expenses for a minimum of 10 years.

Coast has an obligation at Seymour Place to identify suitable tenants for 30 units in a timely manner, and provide support services or assist the tenant to access support services as needed. Suitable tenants are considered those who pay their rent on time, maintain their suite to a reasonable standard and do not affect other tenant's right to quiet enjoyment.

The Resource Centre has a sublease from Affordable to Coast for a 60-year term at nominal rent.

Initiative

Who is served

Seymour Place provides 136 units for single individuals and a few couples. Men occupy 66% of the units, women, 33%. Approximately 1% of residents are transgendered individuals. Seventy units are designated for mental health consumers (50) and people living with HIV/AIDS (20). These individuals are integrated throughout the building.

Reserved Units

Number of units	Assigned to	Selected by	Supported by
15	Mental Health Consumers	Coast	Coast, with funds from the SIL program
15	Mental Health Consumers	Coast	Coast
20	Mental Health Consumers who are Members of the Resource Centre	Affordable (through its normal intake process)	Coast
20	People living with HIV/AIDS	McLaren	McLaren
Total: 70			

All 30 tenants placed by Coast have a significant and serious mental illness including 60% who have concurrent disorders. The 20 tenants placed by Affordable are members of the Resource Centre and are connected in some way, either to a GP, a psychiatrist, or a Mental Health Team. There are likely other tenants in the building with mental illness who have had no formal diagnosis and are not connected. There are no formal arrangements with either transition houses or the criminal justice system, but some tenants will have been their clients.

Housing and services

All 136 units are self-contained, permanent non-profit housing. There are 126 bachelor units. Of these, 117 are 340 sq. ft., and 9 are 400 sq. ft designed for occupants who use a wheelchair. There are 10 one-bedroom units approximately 675 sq. ft. designed for couples.

A majority of the tenants initially moved into Seymour Place from SRO hotels. As such they owned little furniture and the units were designed accordingly. The full kitchens have a built in dining counter and include bar stools, and Affordable supplies a sofa bed for each unit. Originally, the building design included balconies, but it was determined that unit sizes could be increased by incorporating the balconies into the interior floor space and providing, instead, a French balcony. Amenities include a top floor suite connected to an outside roof deck for the use of all tenants and their guests, a larger second floor amenity space for meetings and social gatherings and a TV room off of the laundry room.

The Resource Centre occupies 10,877 square feet on the ground and second floors. It contains a kitchen and dining room, spaces for socializing, a library and computer room, as well as office space.

Services

Vancouver Coastal Health tries to contract for sufficient units to allow for a 1.4 FTE Community Support Worker per building to cover the 7-day week. The support workers try to work flexible hours, including evenings. They are not case managers, but offer practical assistance, e.g. money management, getting to appointments, and keeping apartments operating and clean. Case management in this program is supplied by the tenant's connection to a mental health team, GP or private psychiatrist, whose services include medication management. Tenants with addiction issues must be connected to a Vancouver Coastal Health addictions counsellor.

Coast provides the 50 tenants that are mental health consumers with services such as meals, vocational programs, and/or a homemaker. These services are mainly delivered through the Resource Centre.[18] Some tenants receive the services of the Assertive Community Treatment (ACT) team.[19] If a resident needs intervention during those hours when a mental health worker is not available, the on-duty manager has been trained to assess the situation and if required to phone Car 87. [20]

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[18] NB.: The Resource Centre in Seymour Place provides service to 2000 people per month (in 2004). 230 people/day eat there. This is an increase from 50/day when the Seymour Place opened. The meals served are a hot breakfast and a lunch for $1.00 each, and a free snack. As well as the meals and outreach services, the centre offers free laundry services and showers, member-run programs such as a food store, donated clothing and special events and social programs. Those accessing the Resource Centre must have an assessed mental illness and go through a member intake process.

[19] Assertive Community Treatment is a program of Mental Health Services which provides flexible, comprehensive and intensive services to individuals with complex needs, including mental illness.

[20] Car 87 is a joint service between Mental Health Services of the VCHA and the Vancouver Police Department. A Psychiatric nurse and a plain clothes police officer who undertake site assessments seven days a week until 0330 hours.

Other services that Coast funds and delivers to tenants who are mental health consumers are set out below:

Types of Service	Nature of services
Substance use	Dual diagnosis anonymous group meets once a week at Resource Centre; also a program for issues around concurrent disorders.
Employment assistance	The Resource Centre accesses employment opportunities. Coast has a landscape business and tenants may work there. Coast will refer tenants to its main clubhouse where there is a wide range of services.

Money management and assistance with life skills are a daily occurrence between the tenant and the SILP Community Support Worker.

An advantage of the SILP funding is that it allowed for a Community Support Worker to be stationed at Seymour Place, working out of the Resource Centre. The CSW can also assist tenants who are not placed through the program but who are experiencing possible mental health difficulties.

Access to housing

Affordable selects tenants using the Housing Registry[21], by word of mouth, and through various referrals. As well, potential tenants can contact the building manager, fill out an Application For Tenancy form and place their names on the wait list.

When Seymour Place first opened, Coast selected its 30 tenants using a similar criteria as Affordable, i.e. individuals who were displaced in the Downtown South by redevelopment. Now, when a vacancy occurs, Vancouver Coastal Health refers an applicant. Coast has a right of refusal. Coast is responsible for the completed Application for Tenancy, and Application for Rent Subsidy forms, any documentation arising out of an application for SIL funding, and reference and credit checks for the clients it supports. Coast supplies Affordable with a written record of their findings on a potential tenant. Any concerns by Affordable about a client chosen by Coast are discussed with Coast. Affordable may interview the applicant with Coast before making a decision on a possible rejection. Once a Coast applicant is accepted, Affordable meets with them to complete a tenancy agreement.

Vancouver Coastal Health manages a waiting list for mental health clients (known as the Mental Health Housing Services waiting list). There are 700 mental health clients on this list who are waiting for housing. Housing providers involved with Vancouver Coastal Health are required to choose mental health clients from this list. There is a specific wait list for Seymour Place. Vacancies are filled on a needs basis.

[21] The Housing Registry is a partnership that includes BC Housing, the BC Non-Profit Housing Association, the Co-operative Housing Federation of BC, non-profit housing providers, housing co-ops, Lower Mainland municipalities, information and referral service groups, and other community based organizations. Among other services, it maintains an up-to-date database of applicants. http://www.bchousing.org/Housing_Registry/

Eligibility

Seymour Place is a Lower Income Urban Singles (LIUS) building. BC Housing lists the criteria for eligibility at LIUS buildings as:

- Adults at risk of homelessness because of the conversion or demolition of single room occupancy (SRO) hotels, motels, and rooming houses particularly in large urban centres;
- Adults without dependent children. (Some LIUS developments have a few family units. In these cases, households with children may be eligible.)
- Applicants must also be under the Core Need Income Threshold and unable to afford or obtain adequate and suitable accommodation.

Coast requires that the tenants it selects have a serious and persistent mental heath issue. Preference continues to be given to individuals from the Downtown South area.

Expectations

Tenants not supported by Coast must be able to live independently. They receive no formal supports in conjunction with their housing.

Coast's tenants must maintain support with a GP, psychiatrist or mental health team to manage their medications. They are encouraged to seek other support, but there is no requirement to do so.

Policies and issues

Substance use issues

All tenancies at Seymour Place fall under the *Residential Tenancy Act*. As well, tenants sign an Addendum for Crime-Free Housing, which prohibits, amongst other things, "(A)ny drug related criminal activity." As building manager, Affordable is proactive in preventing dealers from operating in the building and victimizing tenants. Those with a mental illness may be especially vulnerable to being preyed upon.

Temporary absence

Any tenant temporarily absent from the building needs to make arrangements to continue paying rent. BC Housing's policy is that a tenant cannot qualify for a rent subsidy if they are absent for more than a three-month period. Affordable enforces this policy. If a Coast tenant enters a residential treatment program or is temporarily hospitalized the rent is maintained for at least three months through social assistance. Extensions are possible. 99% of Coast-supported individuals are able to keep their unit while away for treatment.

Termination

Violations of the Crime Free Housing Addendum may be cause for eviction. Grounds for eviction are contained in the *Residential Tenancy Act*. However eviction is the last resort. Coast and McLaren work with Affordable to provide additional support to tenants to avoid eviction.

If the building manager has a concern with one of the Coast's tenants or one supported by the Resource Centre, he will approach the Community Support Worker. He will know which tenants are supported, but details concerning the individual are given to the building manager only on an as-needed basis to maintain the individual's right to privacy.

Costs and Funding

Capital costs

BC Housing funded the cost of construction ($11.7 million) through its HOMES BC program, including the Resource Centre.

One of the more complex challenges facing Coast was financing the Resource Centre. The Resource Centre was an ineligible space through HOMES BC, i.e. it far exceeded the normal amenity space allocation for a social housing building. Affordable and BC Housing agreed to include $1.2 million of the $1.7 million cost of the Resource Centre in the mortgage for the residential project. Coast then signed a lease arrangement with Affordable to repay the $1.2 million over the 35-year loan amortization and it raised the remaining $500,000 through donations. As well, the City of Vancouver agreed to step in and assume the lease payment if Coast, for whatever reason, is forced to default. Coast fund-raises to cover part of its lease payment.

Operational Costs for Seymour Place

Funder	Responsibility
Coast	• Responsible for lease payment on the Resource Centre of $89,000 per annum • Fund raises $250,000/year for operational costs for the centre
BC Housing	Funds the rent subsidies of $361/unit/month for 121 units
Vancouver Coastal Health	• Provides Coast with annual funds to cover the Resource Centre's mortgage and common building expenses for a minimum ten years[22]. This is approximately $122,000 per year. • Funds the rent supplements of $361/unit/month for 15 units (SILP funding) • The Community Support Worker is funded through SILP.[23]

The City of Vancouver forgave Affordable the 60-year prepaid ground rent for the site amounting to $1,275,000. Affordable then passed on to Coast the benefit of the City's forgiveness of ground rent for the resource centre, worth approximately $175,000.

[22] Generally, agreements are year to year, but agreements for this program are with recognized service providers and so in effect they are continuous and only terminated for some cause, such as the provider is not fulfilling the terms of the contract. Seymour Place is unusual in that the agreement is for a ten-year period, and was specific to this building.

[23] At Seymour Place, the Community Support Worker is funded through the SIL program but in the other six LIUS projects the support worker (1.4 FTE per building) is funded by Vancouver Coastal Health through its Supported Housing Program.

Unit charges

Residents pay $290 per month, which amounts to the shelter allowance of $325 less a utility allowance, or they pay 30% of income. They cover their own costs for hydro, telephone and cable.

Lessons Learned

Outcomes

Vancouver Coastal Health expects service providers to be accredited or self-monitoring. However, it is currently working on key performance indicators for this program that can be monitored over time. These are expected to be in place by April 2005. One indicator will most likely be a tenant satisfaction survey.

As well:

- In 2002 BC Housing conducted a LIUS review that included residents of Seymour Place. High satisfaction rates for the LIUS housing were reported in this review (91%), though it is not possible to extract data for Seymour Place alone. As well, 75% of residents who responded to the review stated that moving into the new housing had increased their ability to meet basic needs.[24]

Outcomes at Seymour Place	**Examples of changes since resident housed**
Residential stability	About 70% of all tenants have been there since the project began.
Substance use	A good proportion of the tenants with dual diagnosis have worked either with their mental health team or with other dual diagnosis supports in the downtown area.
Mental health	90% of Coast's 30 tenants are working consistently with the primary mental health support provider.

Neighbourhood response was non-existent. Seymour Place was one of the earlier new buildings in the neighbourhood. Most of the condominium towers were not yet in place to give rise to any NIMBY response.

Challenges

Partnership challenges:

- Each partner comes to the table with different mandates and values, and these must be reconciled. There is the potential for loss of insight as to the roles of the various partners. Mutual respect and appreciation is necessary.
- All partners must commit to the agreement as well as provide financial stability and adequate resources to the project.
- Good risk assessment skills are needed to alleviate the possibility of any funding shortfalls.

[24] Copas, Jason, *An Examination of Housing Options for Low Income Singles in Vancouver,* prepared for BC Housing, the City of Vancouver and the Vancouver Coastal Health Authority, 2002.

Other challenges:

- The project must clearly identify its target population and not segregate this population into a “program” which immediately labels them.

Reasons for success/ lessons learned

Affordable and Coast identified the following reasons for success:

- A project of this size involved credible, competent and experienced partners. The relationship between the partners was one of mutual trust.
- The partners had the staff required for a partnership and project of this type and magnitude.
- The project had champions. The City played an important role with their ability to envision and promote a largely untried project. Vancouver Coastal Health came to the table with funding for 15 Rent Supplement units.
- With regard to the Resource Centre, BC Housing included the outstanding mortgage with the residential building and the City of Vancouver agreed to step in if Coast is forced to default on the mortgage for the Centre.

Vancouver Coastal Health believes this project and the other similar LIUS partnerships have:

- Expanded the capacity of the health authority to serve individuals with complex needs;
- Allowed individuals to be integrated into a mainstream housing option;
- Helped housing providers feel more comfortable housing the target population; and
- Helped to debunk myths about the mentally ill.

As well, the support worker allows for more potential for intervention if required. The worker is on site and is able to alert the case manager.

Lessons learned

Affordable and Coast both emphasized that partners in a project such as this must:

- Formalize relationships and roles through the development period.
- *“Spend more time than you think you need”* discussing the arrangement and capturing it on paper, because the unexpected inevitably occurs over the course of the project.
- Maintain open lines of communication throughout the development phase and once operations have commenced.
- Ensure that agreements, such as the one defining the usage of the Resource Centre, are flexible enough to respond to changes in the needs of local residents and required community services over time.

As well, it is important to schedule regular meetings between partners, at least quarterly, once the project is operational.

Contacts

Organization	Address	Telephone/Fax/E-mail
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Additional Sources

Residential Tenancy Agreement Addendum for Crime Free Housing

Letter of Agreement between Affordable Housing Societies, Coast Foundation Society, The City of Vancouver, The Vancouver Richmond Health Board and BC Housing.

www.city.vancouver.bc.ca/ctyclerk/cclerk/990504/a1.htm

www.mclarenhousing.com/

www.bchousing.org/Housing_Registry/

http://www.bchousing.org/Applicants/Rent_Supplements.asp#T3

Copas, Jason, *An Examination of Housing Options for Low Income Singles in Vancouver,* prepared for BC Housing, the City of Vancouver and the Vancouver Coastal Health Authority, 2002.

Administrative Report to Vancouver City Council from the Director of the Housing Centre, J. Jessop, May 4, 1999 and Letter of Understanding addressed to Affordable Housing from BC Housing, April 9, 1999,
www.city.vancouver.bc.ca/ctyclerk/cclerk/990504/a1.htm

#4 Special Referral Agreements and Condominium Initiative to House People with Multiple Challenges – A Housing First Approach, Ottawa, Ontario

Introduction

Several housing providers in Ottawa enter into Special Referral Agreements with service agencies to make a certain number of units available to agency clients. In return, the service agencies agree to provide support to help ensure a successful tenancy.

The Special Referral Agreement described in this initiative was implemented in 2000. There were formal and informal agreements prior to that, but specific funding for this initiative was made available in 2000 through the Ministry of Health.

Partners involved in this initiative include the Canadian Mental Health Association, Ottawa Branch (CMHA), two non-profit housing providers (Ottawa Community Housing and Centretown Citizens Ottawa Corporation) and a number of private landlords.

The goals of this initiative are to:

- Take people who have a serious mental illness off the street or out of shelters and provide them with stable, permanent housing, where they can live independently.
- Integrate individuals with special needs within the community.
- Ensure that individuals receive the support they want and need to maintain a successful tenancy.
- Ensure that housing providers receive support for agency referral clients as needed.

Partnership at a glance	
Description	• Private and non-profit housing providers make a certain number of units available to the Canadian Mental Health Association, Ottawa Branch (CMHA), and CMHA agrees to provide support. Special Referral Agreements outline the roles and responsibilities of each partner.
Partners	• Service agency (CMHA); and • Housing providers (Ottawa Community Housing, Centretown Citizens Ottawa Corp., and private landlords).
Goals	Give homeless people priority access to permanent, integrated housing, and provide support to maintain a stable tenancy.
Target population	Individuals with a serious mental illness who are homeless or at risk of homelessness.
Number of units	90-92 (some variability because of budget limitations)
Factors for success	• Matching of clients to appropriate units; • High level of trust between the housing providers and service agency; • Quality of the housing; and • The level of support.
Location	Ottawa, Ontario
Date implemented	2000

Partnership

Partners

Canadian Mental Health Association, Ottawa Branch (CMHA)

CMHA is a non-profit organization in Ottawa dedicated to promoting good mental health, developing and implementing support systems and services and encouraging public action to strengthen community mental health services and related policies and legislation.

The CMHA Ottawa Branch has been targeting its services to people who are homeless since 1989. In 1997, the CMHA Board decided that all their direct services should be targeted to people who are homeless.

Ottawa Community Housing (OCH)

OCH was created from the amalgamation of the City of Ottawa Non-Profit Housing Corporation (City Living) and the Ottawa Housing Corporation in 2002. They provide affordable housing to nearly 15,000 low and moderate income households in townhouses, apartments, and rooming houses. Most of the units are rented on a geared-to-income (RGI) basis, while others are rented at or near market rent levels. Both City Living and the Ottawa Housing Corporation accepted referrals from CMHA before the amalgamation, and continue to do so as Ottawa Community Housing (OCH).

Centretown Citizens Ottawa Corporation (CCOC)

CCOC is a private, non-profit housing corporation with 30 years of experience as a dynamic and innovative community leader. They own and manage 47 properties with close to 1,300 units in the City of Ottawa. Their portfolio includes different kinds of buildings, such as duplexes, triplexes, town and row houses, and large apartment buildings. They charge a wide range of rents, with some tenants paying rent geared to their income, and other tenants paying market rents. CCOC is directed and controlled by volunteers and tenants.

Private landlords

Ten private landlords in Ottawa are participating in the Special Referral Agreement initiative and accept referrals from CMHA. Together, they are providing a total of 26 units to CMHA clients.

Planning

OCH and CCOC have a long history of partnering with a number of different support agencies. OCH estimates that approximately 300 of their units are designated to service agencies that provide some degree of support to their tenants/clients. When making their units available to service agencies, OCH and CCOC have used different types of agreements. These include:

- Agency leases – the housing provider signs a lease with the agency and the agency enters into an agreement with their client to live in the unit;
- Block leases - an entire building is leased to an agency; and
- Direct tenant leasing/special referral agreements – the tenant signs a lease directly with the landlord.

OCH (through City Living) first started working with CMHA in the 1980s, and allocated about 30 units to CMHA clients. All of these units were available using direct tenant leasing.

CCOC began working with CMHA in 1998. Following a conference on Ending Homelessness in the fall of 1997, a generous citizen donated the equity in his building, a semi-detached property, to CMHA. CMHA approached CCOC to develop and manage this housing. CMHA did not want to be a landlord but was willing to provide support. CCOC agreed to be the housing provider.[25] Working together on this project was a positive experience for the two organizations, and they expanded their previous

[25] This project serves 6 individuals with a history of homelessness and severe mental illness.

informal relationship into a more formal one. CCOC learned that it could count on CMHA if a difficult situation arose with a tenant.

In 1999, the Ministry of Health issued a Phase I Request For Proposals (RFP) as part of a Homelessness Initiative. The purpose of the RFP was to fund initiatives that would result in a quantifiable number of people being taken off the street or out of shelters and being provided with stable housing. Stable housing was defined as permanent housing. No housing outcomes were counted unless individuals stayed for at least 3 months. CMHA thought about partnering with some landlords, including CCOC and City Living so their clients could access their units. CMHA asked, "What would it take to give us some units." The housing providers said "You have great support, but it is available Monday to Friday, 9-5. When your staff go home, we have problems." The housing providers wanted services to be available evenings, weekends and during holidays.

CCOC and City Living also said that they did not want agency leases. They preferred direct tenant leasing/special referral agreements because this arrangement is consistent with the objective to separate housing from support. Both the housing partners and CMHA agree that people should be entitled to keep their housing even if they no longer require support. In addition, the housing providers wanted to have a direct and contractual relationship with the tenant. Over time, most agency leases were converted to direct leases between the landlord and tenant.

CMHA believes that the clear direction given by these housing providers was very helpful in the planning process.

In 2000, the Ministry of Health announced a second phase of funding to address homelessness. CMHA met with several other agencies to consider housing options. Capital dollars were available, but mostly for congregate housing. CMHA suggested an approach where new units could be provided but not in buildings dedicated to mental health clients. CMHA felt this was a gap that needed to be filled. However, the other agencies were not interested. CMHA did not want to be a landlord, since they are a support agency. However, since no other agencies were interested in this approach, CMHA purchased 22 condominium units for their clients. This initiative is fairly recent, with initial rent-up of the first unit occupied being July 1, 2003, and so only a few clients are approaching their first year of being housed in the condominium units.

Implementation

The Special Referral Agreement described in this profile was implemented in 2000, as a result of funding from the Ontario Ministry of Health.

The non-profit housing providers and CMHA signed a Special Referral Agreement, which outlines each of their roles and responsibilities and the number of units to be allocated to CMHA.

When a unit becomes available, CMHA, the housing provider and tenant each sign a letter of understanding which sets out the nature of the relationship between the tenant, housing provider, and CMHA. A memorandum of understanding is also signed, which explains how the rent subsidy works.

The following are the roles and responsibilities of each party to the agreement (agreement to be attached):

Service agency (CMHA):

- Identifies potential clients and refers them to the housing provider;
- Helps ensure their clients receive the services they want and need to maintain a successful tenancy; and
- Provides a rent supplement to the housing provider for the difference between the market rent and the rent paid by the tenant (funded by the Ministry of Health).

Housing providers:

- Allocate a certain number of housing units for individuals with a serious mental illness who are homeless or at risk of becoming homeless; and
- Contact CMHA if an unresolved problem arises that could affect the client's tenancy so CMHA can keep on top of the situation and avert any potential problems.

Tenants:

- Sign the lease with the housing provider and are responsible for paying rent;
- Contract with CMHA for the provision of ongoing services; and
- Acknowledge that if they dismiss their support worker, or there is a mutual agreement to discontinue support services, the support worker will continue to provide advice and support to the housing provider if problems arise with the tenancy.

One of the key features of this agreement is that a client's tenancy does not depend on whether the client continues to accept support services. If a client's need for support services diminishes or a client decides to terminate the support services, the tenancy remains intact. The lease will continue and CMHA will continue to provide the rent supplement assistance. Another key feature is that CMHA will continue to assist the housing provider in dealing with any subsequent issues that might affect the client's tenancy. For example, CMHA could give the landlord suggestions on how to approach the tenant or provide information about what has worked with the tenant in the past. CMHA would not divulge personal information. CMHA could also contact the tenant to see if they wish to receive their services.

Reasons for participating – "what's in it for me?"

CMHA wanted to secure units for their clients. There is a long waiting list for social housing in Ottawa. In addition, CMHA clients had difficulty accessing housing because they do not present well at interviews, and most of them need support.

The non-profit housing partners appreciated being able to house people who came with their own back-up support system. The Special Referral Agreement ensures that while

the individuals being housed have some challenges, they also have support. The housing providers were also aware that many households on their waiting lists have special needs, but do not have support. However, the provider may not be aware of the need for support when they offer a unit. In addition, the participating housing providers are committed to serving individuals with special needs, and believe these individuals should be integrated into their housing. For example, OCH has a target that up to 10% of units in a building should be rented to individuals with special needs.

One of the private landlords who participated in the interviews stated that when he was contacted by CMHA to see if he could make any units available to CMHA clients, he checked with some of the other landlords who were participating. Based on their input, he decided to get involved with the program. A second landlord reported that someone who answered an ad for a vacant unit subsequently became a client of CMHA. The landlord liked working with CMHA. The next time he had a vacancy he decided to contact CMHA directly. This landlord appreciates that CMHA provides a stable source of tenants who come with support.

Coordination/management

The agencies speak with each other as needed, such as when a unit is available or there is an issue with a particular tenant. There are no formal processes for ongoing dialogue.

Initiative

Who is served

This program is targeted to individuals with complex needs. This includes people who are homeless or at serious risk of becoming homeless. All individuals have a mental illness with a formal diagnosis or have patterns of behaviour that suggest a mental illness. Between 40 and 60% have a concurrent disorder (mental illness and substance use). The behaviour of some individuals can be bizarre at times, but this is not true for all clients.

Most of the tenants (close to 90%) are single men (44%) and women (44%). However, there are a few families with children (9%) and couples (2%).

Housing

All the housing in this initiative is intended to provide a permanent place to live. Almost all the units are self-contained, and are scattered (i.e. integrated within a mixed population building). There is only one dedicated building that contains, six units.[26] Two units in that project are self-contained. Tenants in the remaining four units each share a bathroom with one other tenant.

[26] This is the CCOC project referred to earlier.

CMHA itself is providing 22 condominium units for their clients.

Landlord	Number of units	Types of Units	Dedicated building or scattered units
Ottawa Community Housing	22	Self-contained 1- and 2-bedroom apartments	Scattered units, integrated within a mixed population building.
Centretown Citizens Ottawa Corp.	21	All self-contained bachelor and 1-bedroom apartments (except 4 units where tenants share a bathroom with one other tenant).	Scattered units, integrated within a mixed population building – except for one dedicated building with six units.
CMHA (Ottawa Branch)	22	All self-contained 1-, 2- and 3-bedroom units in condominiums owned by CMHA.	Scattered units, integrated within a mixed population building or townhouse complex.
Private landlords (10)	26	Self-contained 1- and 2-bedroom apartments	Scattered units, integrated within a mixed population building.
Total	91		

Services

Role of CMHA

CMHA uses outreach workers to engage individuals with a serious mental illness who are homeless or at risk of becoming homeless. The goal is to establish trust, assess need, and see if the individual would be interested in housing. This can take one day, a few months or longer. The nature of this work is considered "short-term" case management, and the service ratio is one outreach worker for about 15 clients. Most clients will be able to access some form of housing. Once the person is housed, the outreach worker continues to work with the client for about 3-6 months. Then, the outreach worker decides if the person is sufficiently connected to community resources and is able to manage without additional support from CMHA, or if the person requires longer term intensive case management support.

The goal of longer-term intensive case management services (also called community support services) is to help clients in their growth towards community integration. The service ratio is one community support worker for 12 clients. Support workers assist clients with a variety of issues, including housing, vocational/educational, social matters and treatment. Community support is long-term (it can be permanent), is comprehensive (addresses the client's needs), and is flexible (the intensity of involvement varies as needed). Services can be provided monthly, weekly or more frequently. They are usually provided at least weekly. They are offered wherever the client needs them, i.e. in his/her place of residence, and on the street, but rarely in the office. Services are portable (i.e. they follow the client wherever the client goes), and are client-directed (clients determine what is worked on). Extended hours of service are available to all clients until 10 pm and on weekends and holidays 365 days/yr.[27]

[27] Special Referral Agreement between Centretown Citizens Ottawa Corporation and the Canadian Mental Health Association, Ottawa-Carleton Branch, Appendix A, Summary of Support Services.

The following services are also provided by CMHA.

Type of Services	Nature of services
Mental health	There are 1.5 FTE mental health nurses on staff and 1 FT psychiatrist. All front line staff (e.g. case managers and outreach workers) are trained in mental health. They help clients access services in the community. The frequency of service depends on the client.
Substance use	CMHA has 2 concurrent disorder specialists. Group therapy is also available. All front line staff are trained on concurrent disorders.
Employment assistance	All front line staff work on this. There is also one FT Occupational Therapist who specializes in this.
Money management	All front line staff spend some time on this. They help with budgeting. There is no requirement for rent to be paid direct. A few tenants rent paid directly in the condominium and other units.
Help with life skills, food, transportation, clothing etc.	Front line staff work on this. There is also a recreation therapist on staff.
Other (please specify)	Front line staff do whatever is necessary to ensure their client will maintain housing. They work to get people connected to doctors and various agencies in the community.

All the funding for these services is provided from the Ministry of Health.

Some services are provided in the client's unit. Services are also available in various centres in the community. There are no dedicated spaces in the tenants' buildings for services or service providers.

Housing providers

The non-profit housing agencies provide some support for their tenants, and try to address issues themselves first before contacting CMHA. Tenant Community Workers at OCH assist with community development, conflict resolution, mediation, and help support tenant associations. If a tenant is experiencing difficulties that are beyond what housing staff can address, the housing staff will liaise with the CMHA worker to address the situation.

Access to housing

Becoming a CMHA client

In order to access housing through the Special Referral Agreement, an individual must be a CMHA client. Individuals can become involved with CMHA through several points of contact.

- Outreach workers work in different locations and talk on a weekly basis with different agencies to discuss who might be interested in services. Outreach workers may also scout the community to find people who are homeless.
- Drop-in centres, shelters, the court, Community Health Centres, and other agencies may refer potential clients/tenants to CMHA. There are formal referral agreements with all relevant shelters and most relevant other agencies.

- Individuals can self refer for services and can then become a CMHA client to qualify for housing.
- CMHA is involved with discharge planning at hospitals and hospital outreach, and can receive a referral directly from the hospital.

The outreach worker assesses the individual to determine if he/she meets CMHA's program criteria. Eligibility criteria include:

- Diagnosis – either a diagnosis of a severe mental illness or a set of behaviours consistent with this.
- Duration – the condition must have existed for some time or be a severe first episode.
- Disability – the condition must have a severe impact on the individual's level of functioning.

The outreach worker will ask the person to sign a consent form to receive services. Some people won't sign forms because they suffer from paranoia. In this situation, there are policies to obtain verbal consent. A witness is required. Even if CMHA gets a "no", they continue to be persistent in a respectful way.

Referral process

The referral process involves the following steps:[28]

1) The housing provider contacts CMHA when a unit is about to become available.

2) CMHA identifies potential clients and will forward the name of the client and the client's support worker within one week. [Time limits are necessary to avoid vacancy loss].

3) The support worker will contact the housing provider and make an appointment to bring in the client with a completed application and up-to-date income verification.

4) The housing provider ensures that the client meets their eligibility criteria.

5) Once a client is accepted as a tenant, they will sign a lease and other documents as set out in the Special Referral Agreement.

6) Each housing provider may have its own particular requirements. For example, CCOC will carry out landlord and credit checks, as they do for all their other tenants. They would not turn away a CMHA referral who had a poor landlord reference or credit history, but would determine what tools would need to be put in place to make the tenancy work e.g. rent direct or a financial management program. CCOC has an orientation session with all the tenants, and gives them as much information as possible on how to be responsible tenants and what they can expect from CCOC as a landlord.

[28] Clients who are referred from CMHA do not apply through the social housing waiting list. This is because the goal is to give priority access to the target population. In addition, the waiting list is for applicants seeking rent-geared-to-income housing. The special referral clients are housed mostly in market units. Rent supplement funding is provided through the Ministry of Health. Applicants on the social housing waiting list are housed based on chronology, and the wait is several years long.

CMHA makes every effort to match people to specific living situations. They want the tenant to be a good fit in the community. If there has been an incident in a building, CMHA will avoid referring a person there who might exhibit frightening behaviours. However, there is a need for some units where these people with can go, and CMHA will try to find the most appropriate place. CMHA finds it easiest to find placements for individuals who present well most of the time. If a person can be stable for 6 months and then have a crisis, the neighbours can see that the person "got sick", but is fine most of the time. CMHA also considers the environment. If there is a building with a lot of families, then they look for a client with a child – even if it is a child who visits. CMHA has been successful in accessing units for clients with children so their children can visit or the parent can have custody.

Degree of "housing readiness"/Expectations

CMHA does not restrict access based on housing readiness. They do not believe that clients can learn to be "housing ready" anywhere but in a permanent, independent unit. Tenants are not required to participate in any kinds of programs to be eligible for housing – nor do they have to be on medication or "compliant" with any prescribed treatment.

This is consistent with a "housing first" approach, which means that tenants are provided permanent housing regardless of their participation in psychiatric or substance abuse treatment programs. The underlying philosophy is that if clients are provided with stable and secure housing first, they will then begin addressing the other issues in their lives.

If a problem arises, CMHA deals with it accordingly. For example, if an individual starts to demonstrate challenging or bizarre behaviour, CMHA works with the tenant to minimize the harm and the way in which the conduct is impinging on others. The threat of losing their housing often works to motivate a person to take some action. Most of the time, CMHA can deal with the problems. If the person is not a danger (just having/ causing a problem), they work hard to develop a plan. If a person is a danger to himself or others, CMHA will get the person admitted to hospital.

Policies and issues

Substance use issues

The housing providers have no policies, rules, or restrictions regarding the use of substances other than what is covered by the Tenant Protection Act. The governing philosophy is that what tenants do in their own unit is their own business. The only time substance use will become an issue is if the behaviour is interfering with other tenants (e.g. lots of people coming and going, noisy arguments, and doors slamming.) Therefore, behaviour that disturbs other tenants could lead to eviction, but the simple use of drugs or alcohol would not.

Guests and visitors

There are no policies about visitors or guests other than that the person is responsible for the behaviour of their guests, in accordance with the Tenant Protection Act.

Temporary absence

If a tenant enters a residential treatment program or is temporarily hospitalized, there is no established time limit after which a tenant will lose the unit. However, the rent must be paid. Financial assistance usually continues during the time clients are in the hospital, and to date this has not been an issue.

Program demand

CMHA does not maintain a waiting list for their housing program. They refer clients based on need. If there are no units available through the Special Referral Agreement, the outreach workers will try to help the individual find a unit on the private market e.g. in a rooming house.

Termination of tenancies

The most probable reasons for an eviction include:

- Failure to pay rent;
- Causing significant disturbances;
- Interfering with the neighbours; or
- Conflict with others.

If a housing provider becomes aware of a problem, they investigate and will contact CMHA for assistance if appropriate.

CMHA works closely with the landlord and tenant to develop a plan and work out a resolution. CCOC has found that meetings with themselves, CMHA and the tenant can work well.

If a problem is with a specific neighbour or landlord, CMHA will work to find the client another unit somewhere else. On occasion, a client will be hospitalized and return to the unit afterwards.

CCOC reports that CMHA has been very helpful in moving tenants on if they aren't working out in a particular unit and after other interventions have failed. Workers actively find other accommodation. The process of working together saves time and money for CCOC as they do not need to institute legal action. It is also better for tenants because they avoid a documented history of being evicted.

Very few tenants who have been referred through the Special Referral Agreement have been evicted.

Costs and Funding

Tenants generally pay the Ontario Works maximum for rent ($325 in August 2004) or the Ontario Disability Support Program (ODSP) maximum ($414). If a tenant is working, rents will be 30% of gross income – but this happens very rarely. In the condominiums and RGI designated social housing units, rent supplement funding comes from the City of Ottawa and is based on their formulae.

In the remaining Special Referral units, CMHA, through Ministry of Health Funding, pays the difference between what tenants pay and the market rent. Also, CMHA has agreed to pay to CCOC and OCH up to 3% of the market rent for all the referral units per year to cover any bad debts, vacancy loss or damage to units.

Lessons learned

Outcomes

CMHA believes they have been successful in meeting the needs of their clients. The Special Referral Agreement initiative is consistent with the outcome of three different client surveys that CMHA conducted between 1988-1998. When CMHA asked clients what they wanted, they said they wanted independent living in an anonymous setting. CMHA is especially pleased about the quality of units they are able to provide through their condominiums. The units are a step above what the clients are used to. CMHA believes that people's self image is shaped by where they live, and that having a nice place to live has a positive impact on them.

The housing providers also believe the program has been successful because the target population is able to be housed more quickly than if they had been on the social housing waiting list (which is several years long), and most of the tenants referred have achieved a stable and successful tenancy. Most of the tenants have been with the housing providers since the beginning of the initiative in 2000.

Both CMHA and the housing providers prefer to accommodate (integrate) individuals with special needs in scattered units rather than to have entire buildings dedicated to this population. CMHA believes their clients prefer to live in scattered units. With scattered units, nobody knows if the tenant next door has a mental illness or not.

CMHA has not had the resources to devote to tracking specific outcomes of their clients who have participated in the Special Referral Agreements. A great deal of the literature from the U.S. talks about the impact of similar programs and CMHA believe the results of their program would show similar outcomes.

Measures of success	**Outcomes**
Residential stability (length of time housed)	Most of the tenants have been very stable. Some tenants have posed no problems at all and have always paid rent on time. One would never know the individual had a mental illness. Other tenants have required varying degrees of interventions. Very few tenants have been evicted (e.g. CMHA has issued only 2 eviction notices (to one client) in the condominium units. CCOC has evicted tenants from the dedicated building, but some of the issues have arisen as a result of the shared nature of the housing.
Substance use (e.g. decreased use/participation in treatment programs)	CMHA has not done a study to compare their clients who have been housed through the Special Referral Agreements compared to others on their caseload. Studies of their treatment groups show that after 9 months, people reduce substance use and have a higher quality of life. They find that if a person is in treatment, gaining access to a unit can make a significant difference.

Mental health (e.g. maintaining medication, reduced hospitalizations)	Research shows reduced hospitalization as a result of case management – housing and support.
Education (e.g. going back to school)	CMHA works on this with clients. They have a few good success stories but furthering education is not a generalized goal.
Employment (e.g. part time work)	One housing provider reported that a few tenants have secured full and part-time jobs. This has not been reported for clients in general. In 2004, CMHA hired an Occupational Therapist to help clients access employment.
Personal networks (more contact with family, new friends)	By the time CMHA comes into contact with clients they have often been alienated from their families for some time. There are some stories of people reconnecting with families or strengthening their relationships, but this is not an outcome for the majority of their clients. It is more likely that people will make friends.
Personal development	One housing provider reported that some tenants have become active participants in tenant associations, within the community, and in other community activities. Another reported that problem solving skills have improved.

Community response

Community groups

Referral agencies have reported that they are very happy to see their clients getting decent housing.

On the other hand, on some occasions, an agency has told CMHA "you are crazy to house that person there". Some shelters have expressed worry about what will happen if the housing doesn't work out. CMHA has found that often, the tenancy is successful. Although it may be necessary to evict some tenants, CMHA is inspired by the number who are able to keep their housing.

Neighbours

CMHA has not received many complaints from neighbours, although there have been times when neighbours were frightened by the behaviour of a client who was referred to housing. When neighbours do call, CMHA sends staff to address the issues, and the neighbours appreciate this. However, if a neighbour has lived through a difficult situation involving the tenant, they may not understand why the person was housed in the first place.

Tenants

CMHA believes they are providing clients with the kind of housing they have said they wanted.

CMHA receives many calls from tenants thanking them for their housing. When CMHA has housed individuals in their condominium units, some have cried with happiness. On the other hand, some tenants have found it difficult to fit into a particular building, or get

along with a particular landlord. They may also have experienced conflict with a particular tenant in a building.

The partners

On the whole, the housing providers feel the partnership works well and has been mutually beneficial. They have found that CMHA "does a great job" assessing their clients. The housing providers also find it reassuring to know that a tenant has support and that there is someone they can call if a problem arises.

The housing providers report that they have found CMHA very dependable. As one provider said, "They always come through. You know when you call that someone will attend to the tenant." On the other hand, it can take time for a new worker to get to know the housing provider and to understand that just because the housing provider is a landlord doesn't mean they are a "bad guy". One housing provider commented that while CMHA is mostly responsive, glitches can occur even if supports are in place. One of the private landlords who participated in an interview welcomes the way in which CMHA goes out of their way to show appreciation to the landlords who participate in this program (e.g. they received a plaque).

CMHA appreciates the level of commitment from the housing providers.

Challenges

1. Legal liabilities. CMHA found that a lot of learning and worry was involved in negotiating the legal agreements with the Ministry of Health for the rent supplement assistance. They were concerned about what would happen if a new government decided to terminate the funding.

2. The condominium units. CMHA is still learning about the difference between rental housing and condominiums.

3. Fairness when allocating units. CMHA finds it a challenge to be fair when the resources are so scarce. It is difficult to determine who is most in need of a unit when two people are both homeless and living on the street. They would like to have access to more units.

4. Housing providers cautioned that it is often more work and more expensive to house this population – although the same issues can arise with tenants who have not been referred and who don't come with their own back-up support.

Reasons for success/lessons learned

Factors for success

CMHA believes the main reasons for the success of the Special Referral Agreements include the following:

1. Matching of clients to units. CMHA and the housing providers believe one of the important factors for success is placing people in the most appropriate units.

2. The high level of trust between the housing providers and CMHA. The housing providers trust CMHA's ability to make appropriate referrals and that CMHA will

be there when needed. At the same time, CMHA appreciates the level of commitment from the housing providers.

3. The quality of the housing. CMHA believe that people's self image is shaped by where they live, and that a nice place to live has a positive impact on their lives.

4. The level of support provided by CMHA – particularly being available evenings and weekends.

5. Equity. It is important that the tenants who have been referred aren't treated differently than any other tenants.

6. The Special Referral Agreement, which clearly defines the roles and responsibilities of each party.

Lessons learned

1. The service agency needs to find housing providers/landlords they can work with, who are large enough to be able to commit units, and who are committed to working with their clients.

2. Some private landlords are willing to make some units available to individuals with special needs. They appreciate that if a problem arises, they have someone to call. CMHA has found some who "are real gems" and are willing to go the extra mile to help clients achieve their goals - including getting off drugs and moving out of the sex trade. More private landlords might be willing to accept referrals from an agency such as CMHA if they knew about the program and that:

   - The agency refers tenants who they think will be a good fit (e.g. able to live with others, and not violent);
   - The tenant receives a rent subsidy; and
   - The agency is available to provide support if any issues arise.

   The private landlords also noted that a market with a high vacancy rate might provide a greater incentive to participate.

3. Units should be self-contained wherever possible. When CCOC first developed the dedicated building project, they provided 6 rooms. Each was equipped with its own fridge, however, tenants shared a common kitchen, living room and bathrooms. It soon became obvious to both CCOC and CMHA that the built form was not working for this population. CCOC found that it was hard for this target population to live with other people in close proximity. The level of interaction required was creating problems. Tenants would argue about cleanliness and food.

   CCOC received Residential Rehabilitation Assistance Program (RRAP) funding to make the units more self-contained. They converted the ground floor rooms and common areas into 2 one bedroom apartments. The remaining 4 rooms were expanded and equipped with built-in counters and cupboards with an ensuite fridge, sink and microwave. There are two bathrooms for the 4 rooms. The renovations had a direct impact on reducing turnover. The average length of stay for tenants at the building before the renovations was 4.4 months, compared to 7.4 months afterwards.

4. Communication is essential. The partners should work through expectations up front and together. They should also establish mechanisms to ensure that communication will occur on a regular basis. Each organization should be clear about its role and responsibilities. This includes managers as well as front line staff. It is also essential that landlords communicate with the service agency at the earliest possible time if they see a problem is emerging. All parties need to be clear about what are appropriate response times.

5. Establish up front markers for success of the initiative. This could include determining what is a stable tenancy, and monitoring why tenants leave.

6. Recognize that it can take time to develop a positive and trusting working relationship.

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Additional Sources

Referral Agreement for Direct Lease Arrangements between City Living (City of Ottawa Non-Profit Housing Corporation) and Canadian Mental Health Association, Ottawa-Carleton Branch

Special Referral Agreement Between Centretown Citizens Ottawa Corporation and the Canadian Mental Health Association, Ottawa-Carleton Branch (to be attached)

#5 Referral Agreements between Housing Cooperatives and Service Agencies, Toronto, Ontario

Introduction

Several housing co-operatives in Toronto accept housing referrals from agencies that work with people who are homeless or have other special needs. The housing co-op makes a certain number of units available to the agency clients. In return, the service agency agrees to provide support.

The Referral Agreement described in this profile was implemented in 2003. It features the Hugh Garner Housing Co-operative, which accepts referrals from agencies that serve individuals and families who are homeless. The particular client groups include gay, lesbian, transsexual and transgendered youth; refugees; and Aboriginal people. Rent supplement funding is provided for units that are part of the referral agreement so that the residents can pay rents geared to their incomes.[29]

Partnership at a glance	
Description	Housing co-ops accept referrals from agencies that serve people who are homeless, and the service agencies provide support.
Partners	Housing Co-op (Hugh Garner); Service agencies (Supporting Our Youth, Romero House, and Anduhyaun Inc.,); and the City of Toronto.
Goals	Give people who are homeless priority access to RGI co-op housing units.
Target population	Homeless people including: • Gay, lesbian, transsexual and transgendered youth; • Refugees; and • Aboriginal people
Number of units	Target of 12 units - 6 referrals accomplished by 2004.
Factors for success	• Support from co-op members; • Shared commitment to ensuring a successful housing relationship; • Clear roles and responsibilities; and • Good communication among the partners.
Location	Toronto, Ontario
Date implemented	2003

Goal

The goal of this initiative is to give people who are homeless priority access to co-op housing units, where rents are geared-to-incomes (RGI).

Background

Housing co-ops in Toronto have a long history of accepting referrals from agencies that serve people with special needs. The Co-operative Housing Federation of Toronto (CHFT) estimates that about 40 to 50 co-ops in the greater Toronto area have units that are designated for individuals and families who were referred from shelters or other agencies.

[29] Rent Supplement funding is provided under the Strong Communities Rent Supplement program which is 100% funded by the provincial government.

Some larger co-ops have agreements with 2 or 3 referral agencies and may accept referrals for 5% of their units. Units may be targeted to people who are homeless, women fleeing violence, people living with AIDS, and others who face barriers to housing.[30]

In 2002, the City of Toronto, decided to make rent supplement assistance available to non-profit housing co-ops. Before this, most of the funding had been designated for private rental units. A co-op could receive rent supplement funding for units they made available to agencies working with people who were homeless. The Hugh Garner Housing Co-operative decided to take advantage of this opportunity.

Partnership

Partners[31]

Hugh Garner is a federally funded housing co-op. They provide 181 units of affordable housing, with a mix of 1, 2 and 3-bedroom units. They also have one 4-bedroom unit. Half of the units are rented on a rent-geared-to-income (RGI) basis. Market rents are charged for the remaining units. The building was first occupied in 1983. Hugh Garner has a history of involvement in community activities. It is partnering with 3 service agencies to make units available to their clients. These agencies include:

- **Supporting our Youth (SOY)** was established in 1998 to improve the lives of gay, lesbian, bisexual transsexual and transgendered youth in Toronto. They work to create healthy arts, culture and recreational spaces for young people; provide supportive housing and employment opportunities; and increase youth access to adult mentoring and support. One of their goals is to promote youth positively in communities and support the building inclusive communities. SOY has secured a limited number of subsidized housing units in the non-profit and co-op housing sectors. The need for housing greatly exceeds the availability, and SOY is working very hard to expand its housing pool.

- **Romero House** provides transitional housing and a range of services for refugee claimants and new immigrants.

- **Anduhyaun Inc.** is an agency that works with Aboriginal people, and operates an emergency shelter.

The **City of Toronto**, through a separate corporation, Access Housing Connections Inc., which administers the rent supplement program and a centralized social housing waiting list. The rent supplement program enables households who are referred to housing agencies to pay rents geared to their incomes.

[30] Conversation with Jon Harstone, CHFT.
[31] This profile is based on interviews with Hugh Garner and SOY. The Co-operative Housing Federation of Toronto and City of Toronto were also consulted.

Planning

The Co-operative Housing Federation of Toronto (CHFT) notified all the housing co-operatives that Rent Supplement funding was available to co-ops that wished to accept referrals from service agencies working with people who are homeless. Hugh Garner was interested. They went through the telephone book and identified some potential agencies they could work with. At the same time, SOY was involved in a referral agreement with one co-op and wanted to find another that would accept referrals. They approached CHFT, who informed SOY that Hugh Garner might be interested in accepting referrals from them.

Hugh Garner set up meetings with each potential agency to identify what each wanted to accomplish.

Hugh Garner agreed to make 12 housing units available. At the same time, they made it clear that they could not provide support. Some of their other objectives were to:

- Achieve a mix of residents. It was agreed that as units became available, Hugh Garner would plan to contact each agency on a rotational basis – recognizing that flexibility would occur depending on the nature of the units. For example, it was noted that if a 3-bedroom unit became available, it would be more appropriate for a family than a single youth.

- Ensure that individuals who are referred will be treated the same as all their other residents.

The referral agencies agreed to ensure that supports were in place for the people they were referring. It was further agreed that if problems arose, Hugh Garner would contact the referral agency.

One of the underlying assumptions was that just because a person is homeless doesn't necessarily mean they will need ongoing support.

Implementation

Members of Hugh Garner voted in favour of proceeding with this initiative. They had an opportunity to discuss the issues, and while some members expressed concerns, it was recognized that "everyone can go into crisis".

In May 2003, Hugh Garner housed their first referral client. They had a wheelchair accessible unit available, and Romero House had a client who needed it. Hugh Garner subsequently housed clients from each of the other agencies. As of August 2004, Hugh Garner has housed 6 individuals and families through the referral process. They plan to house 6 more individuals through this arrangement by 2005. The process depends on turnover, and units do not become available very often.

Coordination/management

The relationship between Hugh Garner and the referral agencies is informal. Hugh Garner contacts the referral agency when a unit is available, and the referral agency contacts Hugh Garner if they are working with a client in desperate need of housing.

Hugh Garner will also contact the agency if a problem should arise. Other than that, there is not much ongoing contact.

Initiative

Who is served

Hugh Garner's referral agreements are targeted to individuals and families who are homeless. Hugh Garner accepts referrals from agencies that work with:

- Gay, lesbian and transgendered youth;
- Refugees living in transitional housing; and
- Aboriginal people.

To date, Hugh Garner has housed six households from each of the three agencies. Households include:

Type of Household	Number of households
Single mothers with children	4
Single Men	1
Single Women	1
Total	**6**

Housing and services

Hugh Garner provides high quality, self-contained units. The units have a great deal of storage space and the entire building is well-maintained. The housing is considered permanent. The agreement with the City of Toronto is for a period of 5 years, however, Hugh Garner expects the rent supplement assistance will continue for the units.

While Hugh Garner does not provide support services to their residents they will refer residents to services if this is appropriate. They have many brochures for different services and information about services is also posted on a notice board in the office. Staff are able to give out lots of phone numbers.

The referral agencies are responsible for ensuring that their clients have access to whatever support is necessary to make their housing tenure a success. It is up to them to ensure that supports are in place prior to move-in.

One of the key services provided by SOY is to ensure that their youth have a mentor to help them learn the ropes of living on their own. Mentors are "queer big brothers and sisters" who help youth explore their questions about identity, sexuality and community. Mentors provide support, encouragement and a non-judgemental listening ear to discuss issues going on in the youth's life, including family, school, friends and relationships. SOY offers a variety of other programs and services to youth – in house or through referral. These include counseling and help with employment.

SOY has a great deal of contact with their clients when they first move into their unit. The goal is to help establish a stable housing relationship and ensure things work well. One of the things they do is to help youth find furniture, dishes, pots and pans, etc. After that, youth and their mentors generally see each other once a week, and SOY is in touch

with their youth at least once a month. The youth can also call SOY any time if they any concerns about their housing. It is also understood that Hugh Garner will call SOY for assistance if problems arise.

Access to housing

If Hugh Garner has a vacant unit, they contact one of the referral agencies. Or, if one of the agencies is working with someone in great need, they contact Hugh Garner and tell them what kind of housing unit they are looking for. Most of SOY's clients require a one-bedroom unit. However, clients from Romero House and Anduhyaun Inc. often require a 3 bedroom unit.

Applicants who are referred to Hugh Garner must go through the following process:

1. Applicants must fill out an application for housing. The referral agencies help with this.

2. This application is submitted to the Membership Committee.

3. The applicant meets with a sub-committee of 2 individuals from the membership committee. The sub-committee provides information about the co-op and about what is expected from individuals living in a co-op – as well as what they can expect from the co-op.

4. The sub-committee makes a recommendation to the Membership Committee.

5. The Membership Committee makes a recommendation to the Board.

6. The Board makes a final decision whether or not to approve the applicant for membership in the co-op. Some of the issues that the Board will consider is what kinds of supports are needed or in place for the individual and is there a person to contact if any problems arise.

In Toronto, housing providers administered by the City of Toronto (subject to the Social Housing Reform Act) must accept all RGI applicants from the City of Toronto's centralized waiting list – Housing Connections. Where applicants are referred by a service agency, they do not need to "wait" on the list. However, they do need to be registered and they must meet the same criteria as other applicants seeking social housing. Housing Connections verifies eligibility for RGI assistance. If an applicant owes rent to another housing provider, they will not be eligible.

Both Hugh Garner and the referral agencies work together to ensure a smooth move-in process.

A Welcoming Committee greets all new residents, makes them feel "at home" and helps them settle in. For example, they often provide information about the services available in the community, bus routes and schools.

Policies and issues

Hugh Garner treats all the residents the same, regardless of whether or not they are housed through the referral process, and regardless of the amount of rent they pay.

Substance use

Illegal activities are not permitted in the units. The use of drugs or alcohol is not permitted in any common areas.

Guests and visitors

Visitors and guests are permitted, but residents are responsible for their actions.

Temporary absence

If a resident enters a residential treatment program and is temporarily hospitalized, the rent must be paid in order to retain possession of the unit. The co-op has no financial resources to cover the loss of rental revenue.

Costs and Funding

Residents pay 30% of their income or rents according to a government scale. The City of Toronto provides rent supplement funding to cover the difference between the rent paid by the resident and the market rent.

Lessons learned

Outcomes

No formal evaluations have been conducted of this initiative. However, Hugh Garner believes the initiative has been very successful. They have housed people who were homeless in very nice units and they have had no difficulties with any of the individuals housed through the referral process. A few of the residents have found employment since they were housed.

Residents who have been housed through the referral process have told Hugh Garner staff that they are very happy. One resident cried with happiness upon seeing the unit. Another resident told the service agency that she is proud of where she lives and has hope for her life. She has said that she likes the people in the co-op and has made friends. The other residents have helped with many practical issues. One resident with a baby appreciates that the co-op is a “baby-friendly” environment. She does not feel isolated as a sole-support parent. When the co-op was doing renovations to her unit, she appreciated being able to make some choices and having some control over her living space. In summary, she reports feeling safe and secure.

The agencies have expressed support for this initiative. Many other agencies have indicated that they would like to be able to refer their clients to Hugh Garner.

Satisfaction with the partnership

Hugh Garner staff have reported that they feel the partnership is working very well. They know the workers at the service agencies and have a good understanding of who to call if an issue arises.

SOY has also reported that they feel great – very positive about the partnership. They find Hugh Garner easy to talk to, youth-friendly, welcoming, and willing to support youth in the community.

Challenges

Some of the challenges reported by Hugh Garner are:

1. Staff turnover within a service agency. It can be difficult to establish new relationships, and these relationships are critical to success.

2. Working out the kinks and unknowns with each new resident e.g. to make sure they are eligible and meet all the program requirements.

According to SOY, the main challenge is the need for more housing. SOY receives numerous calls from youth seeking safe, secure and affordable housing. Also, it is difficult to predict when units will become available.

Reasons for success/Lessons learned

Factors for success

Reasons for the success of the referral agreement include:

1. Support from the co-op members. This includes involvement of a welcoming committee that greets all new residents and helps them settle in.

2. A shared commitment to ensuring a successful housing relationship for the clients being referred, and having their best interests at heart.

3. Clear roles and responsibilities for each partner.

4. Good communication among the partners. This is especially necessary when filling a vacancy. [It is important to that this process be handled efficiently to avoid vacancy loss.] Being able to speak with the same person all the time is very helpful.

According to SOY, another reason for success is the fact that their program is voluntary. The youth who are involved with the mentoring and housing program are there because they want to be. They want the mentoring and support. The fact that youth have entered the program shows that they are motivated and willing to make their lives better.

Lessons learned

1. Housing co-ops should identify service agencies they think they will be able to work with.

2. Housing co-ops should keep their members fully informed so they all know what is happening.

3. Service agencies should educate co-ops about their organization, and do some education and awareness building. They should form and pursue relationships. Many co-ops have mandates to be inclusive and diverse. Agencies should educate them about why it makes send to include their population in their housing.

4. Both the housing co-op and service agencies should work with the individual being referred so they are fully prepared for what will be expected of them in their housing.

5. Start small - with a few units – and with residents that have the greatest likelihood of success. This will get the relationship off to a good start.

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Additional Sources

Jon Harstone, Co-operative Housing Federation of Toronto

#6 Housing, Health and Integrated Services Network (HHISN), San Francisco, California

Introduction

Description

The Housing, Health and Integrated Services Network (HHISN) is a collaboration of public and private agencies that provides housing and support services for formerly homeless people in San Francisco and surrounding counties. It is a multi-agency multi-disciplinary collaboration of approximately 40 public and private agencies in six San Francisco Bay area counties.

HHISN is effectively serving formerly homeless people with multiple disabilities living in permanent housing with ongoing services to assist them in improving the quality of their lives. The California office of the Corporation for Supportive Housing, a non-profit intermediary organization focusing on supportive housing, spearheaded the Network in 1995.

HHISN is a management and coordination system that weaves various specialties into an effective whole. Today with the success of HHISN having been demonstrated, the network continues operating and other communities in California are providing integrated services for this population, loosely based on this model. The original partners have expanded their supportive housing portfolios using the HHISN model, and new initiatives have been developed based on the HHISN model, including Direct Access to Housing (DAH) in San Francisco.

Partnership at a glance	
Description	A multi-agency multi-disciplinary collaboration of approximately 40 public and private housing and service providers in six San Francisco Bay area counties working together to house and maintain individuals with complex needs in housing with supportive services. All operate according to a memorandum of understanding.
Partners	• Service agencies (several) • Housing providers (several) • Corp. for Supportive Housing
Goals	• Integrate services that are needed by people with complex needs to enable them to live in their own housing with stability; • Integrate the systems that finance and deliver social services to sustain cost-effective client-centred service strategies linked to housing.
Target population	Individuals formerly living in the streets or in shelters, with multiple service needs, including substance use and mental illness
Number of units	1,200 units in 2000
Factors for success	• Supportive housing works • Courage and commitment of partners
Location	San Francisco, California and other surrounding counties
Date implemented	1995

Goals

The broad goals of the HHISN are:

- To integrate services that are needed by people who have been homeless and disabled by mental illness, substance abuse, HIV/AIDs or other chronic health conditions to enable them to live in their own housing with stability;
- To integrate the systems that finance and deliver health care, housing, mental health, drug treatment, vocational and employment services, and social services to sustain cost-effective client-centred service strategies linked to housing.

Background

The HHISN began in San Francisco and nearby Oakland, California. While supportive housing had been demonstrated to be an effective solution for those formerly homeless who were "housing ready", there remained a smaller group of chronically homeless people who were not yet fully housing ready, were found repeatedly in public hospitals and in penal institutions, at an alarming cost.

At the same time, the Clintons were discussing universal health care. There was a sense that supportive housing could have an impact on health care costs by reducing emergency hospital use. As such, supportive housing could be seen to be an essential component of a universal health care system, particularly managed care. A network such as HHISN could play an important role in service provision for this group of people.

As an intermediary, CSH was involved with many different supportive housing projects, with non-profit housing providers who had no connections with service providers, and vice versa. All had difficulty accessing funding for supportive housing from a myriad of sources. San Francisco housing providers and service agencies were already well connected and organized but lacked the necessary linkage to fund and operate a network of supportive housing providers.

Partnership

The Network consists of housing providers and service agencies in each county who decide to work together, and operate according to the terms of a memorandum of understanding. At the outset, the Corporation for Supportive Housing spearheaded the initiative and coordinated it along with housing and service agencies. Currently, the CSH is less involved as the teams are effectively managing themselves.

Partners

The partners are a diverse collection of housing providers and agencies, the latter roughly divided into two types: those who serve homeless people through social services, employment training etc, and mainstream public/county health, mental health and substance use treatment service providers. A few private landlords also participate in the network. The homeless service agencies connect tenants with mainstream systems and people that have the clinical expertise to serve them. The partners joined the Network because they recognized that no single agency could deliver all necessary services and saw the opportunity to coordinate service delivery. In San Francisco, the partners are:

- Mercy Housing (non-profit housing agency, one of the original housing providers)
- Episcopal Community Services (a housing and service provider)
- Conard House (social and mental health services and housing for psychiatrically disabled)
- Baker Places (residential treatment for clients with mental health, substance abuse and HIV/AIDS and services in supportive housing settings operated by other housing providers)
- San Francisco Dept of Public Health, Tom Waddell Health Centre (primary health care, psychiatric and outreach focusing on special needs)
- Community Housing Partnership (housing, social services for homeless)
- Chinatown Community Housing Development Corporation (CCHDC) affordable housing

The Corporation for Supportive Housing is an intermediary organization whose mission is to help communities create permanent housing with services to prevent and end homelessness. It does not deliver services directly, rather it supports others to do so by acting as a financial intermediary, offering technical assistance and advice, conducting or sponsoring research and engaging in public policy advocacy. Staff at one of the foundations did some research on solutions to homelessness and concluded that supportive housing was the most effective approach to the complex challenges facing homeless persons. The organization was instrumental in forming and developing the Network, and facilitating it in the early years. CSH is no longer directly involved in the day-to-day activities of the network having devolved that responsibility to individual partners, although it does provide technical assistance.

Planning

A planning grant helped finance a large collaborative planning process that was initiated in 1994 and concluded in 1995 with the implementation of the HHISN. It included executive directors and/or senior staff of a mix of county and non-profit agency representatives. CSH had the lead role in the planning process, as a neutral arbiter of different types of members (including public / private, homeless / mainstream, health care & mental health systems / homeless & social services). Consumers were involved initially via focus groups, but this developed later on to more hands-on involvement.

At the planning meetings, the concept of integrated services was developed, as were goals, and potential funding sources and mechanisms. The network strove to create equality between the non-profit service providers and the county, although this was difficult since the county had a dual role as both a service provider and a purchaser of services. The group decided to form a provider network in each county, owing to existing administrative structures in health care.

Implementation

In 1996, after an 18-month planning and development process, the first HHISN integrated services team began serving tenants in six housing sites in San Francisco.

Implementation of the day-to-day work of the HHISN takes place at the housing site level with the operation of the Integrated Services Team (IST). This team is comprised of staff of different service agencies, and is responsible for delivering needed services to building tenants. Day to day decisions are made by the IST, and working groups consisting of the IST together with property managers.

The IST coordinates service delivery with property managers, who are typically employees of a property management company hired by building owners. There is a services coordinator at each site, responsible for day-to-day supervision of the team. At most HHISN sites in San Francisco, the services coordinator is hired by the housing provider, ensuring that the housing providers are represented on the team.

CSH facilitated the network but gradually became less involved in each site. Eventually the partners in the operations teams elected their own chairs and ran these groups independently, without CSH. For, example, at the Rose, one of the original housing projects involved in HHISN, little oversight or management or coordination is needed. On site staff of various agencies involved collaborate effectively and "virtually run themselves."

According to an evaluation,[32] the partners were aware at the outset of the challenges involved in coordinating the often different roles and objectives of property managers and service providers. Property managers/landlords are interested in maintaining their property, collecting rents, and ensuring tenant safety. Service providers' interests lie in delivering services and advocating for tenants. Polices and procedures were adopted to help bridge this gap and help the network function.

Coordination/management

Three groups operate HHISN in each county – the Oversight Committee, the Operations Group and the Integrated Services Team. The Oversight Committee, comprised of senior staff, has the responsibility for general oversight in the development and maintenance of the network. Membership on the Oversight Committee includes tenant representatives and family members.

The Operations Group consists of senior managers and service coordinators responsible for the supervision of front line staff delivering services. It develops policies and procedures; addresses training issues, shares experiences and problem solves issues affecting the entire county network.

A memorandum of understanding is signed by all HHISN partners, covering the objectives of the network, and the specific roles of each type of partner: housing agency, social service agency, mental health or health care provider, government agencies and the CSH. Site partners are also encouraged to develop a site-specific agreement. Some of these are formal, some informal.

Initiative

Who is served

HHISN serves tenants who were formerly living in the streets or in shelters, with multiple service needs, including substance abuse and mental illness. At the time of an evaluation undertaken in 2000 HHISN had accommodated over 1,000 participants in 12 sites in half a dozen counties. Each site has a somewhat different tenant profile, depending on its location, funding source and mandate. The following is a profile of the tenants at two San Francisco sites, the Canon Kip and Lyric.

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[32] Holupka, C. Scott and Debra Rog. 1999. *Health, Housing and Integrated Services Network. Evaluation Report.* Vanderbilt Institute for Public Policy Studies. Washington, DC For CSH. p 17.

Characteristics of HHISN residents at 2 sites	Percent
Previous living conditions	
Living in a shelter at intake	62%
Living on streets at intake	28%
Gender	
Male	72%
Female	27%
Transgendered	0.4%
Ethnicity	
African-American	54%
White	31%
Latino	8%
Native American	5%
Asian	2%
Other	.7%
Veteran	21%
Median age	43
Issues	
Mental health – formal diagnosis	87%
Mental health – not connected	N/a[33]
Substance use diagnosis	92%
Concurrent disorder	79%
HIV/AIDS	14%
Domestic violence	N/a
Criminal justice involvement	40%
Behavioural issues	N/a

N=279 residents.
CSH 2004.

Housing and services

The HHISN housing sites are primarily single room occupancy hotel rooms, studio and one-bedroom apartments and some scattered site units. All units are permanent housing, and generally, an entire building is devoted to supportive housing, although tenants may come from different backgrounds or funding streams. Most units have private bathrooms and shared cooking facilities. Building size ranges from 40 to 140 units, with most between 40 and 100 units. Residents usually pay 30% of income for rent.

In 2000 there were 10 non-profit housing providers with approximately 1,200 units involved in the Network, in San Francisco and five surrounding counties. (About 300 of

[33] Although 87% had mental health diagnosis to establish eligibility for supportive housing, 52% of residents had not received services from the county mental health system during the 24 months before they moved into supportive housing. Some of these individuals were assessed and/or given some treatment in hospital emergency rooms, jails, and/or Veterans Administration hospitals but were not connected to ongoing MH care.

these units were in San Francisco.) There are also some private landlords with 200 units of scattered site private rental, usually in more suburban counties with no SROs.

The service delivery model is one of integrated services, all available on-site, according to tenant needs. The Integrated Service Team comprised of service personnel at each housing site coordinates and delivers services depending on the needs of the tenants and availability of resources in each community. When a new resident moves in, the property manager notifies the IST coordinator, and an IST member is assigned to the new tenant.

Services offered through HHISN are voluntary (although it is rare that clients do not seek service) and client centred. Providers take a pro-active case management service approach. Most residents make at least weekly contact with case managers, although some may engage in services more or less often. The non-profit and public sectors on this team are critical to creating links to mainstream systems of care that offer specialty medical care. If the partner agencies cannot provide a needed service they maintain a heavy referral base.

Services typically offered:

- On site primary medical care delivered at least once per week consisting of a nurse practitioner or physician, a psychiatrist, health outreach worker and health educator
- Licensed clinical social worker with skills in substance abuse treatment
- Case management assistance and life skills
- Peer support from a team member with personal experience
- Vocational, pre-employment and employment services
- Service coordination and coordination with property managers
- Community building, social, cultural and recreational activities
- Money management

The ratio of staff to clients at ECS buildings for example, is about 1:15 (counting staff from all IST member agencies, not property management staff). At any given building, the staffing would include a group of case managers for day-to-day counselling and referrals, an on-site clinic for part-time medical services, as well as property management staff. A psychiatrist visits once per month for counselling, medication monitoring and referrals.

Support service space is essential. Most buildings were designed as supportive housing so have the necessary office and other space, for example, a medical office, counselling office and meeting space for groups. At some sites, residential units have been converted for service and office use.

Two examples:

Canon Kip Community House opened 1994, is a 104 unit building located in the south of Market neighbourhood and operated by Episcopal Community Services of San Francisco.

Conard House, a non-profit specializing in mental health services operates the Lyric opened in 1997, with 58 units, and is located in the Tenderloin.

Access to housing

The aim of HHISH is to *screen in* homeless people with multiple disabilities who have trouble maintaining housing, accommodating people who have often been refused housing elsewhere. In many cases, the source of funding determines the exact eligibility criteria. The partners take a joint approach to screening potential tenants, taking into account their responsibility to provide a safe environment for tenants, although property management staff has primary responsibility.

At most HHISN buildings, applicants are subject to a criminal background check and rental/eviction history check. Prospective tenants are not automatically rejected for these reasons, but this information gives the services personnel some ideas about what that tenant might need to maintain their housing.

As last resort housing, very few tenants are turned down. The main reasons would be inability to complete the screening interview or to meet the terms of the tenancy agreement. In some buildings, applicants are given three chances to complete a screening interview successfully.

There are substantial waiting lists – usually on a building-by-building basis. Some waiting lists are closed. In San Francisco, tenants are/were selected by lottery.

Policies and issues

Several policies have been developed to operate the buildings effectively, the most important of these being visitor policy and substance abuse policy.

The visitor policy is contentious – front desk security coverage is meant to restrict overnight visitors, restrict the number of visitors at one time, and require identification. The aim is to prevent parties, drug dealing and couch surfing.

One of the challenges facing HHISN staff was developing policies on substance abuse and harm reduction. Enforcement generally focuses on illegal and/or disruptive or dangerous behaviours. If necessary, police may be called or eviction procedures implemented.

Most sites operate using a harm reduction philosophy - meeting clients where they are to help them reduce the harm associated with their lifestyle choices. The principles of harm reduction are:

- Users decision to use drugs is accepted;
- User treated with dignity and respect; and
- Harm reduction measures are first step toward reduction or cessation.

Tenants are given a copy and must sign acknowledgement that:

- Substance use is not condoned but tolerated
- Substance use is not permitted in public areas
- No selling
- No drug seeking behaviour in building
- No interference with responsibility to pay rent
- Tenants responsible for ensuring visitors comply with substance use policies
- Violence not acceptable

- Substance use counselling is encouraged when it becomes a problem

For example, there are fairly stringent substance use rules at the Rose. Residents don't need to be clean and sober, but their drug use must be invisible, in their apartment, on their person, and in their behaviour. The building is staffed 24 hours, and there are fairly stringent rules about guests.

Extra efforts are made to ensure that a tenant entering substance abuse/mental health treatment is not evicted during their temporary absence. This varies according to type of funding but generally the unit is maintained for as long as possible ranging from 45 to 90 days. The need for this type of flexibility is built into project budgets.

Termination of tenancy

Property managers work with service teams to address lease violations and help prevent evictions. Issues are discussed in team meetings, with the property manager present if the tenant has given consent for the disclosure of confidential information. If not, the property manager would not be present. Case managers approach the tenant to help solve the problem.

Evictions can occur for non-payment of rent, threatening or dangerous behaviour. If there were a problem, the property manager would alert support staff if eviction were being considered. Support staff would intervene to help address the problem. There are separate roles here - the housing manager protect tenants and housing – social service staff advocate on tenants behalf.

If there is to be an eviction, the property manager delivers a notice to the tenant and IST staff. IST staff will try to resolve. If the concern is non-payment of rent, the team member will assist with a payment schedule or find emergency rental assistance. If the eviction process continues, IST staff helps the tenant find other housing.

As a result, problems with evictions and high vacancy rates have been reduced; there are low eviction rates and few bad debts. According to staff at the Rose, if people are having trouble adjusting to life in housing, they self-select back to the street.

Costs and funding

Each HHISN network / project is funded separately and funds are obtained from a combination of government and philanthropic sources. Generally each service is funded independently – for example, medical care through Medicaid, mental health through county mental health programs, substance use through the federal government, employment assistance through Rockefeller Foundation and HUD, and life skills through philanthropy. During the mid-1990's Congress eliminated eligibility for Supplemental Security Income – which also establishes eligibility for Medicaid health coverage for persons with substance abuse issues, so City and County funds and some philanthropic support must be used to provide health care and treatment services for these individuals.

Funding remains a patchwork. In San Francisco, the City's Department of Public Health and Human Services is a major funding source. It is estimated that approximately 40% of funding was obtained from philanthropy during the first five years of HHISN implementation. CSH undertook a large amount of fundraising in the early years, seeking funding from private philanthropists and government. As philanthropic support

declined, there has been an increase in funding for the project from state and local government programs, but some services have been curtailed. In two counties HHISN is implemented using tenant based rent subsidies.

Lessons learned

Outcomes

Those interviewed and the evaluations conducted suggest that HHISN has been a positive initiative in providing stable supportive housing for individuals with complex needs. Steps have been made towards integrating service systems, although full financial integration has not been possible, since universal health care did not materialize. CSH had a goal of creating 750 units of supportive housing at the outset and by 2000 there were 1,000 units. One of the advantages of the partnership model is that it allowed agencies to take more risks and serve people they wouldn't normally be able to serve, given the support of other agencies.

The primary measure of success for HHISN and in supportive housing generally is tenant stability (defined as at least 80% of tenants minimum one year tenancy), and secondly, reduced hospital service use.

The Corporation for Supportive Housing sponsored an evaluation of tenant's use of public services before and after entering HHISN supportive housing in San Francisco and Alameda counties. Researchers compared use of emergency health care, hospital services, specialized psychiatric programs, substance use treatment services, and the criminal justice system before and after entering two supportive housing programs whose services are delivered through HHISN. The following are the results.

Outcomes

Outcome N=279	**After 1 year in supportive housing**
Residential stability - housed after 1 yr	80%
Decrease in hospital emergency use (medical and psychiatric)	56% decline
Hospital inpatient days	37% decline
Residential mental health care	disappeared
Outpatient mental health care	declined
Residential addiction treatment	89% decline
Outpatient addiction treatment	increased
Incarceration	44% decline
Employment	Modest increase
Income	Increase due to SSI.

Source: Harder and Company Community Research. The Benefits of Supportive Housing: Changes in Residents Use of Public Services. February 2004 for CSH.

The evaluation did not focus on reducing use of substance abuse programs since most tenants hadn't participated in them before entering HHISN. But, one of the important, measurable outcomes in this area is increased use of methadone, and less residential substance abuse treatment.

Tenant satisfaction has also been found to be positive. An evaluation at one of the sites, the Bonita House Project, found that after 30 days, tenants rated staff helpfulness as 66% positive, 19% neutral, services received as 66% positive, 20% neutral and the best thing about services was the staff (70%). [34]

Respondents felt that HHISN had helped to change prevailing attitudes about who could be housed. There had been controversy around how to serve persons with addictions, and HHISN shows that Housing First works.

One of the way tenants are involved is through representation on the project oversight committee. Residents of the buildings tend to be very proud of their home. For example, in one San Francisco building, a tenant-designed mural on the outside of the building has not been defaced in seven years.

Those involved in the Network feel the partnership to be positive and that staff are managing to work together in a difficult environment.

There is no evidence regarding community response, but staff feel the impact has been positive. In all cases, projects were seen as good neighbours, often providing community meeting space. In some cases, HHISN initiatives contributed to the revitalization of neighbourhoods.

Challenges

The experience with HHISN has demonstrated that partnerships are challenging for several reasons. The first challenge is how to deal with something so big and complicated? Providing accommodation for individuals with complex needs will always be a challenge. Funding is another challenge. There is never enough, and particularly for single adults.

This particular type of partnership, which relies heavily on coordination among staff of service agencies, has its own challenges because service jobs pay low salaries and some staff are young and inexperienced, with a low skill level. CSH played the role of arbiter and trouble-shooter, helping to resolve day-to-day interpersonal and inter-agency conflicts. In some cases, internal staff or personnel problems became obvious so CSH assisted with staff selection, training and supervision. Some organizations had to leave the network because they didn't want to be accountable to the network, or had uncompromising ideologies. Effective front line supervision is essential.

Partnerships in general are not simple. Team members of IST come from different agencies with differing philosophies, missions, methods and policies. Integrating them is no easy task, and poses an ongoing challenge. Organizations participating in HHISN have struggled to agree upon and implement a set of strategies that work.

The initial desire for equality between county and non-profit agencies within HHISN was difficult to maintain. While it did equalize the relationship, it diffused responsibility, requiring CSH to play more of a leadership role. Over time HHISN moved to a more hierarchical management model with accountability. It was found to be desirable to have one agency lead, and sub-contract to other agencies, rather than have three agencies

[34] Marjorie Robertson, Mara Decker. Alcohol Research Group, Public Health Institute. 2004.

share responsibility for a contract. There needs to be clear expectations for accountability and performance.

Reasons for success/lessons learned

The two major reasons for the success of HHISN are:

1. Supportive housing works!
2. The courage and commitment of partners to focus on housing people with complex needs, that is, individuals with the most to gain.

Lessons learned from this experience provide some guidance that could benefit other community partnerships.[35] For example, principles for effective service delivery partnerships are:

- Service partners are involved in the planning of service delivery from the development stage;
- Representatives of partner agencies in planning phase must have backing of their executive directors to make binding decisions; and
- Senior management from partner agencies must take the lead in development of policy and procedures, but line staff must be involved.

Functioning of sites:

- Service coordinator organize regular team meetings;
- Coordinator must be given authority by services and housing agency;
- Must share team leadership with clinical supervisors from other agencies;
- Housing provider must maintain relationship with services coordinator and team
- IST members must have access to technical assistance and training; and
- Must be a lead agency that is empowered to enforce performance and quality standards.

Coordinating housing and services:

- Service team members must have working knowledge of landlord-tenant laws, particularly evictions;
- Property management staff must be trained in the health and social issues facing homeless persons; and
- Communication and coordination among the two must be frequent, formal and informal, while respecting tenant confidentiality.

Location of services:

- Sufficient and appropriate space for support services and staff a priority;
- Senior support personnel and tenants must be involved in the decisions about where services will be delivered;
- If new construction, involvement should begin at the design stage; and
- Services should be located in areas that are easily accessible to tenants and that facilitate the support staff engaging with the tenants.

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[35] CSH. 2000. *Health, Housing and Integrated Services Network: Best Practices and Lessons Learned*.

The experience with HHISN has also shown that scattered site projects seem to work well in suburban counties – where neighbourhood opposition to a purpose built project would be fierce. SROs are not the norm in these neighbourhoods, so using low-density rental housing makes more sense. There is also little non-profit housing serving low-income households, so using private rental accommodation and rent supplements makes more sense.

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#7 Beyond Shelter - Housing First: Permanent Housing and Supports for Homeless Families, Los Angeles, California

Introduction

The Beyond Shelter Housing First Program moves homeless families, including individuals with complex needs, as quickly as possible out of emergency shelters and transitional housing into safe, affordable permanent housing. It then provides them with time-limited support services designed to address the crises that contributed to the homelessness.

The approach is in contrast to the general practice of offering services to the homeless individual or family only while they are resident in emergency facilities. Housing First is based on the concept that people who are vulnerable and at-risk are more responsive to interventions to address the root causes of their homelessness while they are living in stable permanent housing than when they are in the unstable situation of homelessness. The Housing First program works with families, but other organizations in North America apply the Housing First model to individuals.

The Beyond Shelter Housing First program includes the following components:

1. The program's partners offer crisis intervention and short-term stabilization of homeless families. These partners include emergency shelters, transition houses, domestic violence programs and substance use treatment programs.

Partnership at a glance	
Description	A housing first program that moves homeless families, including individuals with complex needs, as quickly as possible out of emergency facilities into safe, affordable permanent housing, and then provides them with time-limited support services designed to address the crises that contributed to their homelessness.
Partners	• Beyond Shelter • 35 referring service agencies • Department of Housing and Urban Development (HUD) • Private landlords
Goals	To help families stabilize in safe, permanent and affordable homes and help them attain social and economic well being.
Target Population	Homeless families with dependent children who are at or below the federal poverty level.
Number of households	More than 3000 families have been housed since 1989
Factors for success	• Families most in need are helped out of homelessness • Focused on ending, not merely managing, family homelessness • Close working relationships between partners and staff at Beyond Shelter who deliver different aspects of the housing and services • Staff and families have same goal: to end homelessness
Location	Los Angeles, California
Date implemented	1989

2. Families undergo an in-depth housing and social services needs assessment by Beyond Shelter Social Services Staff. This determines if the family will be enrolled in the program. If the family is enrolled, the assessment results in a Family Action case management plan designed to improve the family's social and economic well being and keep them in their housing. The case management plan begins while the family is in temporary housing and seeking permanent housing, but the bulk of services will be delivered once the family is in permanent housing.

3. Beyond Shelter's Housing Resources staff immediately assist the family in locating permanent affordable suitable housing.

4. Once housed, Beyond Shelter's case managers provide services for six months in accordance with the Family Action Plan. They also as connect the family to community service agencies to address longer-term needs.[36]

Beyond Shelter's Housing First program is designed to provide a critical link between the emergency/transitional housing system and the community-based social service, educational and health care organizations that bring about neighbourhood integration and family self-sufficiency.[37]

Background

The Housing First program grew out of concerns generated by an increasing number of homeless families in Los Angeles starting in the early 1980s, and the fact that most programs designed to combat homelessness were centred only on providing access to emergency shelters and transitional housing. While such access is essential for people in crisis, it fails to address the long-term needs of homeless families. These include:

- Finding affordable, appropriate housing that would rent to large families or single-parents, especially those with poor credit ratings and histories of unemployment and/or eviction;
- Negotiating leases; and
- Securing funds for deposits, move-in, etc.

A majority of families who arrived at the newly opened family-oriented shelters in Los Angeles County in the 1980s were episodically homeless. These were families that had lost their housing due to marriage breakdown, unemployment or other temporary crises. With the support of family, friends or service agencies, they eventually relocated to permanent homes.[38] However some families were unable to overcome the barriers to permanent housing. Despite participating in a variety of programs at family-oriented shelters and transitional housing, these families were returning again and again to the homeless system. Housing First was developed as an attempt to alleviate this cycle of homelessness.

NB: This case study looks at the Housing First program. Another Beyond Shelter program, The Service-Enriched Housing program, where Beyond Shelter serves as both housing provider and service provider, is outside the scope of this report because it is

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[36] Tull, Tanya, *The "Housing First" Approach for Families Affected by Substance Abuse,* The Source, 2004, available through www.beyondshelter.org/aaa_housing_first/ending_homelessness.shtml

[37] www.beyondshelter.org/aaa_housing_first/ending_homelessness.shtml

[38] Pew Partnership for Civic Change, *Solutions for America: A sourcebook of ideas from successful community programs.* 2002 www.pewtrusts.com/pdf/vf_pew_partnership_052002.pdf

not a partnership. However, it was felt that the program could easily be reconfigured to divide the responsibilities between partner agencies, and, therefore, a brief outline is attached as an addendum to this case study.

Partnership

Partners

Beyond Shelter

Beyond Shelter was founded in 1988 as a private, non-profit agency with a mission to combat chronic poverty, welfare dependency and homelessness among families with children. Beyond Shelter currently has more than sixty full-time staff and an annual operating budget of approximately $3.4 million (US).[39]

Thirty-five (35) service agencies referring participants to the Housing First program

These include: emergency shelters, transitional housing programs, residential drug treatment programs, sober living homes, domestic violence programs, and social service agencies.

Department of Housing and Urban Development (HUD)

HUD is the US federal governments housing agency, similar to Canada's CMHC. Housing First participants are able to rent market housing units using HUD Section 8 vouchers, a rent supplement program.[40] HUD also funds the case management services for Housing First participants.

Private landlords

Beyond Shelter places families in the units of private landlords.

Implementation

Beyond Shelter has a Housing Resources and a Social Services Departments. While staff in each department perform different functions for the program, they work collaboratively. Beyond Shelter's Housing Resources staff are responsible for both marketing the program to management companies and private landlords and maintaining good relationships with these partners. Social Services Staff will help draw up the Family Action Plan and serve as case managers.

Emergency shelters and transition houses that refer participants to this program sign a letter of agreement with Beyond Shelter to provide emergency services for a homeless family until housing can be found. Beyond Shelter requires that these emergency shelters and transition houses send new staff and directors for training, so that they thoroughly understand the program.[41]

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[39] For additional information see: www.beyondshelter.org and www.housingplusservices.org/

[40] In British Columbia, rent supplements are available through programs at BC Housing.

[41] Early on in the HF program, Beyond Shelter placed a worker in a 90-day shelter to take on housing relocation and management. As a result of this worker getting to know the families in the shelter, their relocation and stabilization plans proved more appropriate than plans for families in shelters without such a worker.

There is no written agreement between Beyond Shelter and the landlord. The participant holds the lease on the apartment. Often the motivator for the landlord to take a chance on a Housing First participant is the support system offered once the family has moved in. Landlords will often call Beyond Shelter when they have an opening. Some landlords will call about another resident who isn't in the Housing First program but who has a problem. When possible, and to maintain good relations with the landlord, Beyond Shelter will try to serve that resident through a different program. Social service issues, including those related to rent and/or compliance with the lease agreement, will incur the involvement of the Beyond Shelter case manager.

Once the Family Action Plan has been agreed upon, the participant family signs a contract with Beyond Shelter. At that point, the family is enrolled in the Housing First program.

The arrangement with HUD for rent supplements is specific to the U.S Section 8 program. This is similar to rent supplement allocations in BC that can be accessed through BC Housing.

Initiative

Who is served

Housing First serves families with children, 90% headed by a single - predominately female - parent. These families have been homeless 8 to 12 months before enrolment. The average age of the parent is thirty and the average number of children per family is four. Approximately 20% of the mothers are pregnant when enrolled, and about 25% of families have a history with the county Department of Children and Family Services. Many of the mothers in recovery have had their children removed and are attempting to get them back.

In 2001, approximately 83% of Beyond Shelter clients were receiving welfare at the time of enrolment.

Types of Issues	**Number or proportion of residents**
Mental health. No formal diagnosis or connection to a mental health team	High levels of Post Traumatic Stress Disorder, anxiety and depression
Substance use	40% Ideally, the individual should have been in a recovery program for six months. High success rates of stabilization even though they may relapse.
HIV/AIDS	Not officially. Individuals tend to go into more specialized housing, but there may be some people in the tenant population with HIV/AIDS unknown to Beyond Shelter
Domestic violence	40% are single mothers
Involvement in the criminal justice system	15-20% Particularly women with history of substance use,
Behavioural issues	Approximately 40%

Housing and services

All units are intended to provide permanent housing. Housing First places 75% of its families in the private rental market, utilizing Section 8 housing subsidies. As a result of funding cutbacks to Section 8, some families are now being placed in non-profit housing operated by Beyond Shelter even though these buildings are not in neighbourhoods where Beyond Shelter prefers to situate Housing First families.

Beyond Shelter provides services in an integrated, holistic manner. Services are designed to address the root causes of homelessness, poverty and the lack of affordable housing and provide a link between emergency shelter facilities and community-based social services. The services at Beyond Shelter are offered in three stages.

1. Initial Screening

This includes:

- Identification of strengths and weaknesses of the family unit,
- A detailed history of health, welfare, education, employment, housing, substance use, family violence, and other agency contacts.
- Any current history of involvement with the child welfare system;
- Screening all children for special needs.

It leads to the individualized Family Action Plan.

2. Finding housing

Once enrolled, the family and case manager meet with Beyond Shelter's Housing Resources staff to begin the process of finding housing, preferably in a neighbourhood of the participant's choice. Staff help participants overcome barriers such as poor credit, eviction history and lack of move-in funds. They provide tenant education and assistance with obtaining Section 8 subsidies when available and with negotiating a lease.

3. Time-limited home-based case management

The Family Action Plan is the basis for the delivery of services. It is evaluated and modified at regular intervals.

The case manager maintains frequent contact with the family and introduces the family to the neighbourhood and its resources. The case manager also addresses long-term concerns and connects the family with resources to help with these. Support services to the family may include:

- Household management
- Assistance in obtaining child care
- Welfare and legal advocacy
- Parenting education
- Health and nutrition counseling
- Substance use prevention
- Tenant-landlord mediation
- Liaison with schools
- Job development[42]
- Family and individual counselling
- Child abuse intervention and prevention
- Money management and budgeting

[42] Beyond Shelter provides an employment program. See: http://www.beyondshelter.org/aaa_housing_first/housing_first_WtW_overview.shtml

- English language classes
- Basic remedial education

There are few substance use services for families with children. Beyond Shelter will facilitate participation in a recovery or support group.

For eight years, case management in the Housing First program was offered for a one-year period, with evaluations every three months. More recently HUD has reduced funding and case management is now limited to six months. Despite this reduction, high-risk families are generally monitored for up to a year, with some remaining in the program for longer, particularly if an outside agency cannot be found to take over the family's needs. "Graduation" from the program does not mean the family is cut off from assistance from Beyond Shelter staff. Families who experience another housing crisis are helped immediately and may receive a one-time subsidy and short-term case management to move to another unit.

Access to housing

There are 35 service agencies in Los Angeles County that refer clients to the Housing First program. As well, an individual can walk into one of Beyond Shelter's three satellite offices and apply for their services. Once a family is a client of Beyond Shelter, they will receive help to access permanent housing.

Eligibility

All families must consist of one or two adults with legal custody of one or more children under the age of 18, and adult family members must have maintained their sobriety (or have been "in recovery") for at least six months.

If an adult family member has experienced domestic violence, they should have been separated from the batterer for at least four months and be participating in, or have completed, counselling upon arrival.

Beyond Shelter believes that individuals with a severe and persistent mental illness or concurrent disorders are better served by other housing options and they will be directed there. People who are known or suspected to have substance use will not be offered housing unless they are participating in a recovery program, and then they will be closely monitored.

Wait list

There is no waiting list. Attempts are made to enrol families as they come, though priority may be given to certain family circumstances.

Expectations

Beyond Shelter states that it does not believe in the concept of housing readiness but consider housing to be a basic human right. However, they do have some expectations, as described under Eligibility above.

Services are considered voluntary. Housing First clients who choose not to participate in their Family Action Plan post-move in will not lose their housing. However, choosing to adhere to the Plan requires that they work on designated activities and goals. For adults in recovery, the case manager would include as components of the Family Action Plan, ongoing sobriety and continued participation in support groups.

Policies and issues

Substance Use Policies

Beyond Shelter deals with substance use problems on case-by-case basis. If a tenant needs to enter a treatment facility the case manager may arrange for a family member to move into the unit to care for the children, or arrange for children to go to a family member while the parent is in treatment.

Termination

The landlord makes the decision on eviction. The tenant is covered by California residential tenancy legislation.

Beyond Shelter hopes that the landlord will call if there is a problem and that with intervention, eviction can be avoided.

Costs and Funding

Initially, the Housing First program was funded through private donations and as a demonstration project of the federal Department of Health and Human Services. Currently, major funding comes from HUD.

Generally, Housing First participants pay 30% of income for rent and their Section 8 voucher is a rent supplement that tops this up to reach the actual market rent. However, with changes to Section 8, some tenants are now paying more than 30%.

Lessons learned

Outcomes

The goal of Housing First is to help families attain improved social and economic well being. Based on that definition, Beyond Shelter evaluates each family's progress towards that goal. Since 1989, more than 3000 families have participated in the Housing First program. An evaluation by the Pew Partnership for Civic Change, as one of 19 sites included in its study, *Solutions for America: A sourcebook of ideas for successful community programs*,[43] suggested that Housing First has achieved both improved social

[43] www.pewtrusts.com/pdf/vf_pew_partnership_052002.pdf

and economic well-being for many of its participants as well as stability in housing for high-risk families. Some findings are:

- Housing First model is particularly effective with homeless families with histories of substance use. Only 2.3% who came into the program with a reported addiction problem had a relapse.
- More than 80% of participants became employed and/or enrolled in job training programs.
- Less than 1% of domestic violence survivors returned to the dangerous relationship.
- 80% of school-aged children were enrolled in school and 77% attended regularly.[44]

Beyond Shelter also reported that:

- The majority of participating families continue in the social services program for the six-month time limit.
- Approximately 85% of participants maintained their housing and experienced no further episodes of homelessness.
- For a majority of families experiencing a substance use relapse, eviction has been prevented by intervention from Beyond Shelter staff.

Challenges

- Reductions in Section 8: The federal government has cut back on the allocation of housing vouchers and is no longer making new housing subsidies available in LA. As well, families are now paying a greater percentage of their income to rent.
- The affordable housing stock has diminished and increases in market rents have exacerbated the problem.
- The five-year lifetime restriction on welfare makes it difficult for some families to find enough funds for rent and necessities.
- Transitional housing providers can be alienated by the concept of Housing First if they feel the program will usurp the need for their housing.
- With the cutbacks, clients have to live in low-cost housing instead of being placed in nicer apartments in better neighbourhoods using their Section 8 vouchers. Some landlords have been willing to help Housing First clients by substantially lowering their rent, but these are not usually in buildings in nicer neighbourhoods.

Reasons for success

- Families most in need are served and helped out of homelessness.
- The program is focused on ending, not managing, family homelessness. It assists the homeless family to become stabilized in permanent housing, while agencies that provide clients for the Housing First program concentrate on short-term emergency services. According to Beyond Shelter, there is nothing in the research that supports any findings that a longer stay in emergency or transitional housing leads to escaping homelessness.
- Housing relocation and case management (social services) are kept as separate functions in the Housing First program, with each department staffed by people who perform the function best.

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[44] Morse, S. & Gillespie, M. *Solutions for America: What's Already Out There,* Pew Partnership for Civic Change, 2002, citied by Tanya Tull in her article: *The "Housing First" Approach for Families Affected by Substance Abuse,* The Source, 2004

- Homeless families become partners when they realize that the service agencies have the same goal as they do.
- Homeless families are quietly placed in housing in stable middle class neighbourhoods to avoid controversy from neighbours.
- The program succeeds best when there is a close working relationship with landlords and the referring service agencies, enabling the transition from emergency facilities to permanent housing to be as smooth as possible.[45]

Addendum – Service-Enriched Housing[46]

In the early 1980's, a number of townhouse developments in South Central L.A were built to house families who had been living in downtown skid row hotel rooms. A social worker was assigned to visit the townhouses, and be available for crisis intervention and connecting them to community resources. This approach became Service-Enriched Housing.

Service-Enriched Housing is not considered Supportive Housing or Special Needs Housing. It is permanent, basic rental housing targeted to low-income people, in which social services are available. It is for any tenant in the housing, not necessarily for those with multiple problems or special needs, though it does provide them with a housing option. Services are tied to the unit in the case of scattered Service-Enriched Housing or the development and not to the tenant. If a tenant moves out, Beyond Shelter does not continue providing services, unless the tenant moves to another Service-Enriched project

There is no single model for this program. Service-Enriched Housing can be operated by a single agency, as in the case of Beyond Shelter, or through partnerships. Services can be off-site or on-site, depending on need, number and type of residents, space availability, and resources in the community. Often, Service-Enriched Housing focuses on quality of life issues – but all Service Enriched programs provide crisis intervention and resource referral, and they promote resident participation in the decision-making process. Service-Enriched Housing can be privately owned, or developed and operated by non-profit agencies. Any existing rental housing or new development can be made "service-enriched" through simple mechanisms that can also be cost-effective. The goal is to "coordinate" access to existing resources and services already in place in the community, to provide assistance in a crisis, and to help improve quality of life and improved social and/or economic well being for people living in poverty.

Beyond Shelter operates six affordable housing projects that provide Serviced-Enriched Housing to tenants. These projects range in size from 16 units to 48 units. Recently, Beyond Shelter entered into a contract with another non-profit housing developer to hire, train and supervise a Services Coordinator for a 200-unit family complex with approximately 100 families who were previously homeless. In this case, Beyond Shelter is delivering the services portion of Service-Enriched Housing, but not the housing.

Each of Beyond Shelter's Service Enriched buildings includes access to an on-site services coordinator, who oversees the provision of crisis intervention and case

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[45] Pew Partnership for Civic Change, *Solutions for America: A sourcebook of ideas from successful community programs.* 2002

[46] More information on the program can be found at: www.beyondshelter.org/aaa_housing_first/housing_first_SEH_overview.shtml

management. Participation in services and programs is voluntary, so long as the tenant maintains the terms of their lease agreement.

Most methods and formulas used to raise capital and operating funding by Beyond Shelter for their Service Enriched Housing developments are not directly replicable by Canadian organizations since the programs are not available here. These include the Low Income Housing Tax Credit Program, the Tax Exempt Bonds and other government programs. However, the use of Section 8 subsidies is similar to Canadian rent supplement programs and charitable donations and grants from foundations and other donors for capital development are replicable.

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Additional Sources

www.beyondshelter.org

www.housingplusservices.org/

Tull, Tanya, *The "Housing First" Approach for Families Affected by Substance Abuse,* The Source, 2004, available through www.beyondshelter.org/aaa_housing_first/ending_homelessness.shtml

Pew Partnership for Civic Change, *Solutions for America: A sourcebook of ideas from successful community programs.* 2002 www.pewtrusts.com/pdf/vf_pew_partnership_052002.pdf

#8 Fresh Start, Portland, Oregon

Introduction

Description

Fresh Start aims to open doors to housing for individuals with complex needs by creating partnerships among case managers, landlords/property managers and residents.

The initiative permits traditional screening criteria to be relaxed through a variety of means including case management and a landlord guarantee fund. Landlords and property managers agree to rent to people they might not otherwise, and in return receive a commitment from a support agency to assess the tenants housing readiness and to provide ongoing support.

Partnership at a glance	
Description	A new initiative where housing and service providers certified by Fresh Start agree to provide housing and support for individuals with complex needs. The initiative includes formal agreements between landlords and service agencies, a landlord guarantee fund that can provide funds if tenants damage a unit or are unable to pay rent, and a training program for on site housing personnel and service agency staff.
Partners	• Service agencies (several) • Housing providers (several) • Portland Bureau for Housing and Community Development
Goals	• Protect owners and landlords interests; • Mitigate potential risks associated with less stringent screening criteria; • Meet the needs of persons who cannot otherwise access housing; and • Track outcomes, promote accountability and troubleshoot issues.
Target population	Individuals formerly living in the streets or in shelters, with complex needs, including substance use and mental illness
# individuals placed	4 to date
Factors for success	Not available.
Location	Portland, Oregon
Date implemented	2004

Goals

The goals of the programs are to:

- Protect owners and landlords interests;
- Mitigate potential risks associated with less stringent screening criteria;
- Meet the needs of persons who cannot otherwise access housing; and
- Provide a central forum to track outcomes, promote accountability and troubleshoot issues.

Background/Impetus

In 1998, an informal collaboration of service providers, property management firms, Legal Aid, tenant screening company and a law firm developed the Fresh Start program to respond to the needs of the downtown singles population. It became an effective means of helping people with complex needs to access stable and affordable housing. It ensured that they would receive support if landlords rented them

a unit. Between March 1998 and August 2000, 210 units were rented to people using Fresh Start referrals. Seventy seven percent of these tenants became successful renters.

In the US, Fair Housing legislation protects individuals from discrimination in housing, and requires that landlords provide “reasonable accommodation” for persons with disabilities. If the prospective tenant does not feel the landlord has attempted to meet their needs, and produces a “reasonable accommodation” letter from a lawyer, legal action may follow. Fresh Start was seen as a way to avoid the legal process, and it therefore gained the support of landlords.

A non-profit organization spearheaded and coordinated the informal collaboration for the first few years. However the organizing agency realized that the lack of a contractual relationship made it difficult to monitor other agencies. It was also found to be too much work for one agency to coordinate. To address this problem, the non-profit agency requested that a neutral body, which would have a contractual relationship with the agencies, administer the program. In 2000, the Portland Housing Centre, a non-profit agency under contract to the City of Portland, became the coordinator. However, this arrangement also encountered some problems, and the program was in hiatus for a few years.

The Fresh Start program has recently been revitalized and re-designed, is under new management, aims to serve a larger population, and is offering a landlord guarantee fund.

Partnership

Partners

Fresh Start partners include a department of the City of Portland, called the Bureau of Housing and Community Development (BHCD), non-profit service agencies, and private and non-profit landlords. At the current time, nine service agencies are Fresh Start certified with two more pending. Three landlords have signed agreements. One of the housing providers is Rose Community Development Corporation (CDC).

Rose Community Development Corporation (CDC)

Rose CDC was created by a group of residents, business people and social service providers concerned about deteriorating housing in outer SE Portland. Rose projects include rehab and new construction of affordable rental and homeownership housing, a business assistance program for childcare providers, and a community barter program. There are 208 rental units in all their housing projects. Rose CDC agreed to participate in Fresh Start because the agency found they were housing people with complex needs in their buildings anyway, and they had been involved in a number of informal partnerships in the past that had been successful.

Some of the Fresh Start certified agencies are:

Central City Concern

Central City Concern is a non-profit organization that was established in 1979 to address the increasing problems of homelessness in Portland. It is a State licensed and approved outpatient addiction and mental health treatment program. CCC's housing, primary care, chemical dependency and mental health treatment programs, and employment services serve over 12,000 unduplicated individuals each year.

El Programa Hispano/Catholic Charities

The Latina Domestic Violence Program of El Programa Hispano of Catholic Charities serves Latina survivors of domestic violence. The program offers support services including: Case Management, Spanish support groups, immigration services, home visits and general advocacy.

Multnomah County Developmental Disabilities (DD)

Multnomah County DD provides supportive services for eligible individuals who have developmental disabilities. Individual Service Plans are developed and may include assistance with housing including licensed housing options, vocational or school options, assistance with income issues like social security, and coordination with providers, other agencies, and significant others.

Outside In

Outside In is a private, non-profit organization that works with homeless youth, ages 16-21, in downtown Portland. Outside In has four main programs in its Youth Department: a drop-in day program, an employment resource center, case management, and transitional housing.

Portland Impact

The Portland Impact Housing Services Program provides housing, case management, and strength based support services to families with children under 18 years of age. In some of their housing programs income guidelines apply. Their services boundaries are mainly SE and NE Portland.

Human Solutions

Human Solutions serves families in East Multnomah County who are homeless or at high risk of homelessness. Human Solutions provides housing assistance in the form of shelter, motel vouchers, transitional housing and "housing first"**.**

Transition Projects, Inc. (TPI)

TPI serves low-income and homeless adults without children in Multnomah County. Their drop-in and rental assistance services are limited to those who are under age 55, though their case management and shelter services are for all homeless individuals over age 18. Their clients generally seek subsidized housing or housing in the 30% - 50% of the Federal Poverty Guideline range.

Planning

The Portland Bureau of Housing and Community Development (BHCD) convened a design team in May 2003 with 20 members equally representing the service and housing sectors to further develop the Fresh Start model. This included service agencies representing those dealing with HIV/AIDS, family and single homelessness. Also included were housing authorities, the county, non-profit housing providers and private housing providers. Some were representatives of the original Fresh Start organizations. The planning process took six months and resulted in the Fresh Start Implementation Plan.

The Design Team endorsed a model that encompasses both centralized and decentralized elements in its approach. Each service agency is responsible for building individual relationships with landlords or property management companies, but they are expected to provide a minimum level of service and maintain communication with a central, administrative body. Agencies interested in becoming Fresh Start certified are expected to sign Memoranda of Understanding with BHCD and each landlord or property management company.

Implementation

Before becoming Fresh Start certified, prospective service provider agencies must undergo orientation by the Fresh Start Coordinator to review program expectations. Implementation began in January 2004 with a Request for Certification calling for interested service providers to respond. Service providers interested in participating submitted an application, and service agreements are signed with the BHCD. Following certification, staff undergoes orientation and training. Service providers then look for housing providers to partner with, and forge agreements with them to accept less stringent screening criteria.

To ensure a quality program, the Fresh Start Coordinator conducts training and orientation with landlords and service providers that seek Fresh Start certification, and HousingConnections staff. The optional training for the landlords covers topics related to housing those with complex needs. It also covers the rights and responsibilities of Fresh Start participation for all parties. The former Fresh Start Advisory Committee developed a draft of the service provider training, which will be updated and conducted by the Fresh Start Coordinator. The providers are responsible for pre move-in and ongoing training of clients/residents that cover topics such as budgeting, tenant rights and responsibilities, housekeeping, communicating with landlord.

Several referrals have now been made and a few tenants placed. Take-up of the program has been less than expected due to a soft rental housing market. Tenants are able to find housing easily because there is less competition for units. In fact, landlords are contacting the Fresh Start office to join the program.

The Landlord Guarantee Fund is an integral part of the program as it provides an incentive for landlords to rent to individuals and families facing significant screening barriers. It will reimburse landlords for damages in excess of normal wear and tear that exceeds the security deposit. It will also cover one and a half months of non-payment of rent and reimburse for costs associated with formal court evictions. The guarantee is only valid for the first year the tenant is in the building. The amounts available vary according to unit size.

Max amount for 1 bedroom or smaller	$2,000
Max amount for 2 bedroom or larger	$3,000

The earlier version of Fresh Start identified the need for a guarantee fund. It applied for and obtained $18,000 in foundation funding, and the City set aside an additional $150,000, creating a guarantee fund of $168,000. The Housing Authority of Portland administers the fund on contract to the City of Portland. The fund is operating on an experimental basis and will be evaluated at some point early on.

Coordination and Management

The Bureau of Housing and Community Development, a department of the City of Portland, is the project coordinator and administers the program to ensure quality control and monitoring. One staff person spends approximately .5 FTE on this file. It is felt that 12 agencies would represent the limit of what the Coordinator can handle at one time. A number of committees and agreements ensure the proper functioning of the partnership.

Oversight Committee
To ensure quality control, a 12 person Oversight Committee has been convened to monitor Fresh Start. This Committee consists of service providers, landlords, property managers, and other interested parties. Its role as a third-party entity is to track outcomes, make recommendations for program improvements, and provide overall accountability. The Oversight Committee met more frequently at first to ensure implementation in a timely manner, and now meets monthly.

Service Provider and Landlord Group
To support the efforts of persons who work with Fresh Start on a day-to-day basis, the Design Team recommended a peer group. This group is intended to troubleshoot and discuss the day-to-day functions of Fresh Start and share information on how to best administer the program. It will inform the Oversight Committee of the implications of its policies. The provider and landlord group meets informally every other month.

Contractual Agreements

Once Fresh Start certified, the service providers sign a contract with BHCD that they agree to follow the protocol set by the Design Team. If the provider already has a contract with BHCD, they have the option to amend current contracts to include the responsibilities of Fresh Start. Because there are no operating dollars to implement Fresh Start, the contract represents legal, but not financial, accountability. In this way, BHCD has the right to monitor the activities of the providers who participate in Fresh Start.

Service Agreements between Landlords and Service Providers

The ultimate quality assurance is the individual relationship between the landlord and the service provider. The roles and responsibilities of both parties are outlined in a service agreement. If either party is not satisfied with the partnership, they have the option to end it, as outlined in the service agreement. However, termination of the landlord/service provider partnerships does not mean the relationship between the service provider and client ends as well.

The Initiative

Who is served

The initiative is targeting a wide range of formerly homeless individuals, but has placed only four individuals through the Fresh Start program to date, with three referrals pending. The target is to house 100 to 150 households per year.

Housing and services

All housing units are to be permanent housing and consist of self-contained rental units. Some units are in non-profit buildings that have office or meeting space for service providers, while other do not and service is provided in the community.

There is a tendency among landlords to want to concentrate tenants in a few buildings, where managers have taken the necessary training, but buildings containing a mix of tenants are generally preferable.

At this early stage in the initiative it is unknown how many units will ultimately become eligible for Fresh Start referrals. The local housing registry, called HousingConnections, indicates that there are approximately 1,300 units that will accept Fresh Start tenants, suggesting a eagerness on the part of landlords to enter into agreements with Fresh Start certified service providers. Rose CDC intends to make about 10% of their units available for Fresh Start referrals.

Service agencies have discretion over the types and frequency of supportive services they provide to each client. However, at a minimum, service providers have to agree to provide the following:

- Conduct housing assessment of clients to determine housing appropriateness;
- Develop individualized housing goal plan of each referral that defines level and length of services to be provided;
- Provide orientation or training before move-in for clients;
- Send referral letter to landlord;
- Respond to calls by landlord or client within 16 business hours (two working days)
- Track occupancy outcomes at 3, 6, and 12 months and follow-up tracking of housing outcomes at 6 months (18 months after move-in); and
- Provide supportive services as appropriate with the expectation that clients will receive more intensive services immediately after move-in, even if the relationship with landlord dissolves, or locate another provider to support client referrals if relationship with the landlord ends

Landlords have to agree to the following:

- Notify service provider in cases of: 1) written notice to tenant, 2) any contact with 911 or other service entities, 3) late rent, and 4) any other action that may affect the continuation of tenant's tenancy;
- Agree to inform service providers of actions leading to eviction before the action is taken;
- Agree to evict tenant only as a last resort;
- Send required documentation to Housing Authority of Portland to receive landlord guarantee fund coverage for eligible tenants; and
- Fulfill above obligations to tenant even if relationship with service provider dissolves

Clients/Tenants have to agree to the following:

- Abide by housing goal plan
- Sign consent form and release of information form
- Follow lease or rental agreement

Access

The design team discussed various barriers that persons with special needs face to obtain permanent housing and reviewed different criteria used by members to address these barriers. They decided that each service provider should use their own screening criteria to meet the needs of specific landlords and service agencies. Thus access to the program is decentralized to each agency. The criteria are attached to the landlord's rental application. The Fresh Start Coordinator can assist service providers to develop their Fresh Start criteria. With Rose CDC, an independent screening agency conducts the screening for criminal and rental history using less stringent criteria.

Service agencies make referrals to housing providers with whom they have agreements. The service provider undertakes the following as part of the referral process:

1. Identify clients.
2. Conduct housing assessment.
3. Clients agree to participate in program and sign consent form.
4. Providers and clients develop housing goal plan and supportive services plan.
5. Clients prepared for housing by provider through training on tenants rights and responsibilities.
6. Service providers refer client to housing provider and assist with application.
7. Sends letter to landlord outlining barriers and steps that will be taken.
8. Tenant moves in.

Agencies have been cautious about making referrals, preferring to be absolutely certain about people they refer, and their ability to be successfully housed. There is no central waiting list – this would be done through each individual agency.

Landlords are obliged to communicate with the appropriate service provider in the event they are considering an eviction, and must first investigate all available means to avoid an eviction.

Fresh Start team members wanted to operate Fresh Start as a Housing First program, to be able to move potential tenants quickly into housing. Landlords however, preferred the security provided by having tenants take a "housing readiness" course first. A compromise was reached allowing tenants to take the course concurrent with moving into a unit.

Policies and issues

Substance use policies are implemented on an agency specific basis. For example, Rose CDC requires that there is no substance use in common areas. Similarly, agencies make their own policies about whether tenants must participate in program to be eligible for housing and appropriate behaviour. Rose CDC will require tenants to participate in case management. Rose also requires the tenant to be somewhat housing ready, and that the service provider will counsel the tenant on how to be a good neighbour, maintain the units and obey property rules.

Costs and funding

Service providers or housing agencies receive no funding associated with participation in the Fresh Start program, with the exception of the guarantee fund. Each agency delivers its services and housing using their own budgets. The City of Portland received a two-year grant from the Corporation for Supportive Housing to pay the half-time salary of the Fresh Start Coordinator, costs of training and committee expenses.

Lessons Learned

Outcomes

Success of this initiative will initially be measured in terms of residential stability. The goal is that 80% of tenants remain housed after 12 months, although individual agencies have developed their own measures of success ranging from 60 to 80%.

Since the revamped program began operation in January 2004, it is too early to report on outcomes. However, Fresh Start service agencies are required to monitor their clients and track outcomes on a 3, 6, 12, and 18-month basis with communication from landlord and client. They will then provide the data to the FS Coordinator. The BHCD and has developed a database, which will assist in tracking outcomes.

In terms of community response, the initiative has received positive feedback from homeless advocates.

Challenges

Challenges encountered in the planning and design phase included:

- Developing thresholds for service provision given different goals, perspectives, abilities and resources of housing providers and service agencies;
- How to maximize the use of the guarantee fund;
- Finding neutral administration and consistent staffing; and
- Scarce resources.

Take-up of the new program by tenants has been slower than expected due to the unexpectedly soft rental market in Portland. Tenants are able to find accommodation easily as there are excess units available in the marketplace. Private landlords are more likely to make units available to individuals who are hard to house under these conditions. It is felt that Fresh Start will be very important in a tight rental market. In addition, start-up time can be prolonged, since participation in the program is quite time

and labour intensive at the outset, owing to the certification process and the need to draw up partnership agreements between agencies.

Another challenge likely to be encountered during the start up phase is ensuring proper coordination and communication between service agencies and landlords.

Factors for Success

Rose CDC staff believes that the following will be essential factors for the future success of the initiative:

- On site staff training, optional for housing providers (Rose CDC will require their staff to take it);
- The availability of the landlord guarantee fund to mitigate financial risk. Non-profit housing agencies do not have the resources to pay for damage and non-payment; and
- The enthusiasm and commitment of partners.

Contact

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Additional Sources

Susan Wiswell. Asset Manager, Rose Community Development Corporation. Portland.

City of Portland, BHCD. *Fresh Start Implementation Plan*. Nov 6, 2003. For the Fresh Start Design Team. Includes Fresh Start Partnership Agreement.

Powerpoint Presentation. City of Portland BHCD.

Appendix B

Contact information for each initiative

#1 Special Needs Housing Program

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#4 Special Referral Agreements and Condominium Initiative to House People with Multiple Challenges – A Housing First Approach

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#5 Referral Agreements: Housing Cooperatives and Service Agencies

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Fax: 416-338-8228
mcarlson@toronto.ca

#6 Housing, Health and Integrated Services Network (HHISN)

Carol Wilkins, Director Intergovernmental Policy
Corporation for Supportive Housing
1330 Broadway Suite 601
Oakland, CA 94612
Phone: (510) 251-1910 ext 207
Fax: (510) 251-5954
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#7 Beyond Shelter - Housing First: Permanent Housing and Supports for Homeless Families

Tanya Tull President,
CEO Beyond Shelter
520 S. Virgil Ave. Los Angeles CA 90020
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Fax: 213-480-0846
ttull@beyondshelter.org

#8 Fresh Start

Molly C. Rogers
Homeless Programs
Bureau of Housing and Community Development
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Appendix C

Models for Sustainable Partnerships between Housing Providers and Community Agencies to Address Homelessness

Research Advisory Committee

Terms of Reference

Statement of Purpose

The BC Non-Profit Housing Association has received funding from the Government of Canada's National Homelessness Initiative to investigate partnership models that involve non-profit and co-operative housing providers and community service agencies to provide accommodation for individuals who are "hard to house". The project will find out what has been learned from others' experiences in this area.

Specific objectives for this research project are to:

- Identify and describe models of ongoing and sustainable partnerships between non-profit housing providers and community support agencies where community agencies provide ongoing support to tenants in non-profit housing.
- Identify lessons learned from different partnership approaches.
- Identify which ones have the greatest potential to be replicated to address homelessness in B.C.
- Examine the cost effectiveness of these models, including the funds or resources that can be obtained through partnerships, and the ability of partnerships to leverage additional funding.
- Describe other benefits of partnerships and the time involved in establishing partnerships.
- Develop materials that could be used at a focus group to discuss partnerships in B.C.
- Conduct a focus group session with key representatives of stakeholder groups.

The study has linkages with the key research domains and priorities of the NRP as it aims to research solutions related to the *cycle of homelessness,* particularly pathways in and out of homelessness and the service needs of a particular sub-population, the hard to house. The sub-population(s) of particular focus in this study would tend to be persons with mental illness, substance abuse issues or multiple diagnoses, but other sub-groups are likely represented as well. Cross cutting issues of relevance include aboriginal homelessness and links with communities. Homeless persons of all age groups and genders are potential clients of this housing and service model.

The **Research Advisory Committee** is created to act as a resource to the research team and provide recommendations, guidance and support for the project.

Structure

The committee members represent the diversity of players in the fields of community service organizations serving people who are homeless or at risk, as well as non-profit and co-operative housing providers.

BCNPHA Executive Director will chair the committee.

Function:

The committee will:

- Review the work plan and advise of any possible changes/additions
- Advise on possible organizations to contact
- Select initiatives to profile
- Review interview guide
- Review the draft final report.

Members will attend meetings arranged by the BCNPHA Executive Director, and will participate in email communication between meetings, to assist in the selection of the eight models to be profiled, provide information and feedback on the interview process, and review and comment on the draft final report for the project.

Time Frame:

The committee will be established and hold its first meeting by May 14, 2004 and will complete its work by December 31, 2004.

Members:

Jarka Vohradska, Tenant, Entre Nous Femmes Housing Society
Heather Edgar, Coast Foundation
Paul Tubbe, CHF BC
Linda Thomas, Vancouver Coastal Health Authority
Gail Burak, BC Housing Health Services
Monica Jako, BC Housing Management Commission
Lorne Epp, MCC Social Housing Society
Alice Sundberg, BC Non-Profit Housing Association

Appendix D

Interview Guide
Models for Sustainable Partnerships

For Initial Telephone Contact

Hello. My name is_____. I am calling from Vancouver, [in Canada]. I am part of a research team that has been funded to document ongoing and sustainable partnership models that involve non-profit/co-op housing providers and community agencies to provide housing for people who are considered hard to house. We are interested in partnerships that increase access to housing and where community agencies provide ongoing support to the residents. We would like to find out what has been learned from others' experiences in this area.

Our research is being funded by the federal government to support solutions to homelessness, and is being carried out for the BC Non-Profit Housing Association.

We are very interested in documenting your initiative_____

Name of Initiative

and would like to set up a time for a telephone interview in the next few days.

We expect the interview to take between one and one and a half hours.

We recognize that this will take a substantial amount of your time, and would like to offer your organization a small honorarium, $100 [Canadian] to show our appreciation.

1. Do you think your organization would be willing to participate?

   ☐ Yes ☐ No

2. Who would you suggest we speak with about your initiative – would it be you or would you recommend someone else?

   ☐ Person on phone ☐ Someone else

   If someone else, who should we contact? _____

3. If we will interview you, when would be a convenient time to talk?

   Date:_____ Time: _____

4. We will send you a copy of the questions in advance. Would you prefer receiving the questions by fax or email?

   Email address:_____ Fax:_____

5. I would like to be as prepared as possible before we meet and would like to be able to read:
   a) Any write-ups that have already been done to describe your project

b) An annual report and financial statements that show the particular program we are documenting
c) Any relevant policies and/or house rules
d) Any evaluations
e) Tenant satisfaction surveys
f) Anything else you think is important

6. Are any of these available on the internet? If yes, which ones. If not, would you be able to send me this information?

Documents of interest	On internet	Will send
Program description		
Annual report and financial statements		
Policies/house rules		
Evaluations		
Tenant satisfaction surveys		
Other		

Thank you for agreeing to participate in this research project on sustainable partnerships.

Models for Sustainable Partnerships

Interview Guide

The purpose of this project is to document ongoing and sustainable partnership models that involve non-profit/co-op housing providers and community agencies to provide housing for people who are considered hard to house. We are interested in partnerships that increase access to housing and where community agencies provide ongoing support to the residents. We would like to find out what has been learned from others' experiences in this area.

We expect the interview to last between one and one and a half hours. Attached is a list of the questions. If you have any questions or concerns, please do not hesitate to contact:

Deborah Kraus. Phone: 604-221-7772, Email: dkraus@shaw.ca
Margaret Eberle. Phone: 604-254-0820, Email: m_eberle@telus.net
Jim Woodward. Phone: 604-883-0795, Email: jgwoodward@dccnet.com

Thank you for agreeing to participate in this study of **Sustainable Partnerships**.

A. Contact Information

1. Name of initiative_____

2. Person completing the interview

Name of person	**Position**	**Organization**	
Street address	**City**	**Province**	**Postal Code**
Phone	**Fax**	**E-mail**	

B. Questions

Background on organization

1. In what year was your organization established?

2. What is your organization's mission/mandate?

Background on the initiative

3. (If different from Q1) When was your initiative first implemented?

4. Why did your organization decide to go ahead with this initiative? (I.e. what factors prompted this initiative? – What was going on?)

5. Did you work with other organizations to plan and implement this initiative? If yes, which organizations? What were your respective roles?

6. What are the goals and objectives of your initiative – i.e. what does your organization hope to achieve?

Type of people housed

7. What kind of households are currently housed through your initiative?

Type of Household (check all that apply)	Number or proportion of households
☐Single Men	
☐Single Women	
☐Single people who are transgendered	
☐Couples	
☐Families with children	
☐Other – please comment	

8. What types of challenges do the people who are housed through your initiative have?

Types of Issues (check all that apply)	Number or proportion of residents
☐Mental health. Formal diagnosis and/or connected to mental health team	
☐Mental health. No formal diagnosis or connection to a mental health team	
☐Substance use	
☐ Concurrent disorder (mental health and substance use)	
☐HIV/AIDS	
☐Domestic violence	
☐Involvement in the criminal justice system	
☐Behavioural issues	
☐Other (please specify)	

Roles of the different partners

I would now like to ask you about the different partners who are involved in this initiative.

a) Role of organization being interviewed

9. What is the role of your organization in this initiative?

b) Housing

10. Is all the housing in this initiative intended to provide a permanent place to live or is there a maximum length of stay for some units?

☐ All units are permanent housing

☐ Most units are permanent housing

Housing tenure	**Percentage of units that are permanent/temporary**
Permanent housing	
Transitional housing (30 days to 2 or 3 years)	
Other type of housing	
	100%

Non-profit housing

11. How many different non-profit housing agencies are involved in this initiative, including your organization? _____

12. How many units do they provide as part of this initiative?_____

Name of Non-Profit	**Number of units**	Q13. **Describe** e.g. self contained, private bedrooms, shared space (e.g. bathroom, cooking facilities, lounge etc.)	Q 14. Is entire building dedicated to this population or does the population have access to a portion of units in a building.

13. Please describe the types of units available. *Prompt:* Self contained, private or shared bedrooms, shared bathroom, cooking facilities, common areas (SRO/Rooming House) etc.

14. Please indicate if the entire building is dedicated to this population or if the population has access to a portion of units in a building.

Private landlords

15. Do any private landlords participate in this initiative? ☐ Yes ☐ No

If yes, how many units do they make available for this initiative?_____

Private landlords	**Number of units**	Q16.**Describe** e.g. self contained, private bedrooms, shared space (e.g. bathroom, cooking facilities, lounge etc.)	Q17.Is entire building dedicated to this population or does the population have access to a portion of units in a building.

16. Please describe the types of units available. *Prompt:* Self contained, private or shared bedrooms, shared bathroom, cooking facilities, common areas, (SRO/Rooming House) etc.

17. Please indicate if the entire building is dedicated to this population or if the population has access to a portion of units in a building.

c) Services

18. Could you please describe the approach that is used to deliver and coordinate services? (Note: If the terms case management, Assertive Community Treatment, integrated services, wraparound services are used, ask specifically what this means – as noted below

Service delivery model	Please describe: What services, who delivers them, how often, how are they coordinated, and where
Case management	
Assertive Community treatment	
Integrated Services	
Wraparound Services	
Other/no name	

19. What kinds of services are available to the tenants participating in your initiative and who provides them? Please see below. (To be formatted in landscape mode).

Examples of Type of Services	**Describe the service – How often are these services available?**	**Who Provides the Service (name and type of service provider)**	**Are these available on-site (Yes/No)**	**Source of funding** e.g. Government c (which level), Private sector or Charitable foundation
☐ Medical care				
☐ Mental health				
☐ Substance use				
☐ Employment assistance				
☐ Money management				
☐ Assistance with life skills, food, transportation, clothing etc.				
☐ Other (please specify)				

20. What kind of space is available in the buildings for services or service providers?

21. (1) Could you please describe the nature of the relationships between the housing provider and service agencies? For example:

a) Do the housing providers and agencies participate in a network? ☐ Yes ☐ No

(i) If yes, please describe._____

(ii) Does the network have a specific name?_____

b) Is there a formal, written agreement between housing providers and service agencies?

☐ Yes ☐ No

If yes, please describe._____

c) Is there an informal understanding between housing providers and service agencies?

☐ Yes ☐ No

If yes, please describe._____

21 (2) What kind of ongoing relationship do you have with the [housing providers/ service agency(ies)/ other partners]? E.g. how often are you in contact, what kind of issues arise on a day-to-day basis, are these resolved…?]

21(3) How do you feel about your partnerships with the housing providers/service agency(ies)? What has worked well – what hasn't? What are the challenges?

	Positive (describe comments)	Negative (describe comments)
Housing provider		
Service agency		

Access to housing

22. Could you please tell me where the tenants come from who get housed through your program? E.g. are they referred from other programs or services such as drop-in centres, outreach workers or shelters? Other? Do potential residents require a referral or can they just walk in?

23. Are there any eligibility criteria for people to obtain housing through your program? If so, what are the criteria? Under what conditions would potential residents be denied access to your housing/shelter?

24. What expectations does your organization have about the degree of housing readiness for households to be housed through your program? What happens to households who are not deemed to be sufficiently housing ready?

25. Are tenants required to participate in any kinds of programs to be eligible for housing through your program? (e.g. Mental health, substance use?) ☐ Yes ☐ No

    If yes, please describe._____

26. Do you maintain a waiting list for your program? ☐ Yes ☐ No

    If yes, how many people are on it?_____

    Is tenant selection based on chronology or do you have a needs based system?

27. What kind of circumstances would be reasons for a tenant to be evicted or asked to move out? Do you have any written policies on this issue?

28. What steps, if any would be taken to try and avert an eviction?

Substance use issues

29. Do you have any policies, rules or restrictions regarding the use of substances such as alcohol or drugs on the premises? E.g.
    - The use drugs or alcohol in private living space, common areas inside the building, and common areas outside the building?
    - Behaviour that disturbs other tenants?
    - Policies about visitors and guests?
    - Other?

30. How are substance use policies enforced?

31. If a tenant enters a residential treatment program or is temporarily hospitalized, is there a time limit after which the tenant will lose the unit? Does the tenant need to pay rent while in a residential treatment facility? Is there financial assistance for this?

Costs and Funding

32. Review/clarify any questions arising from the financial statements re various sources of funding and costs for the program. If none received, ask about the various sources of funding and costs.

33. How much rent do the residents pay – is it a fixed amount or a percentage of income?

Evaluations/measures of success

34. Review/clarify any questions arising from evaluations received. Ask if any [other] evaluations have been completed, and ask for a copy.

35. How do you define success for your initiative? Using that definition, how successful do you think your initiative has been?

36. Do you have any information about what changes have occurred with residents in terms of the following (if not already answered).

Outcomes	Examples of changes since resident housed
Residential stability (length of time housed)	
Substance use (e.g. decreased us/participation in treatment programs?)	
Mental health (e.g. maintaining medication, reduced hospitalizations)	
Physical health (e.g. less use of emergency services)	
Education (e.g. going back to school)	
Employment (e.g. part time	

work)	
Income (e.g. increase)	
Personal networks (more contact with family, new friends)	
Other	

Community response

37. What has the response been to your initiative from the community?

	Positive (describe comments)	Negative (describe comments)
Community groups that might refer tenants to you		
Neighbours		
Housing partners		
Service agency partners		
Tenants		

Tenant satisfaction

38. Have you conducted any tenant satisfaction surveys that you could share with us? If not, do you have any indication of levels of satisfaction? Please explain. [If no indications, ask what would be the best way to get at some of this information. Ask if there is a tenant council and if we could speak with the chair of this council.]

Reasons and conditions for success

39. In your opinion, has the initiative achieved the goals originally intended?

☐ Yes ☐ No

If yes, what are the top 2-3 reasons for success of the initiative?

If no, please explain._____

Challenges

40. What would you say were the top 2-3 obstacles or challenges to implementing this initiative?

Lessons learned

41. What, if any words of wisdom or advice do you have for other organizations interested in doing a similar project?

Contact information

42. Do we have your permission to include your contact information in the report? OR is there another person in your organization who should be designated as the contact

person?

☐ It is OK to include my contact information in the guide.

☐ You should include someone else as the contact person in the guide.

Designated contact person to be published in the report (if different from above)

Name of person	**Position**	**Organization**	
Street address	**City**	**Province**	**Postal Code**
Phone	**Fax**	**E-mail**	

Next steps

Clarify if you will be speaking with anyone else about this initiative, if you need to find someone else to speak with, and who else you have already spoken with (if not done already).

Conclusion

- Thank you for participating in this project. Is there anything else you wish to add?
- We will send you a draft of what we write about your project for your review and approval so you can review and correct it before it is submitted. Would you be willing to do this? And we will send you a cheque for your honorarium.
- We will send you a copy of the final report.

Supporting information

Check if there is any additional information to be provided:

Information	**Date received**
External evaluations	
Tenant satisfaction surveys	
Annual report/financial statements	
Policies/rules	
Other	

Appendix E

Models for Sustainable Partnerships Between Housing Providers and Community Agencies to Address Homelessness

Focus Group Meeting - Summary
October 26, 2004

A. Review of Initiatives: What participants liked most and least

#1 Special Needs Housing Program, Victoria

Liked most:

- Good that there is such an initiative.
- The coordinated housing registry where housing providers come together to place people with complex needs into housing.

Liked least:

- Concern that there is not enough support.
- Most of the services are not provided on site. Some people may need more services to be available on site.
- Services need to be available evenings and weekends.
- Need for a tougher attitude to get drug dealers out of a building.

Questions: 1) What is the caseload ratio?
2) What services, if any, are available nights and weekends?

#2 BC Housing Health Services Program, Province-Wide

Liked most:

- People with special needs, some of whom have challenging behaviours, are able to get subsidized housing.
- On the whole, tenants are able to access the support they need.

Liked least:

- Concern that once people are housed in a bachelor unit, they will never be able to access a 1-bedroom unit or housing anywhere else. Because they are housed, they will have a low priority on any waiting list.
- There may be some reluctance in seniors buildings to take tenants with challenging behaviours.

Question: Why aren't more non-profits involved?

It was suggested that non-profits that house families may not be involved because the units may not be appropriate (e.g. wouldn't house single persons in 2-bedroom units). Housing providers that serve seniors may be reluctant to house people with special needs for fear that their seniors tenants will want to move out.

#3 Seymour Place, Vancouver

Liked most:

- A good way to serve this target group.
- Seems to be working well.
- Having a resource center on site – and other services in the building.
- The City's role in supporting the resource centre.
- The way everyone worked together to get the project built, and work together on an ongoing basis.
- Crime Free Housing Addendum to the lease.

Liked least:

- Need more.

#4 Special Referral Agreements and Condominium Initiative to Housing People with Multiple Challenges – A Housing First Approach, Ottawa, Ontario

Liked most:

- People are maintaining their housing.
- High level of support.
- Direct landlord and tenant relationship.
- CMHA is responsive if tenants cause problems and finds them another place to move to.

Liked least:

Question: Are landlords able to evict tenants under the Landlord/Tenant legislation?

#5 Referral Agreements between Housing Cooperatives and Service Agencies, Toronto, Ontario

Liked most:

- Able to serve a mix of tenants/residents.
- May have potential for people moving out of transitional housing programs.

Liked least:

#6 Housing, Healthy and Integrated Services Network (HHISN), San Francisco, California

Liked most:

- So many groups are involved. Great to have so many housing and service providers working together.

Liked least:

- Concern about the tolerance for drug use – although each building may have its own policies.

#7 Housing First: Permanent Housing and Supports for Homeless Families, Los Angeles, California

Liked most:

- The idea to place homeless families in permanent housing as soon as possible.
- Case management.
- Trying to place families in good neighbourhoods.

Liked least:

#8 Fresh Start, Portland, Oregon

Liked most:

- Incentives for landlords to participate – e.g. Guarantee Fund

Liked least:

- The maximum amount available through the Guarantee Fund is not enough.

B. Ideas that have the Greatest Potential to be Replicated in BC and Why

- Seymour Place – Need more such buildings that can serve a broader range of tenants, and in more locations. Difference of opinion about whether or not it is necessary for buildings to have supports on site.

- Special Referral Agreements and Condominium Initiative, Ottawa – Service agency purchasing condominium units to serve their clients.

- Housing First, Los Angeles – Case management. Good to have an initiative to serve homeless families.

- Rent supplement assistance to serve people in private rental buildings, plus support to tenants if they want it, and to landlords if they need it. It was noted that some families and individuals do not like living in dedicated buildings (group setting).

- Both scattered/integrated housing and dedicated buildings serve a purpose. Different clients have different needs.

- BC Health Services Program

- Housing, Health and Integrated Services Network (HHISN) – Broad scope.

- Landlord Guarantee fund – For non-profits, it would be simpler if funders would forgive over-expenditures for tenants who cause damage or don't pay rent. For private landlords, such a fund might make it easier for people to access housing (e.g. basement suites). Private landlords may be more willing to "take a chance".

- Special Needs Housing Program, Victoria – Seems straightforward and is working.

C. Summary

Partnership models that are developed to provide housing and support for people who are homeless and who have complex needs, should consider the following:

Housing choices

- There is a need for a range of housing options for the target population.

- Both scattered/integrated housing and dedicated buildings serve a purpose and can meet the different needs of different clients.

- There may be a limit to the extent that non-profit housing providers can accommodate individuals with complex needs within their existing portfolios. For example, buildings designed for families may not have any 1-bedroom units. In seniors buildings, there is a limit to the number of units that can be set aside for non-seniors with complex needs.

- There is support for rent supplement assistance to serve people in private rental housing.

- There is support for service agencies [and housing providers?] to purchase condominium units to rent to clients with complex needs. [Rent supplement assistance would be needed to make the units affordable].

- Individuals and families who are homeless should be placed in permanent housing as soon as possible – recognizing that some support/case management services will most likely be needed for a period of time. The nature/extent of the services will vary depending on the needs of each client.

- It is good for housing projects to be able to serve a mix of tenants.

Support services

- There is a need to ensure that tenants will be able to receive the level of support they need and want.

- There is a need to recognize that some people will require more or less support than others. Some tenants may need services on site, but others may not.

- Services need to be flexible to recognize that the needs of tenants will change over time. Tenants may need more support when they first move into a housing unit.

- Services need to be *available* evenings and weekends – in case clients or housing providers need support during those hours.

- Service agencies should be able to support housing providers if issues arise with a tenant who needs support- even if the tenant has refused services.
- People/staff in a housing development need to be know what to do if a tenant goes into a crisis.

Landlord incentives

- A landlord guarantee fund may serve as an incentive for landlords to rent to the target population.

- In non-profit buildings, instead of a landlord guarantee fund, funders should forgive over-expenditures to cover extraordinary costs if tenants damage a unit or don't pay rent.

Termination of tenancies

There is a need to develop strategies in case a particular tenant isn't working out – other than eviction through the RTA. For example, service agencies or a housing registry could play a role in finding alternate accommodation for such a tenant.

Partners

- Cities, health authorities, housing providers, service providers, and other potential partners, can all play a critical role in making projects work.

- There is a need to explore ways in which more housing and service providers can work together to support tenants in non-profit and private rental housing e.g. through the creation of a network such as HHISN.

Coordinated housing registry

There is interest in the idea of a coordinated housing registry where providers come together to place people with complex needs into housing.

Substance use issues

Strategies need to be developed to address concerns that housing providers and other tenants in a building may have with regard to drug use.