"BUILDING STABILITY"

A Housing First Program for Men in Hamilton

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INTRODUCTION

Since the 1980s, there has been a sharp increase in homelessness in Canada (Gaetz, 2010; Hulchanski, 2009). In Hamilton, a large number of people are currently at risk of homelessness. According to 2011 National Household Survey data, 42.5% of Hamilton's renters spent 30% or more of their household incomes on rent (Statistics Canada, 2013). In Canada, spending more than 30% of household income on rent or mortgage payments is considered living below the threshold of housing affordability. Additionally, allocating more than 50% of household income towards rent places households in the high risk category for experiencing homelessness, which suggests that one in five rental households in Hamilton is considered to be high risk.

Inadequacies in housing affordability have contributed to the present homelessness crisis in Canada. According to Hulchanski (2009), cutbacks in government spending on social housing in the 80s and 90s is one of the greatest contributors to the homelessness crisis our country is presently experiencing. He argues that the solution to this problem is increased and continued financial contributions and commitments from all levels of government. Appropriate and responsive programs, policies, and investments should ultimately lead to a decreased need for funding as associated service expenses decrease (Hulchanski, 2009). However, despite these recommendations, subsidies for affordable housing remain inadequate and social housing waitlist times remain high.

In 2011, the Federal government responded to the homelessness crisis in Canada with additional funding delivered through the Homelessness Partnering Strategy (HPS). This funding was provided to 61 Canadian communities, of which 22 were in Ontario. Hamilton was included as a designated area and received this funding. One of the requirements of the HPS funding was that each designated municipality must develop a community plan to address or end homelessness (Government of Canada, 2013a). Recently, the Government of Canada has announced their plans to renew HPS funding for designated communities in 2014. Significant portions of this funding must be used to support Housing First models in municipalities that require significant investment in programs to address concerns surrounding homelessness (Government of Canada, 2013b).

Research suggests that Housing First models of housing for people with other vulnerabilities (e.g., mental illness, substance abuse disorders) work very well in certain communities (Atherton and Nicholls, 2008; Goering et al., 2011; Hwang et al., 2009; Mental Health Commission of Canada, 2012; Tsemberis, 2010). However, Kertesz et al. (2009) argue that the implementation of these programs should account for the complexities within, and diversity of, communities. In light of the recent announcement by the Federal government that portions of the next round of HPS funding are designated for Housing First programs, evaluating and understanding appropriate place-based Housing First initiatives has become increasingly important and relevant within the Canadian housing policy landscape. This report contributes to this evaluation imperative within the context of the city of Hamilton. Specifically, we present data to answer the following two questions: 1) Has the Transitions to Home (T2H) program been successful in improving outcomes for its participants? and 2) What are the strengths and weaknesses of operating a Housing First program in the city of Hamilton?

BACKGROUND

DEFINING LONG-TERM HOMELESSNESS

Homelessness is a vast and very expensive social problem in Canada. Graham and Schiff (2010) estimate that there are between 150,000 and 300,000 homeless persons in Canada and that government spending ranges between three and six billion dollars per year. Gaetz et al. (2013) recently found that the annual cost of homelessness in Canada is seven billion dollars. Despite these investments, homelessness continues to be a problem in many Canadian cities.

In general, homelessness is a very complex term. Daly (2013) argues that definitions of homelessness must be broad enough to encompass the diversity of the precariously housed population. This definition should include those who are living in unaffordable conditions, as they are likely to experience a loss of housing over the course of their rental careers. He views homelessness as a continuum, with those who are inadequately sheltered on one end and those who reside outdoors, or sleep rough, occupying the other extreme. However, Daly (2013)

argues that those who experience homelessness share common experiences of social isolation and economic poverty, although the severity of isolation and deprivation varies substantially among the population of people who are homeless.

Although we acknowledge the need to develop broad, inclusive definitions of homelessness, in the present study, we define homelessness as residing in emergency shelters, as well as being unsheltered or experiencing absolute homelessness and sleeping outdoors. This definition of homelessness best describes the population of interest in this study. Additionally, this definition is the most commonly used definition of homelessness in the health research literature (Hwang, 2001).

There are variations in the length of homelessness episodes within this population. The number of nights spent in emergency shelters or unhoused is a frequently used measure for computing both long and short term episodes of homelessness (see: Tsai et al., 2010). However, the number of days used to measure short and long term homelessness varies based on study and region, and these categories are often inconsistently operationalized. For example, in Norway, the term long term homelessness applies to persons who have been unsheltered for several years, whereas other researchers use less prescriptive definitions that are broad enough to encompass variations in housing trajectories (Flato and Johannessen, 2010).

In their study of chronic homelessness in the United States, Caton et al. (2007:1) conceptualize the term chronically homeless in a broader way: "Chronically homeless; that is, unaccompanied adults with disabling conditions who experience long or numerous spells of homelessness." This definition encompasses both length and number of episodes of homelessness. However, what constitutes long or numerous is not clearly defined. The HPS provides two definitions of long-term homelessness. The first, chronic homelessness, refers to persons who have been homeless for 6 months or more in the past year. Episodic homelessness refers to persons who have experienced three or more episodes of homelessness in the past year (ESDC, 2014). As a service provider funded through HPS, Wesley Urban Ministries' T2H program considers those who have been residing in an emergency shelter for more than 30 days to be experiencing long-term homelessness (Wesley Urban Ministries, 2013). For the purposes of this study, we have used T2H's definition of long-term homelessness. However, it is important to note that our literature review includes studies that operationalize this concept in a variety of different ways.

PATHWAYS INTO LONG-TERM HOMELESSNESS

Long term shelter use is less common than short term use. A recent study by Gaetz et al. (2013) found that the Canadian median length of emergency shelter habitation is 50 days. However, the majority of shelter users occupy beds for less than a month, with 29% staying only one night (Gaetz et al., 2013). Research suggests that the long-term homeless population represents a small proportion of the total population of shelter users (Caton et. al, 2005; Culhane et al., 2011; Gaetz et al., 2013). However, this comparatively small population tends to access a disproportionately high amount of public and health systems and services (Culhane et al., 2011; Gatez et al., 2013).

Individuals who experience long-term homelessness often have different life trajectories than those who experience shorter periods of housing loss or instability. Chamberlain and Johnson (2011) describe five pathways into adult homelessness. These include 1) housing crises, 2) familial or relationship breakdowns, 3) substance use, 4) experiences of mental illness, and 5) experiences of youth housing precariousness leading to adult homelessness (Chamberlain and Johnson, 2011). They argue that those who experience mental illness and substance abuse are disproportionately represented in the long-term homeless population, resulting from insufficient availability of supports and limited exit options. Inability to obtain appropriate and effective supports results in longer periods of housing instability within this population.

As others have suggested, we argue that the factors leading to homelessness cannot be viewed in isolation from one another. Rather, we must view pathways into homelessness as being paved with intricate and complex connections between inequalities and trauma at both the individual and societal levels (Frankish et al., 2005). In this section, we discuss multiple pathways into homelessness. However, we do so under the premise that none of these pathways are linear or mutually exclusive.

Shorter periods of homelessness are often associated with the ability to access appropriate resources. In studying risk factors for long-term homelessness, Caton et al. (2005) found that the short-term population were often younger, had good coping skills, were able to access familial support, and had no criminal arrest history. Additionally, they found that there were no significant differences in length of homelessness resulting from DSM-IV classified substance use. However, they did find that those who had an attendance history with

substance abuse treatment programs were at greater risk of remaining unhoused for longer periods of time (Caton et al., 2005). This evidence suggests that the use of treatment programs to promote housing readiness may be largely ineffective. However, it also suggests that familial characteristics and degree of stability in childhood impact housing trajectories.

A body of literature addressing the characteristics of individuals experiencing long-term homelessness emerged in the late 80s and early 90s. With clear increases in homelessness occurring in the global north in the 80s, researchers began to look at the differences between those who were quickly rehoused and those who spent more time in shelters or sleeping on the streets. This resulted in a general consensus that the latter group had higher rates of mental health illness and substance abuse (Bassuk and Rosenberg, 1988; Breakey and Fischer, 1990; Drake et al., 1991; Koegel et al., 1988; Shlay and Rossi, 1992). Additionally, findings emerged that many of these individuals experience mental health and addictions concurrently (Drake et al., 1991). These findings began to point to the complex needs and realities of this population.

Current literature continues to point to the role of concurrent disorders or dual diagnoses in contributing to experiences of long-term homelessness (Chwastiak et al., 2012; Grinman et al., 2010). However, additional factors lead to loss of housing in both the short and long-term populations. Experiencing trauma during childhood increases the odds of housing loss as an adult (Buehler et al., 2000; Hamilton et al., 2011; Tsai et al., 2011). Additionally, recent findings suggest that childhood trauma also positively correlates with neurobehavioural impairment and mental health illness in persons experiencing homelessness (Kim et al., 2010; Pluck et al., 2011). This suggests the need to investigate childhood trauma and its contributions to homelessness in general, and more specifically to the longer term shelter use experienced by those with mental health concerns.

Mental health illnesses are frequently cited as contributors to homelessness. In their study of patients accessing mental health treatment centres for severe illness, Folsom et al. (2005) found that 15% of those receiving treatment were living on the streets or in emergency shelters. They note that those with schizophrenia and bipolar disorder are at greater risk of homelessness than those who are treated for major depressive disorders. This suggests the need for appropriate housing interventions for those who suffer with mental health conditions.

Deinstitutionalization, or the release from traditional or psychiatric hospitals, can lead to housing instability or homelessness. Those who experience institutionalization for physical and mental illness often need to find new housing arrangements when they leave hospitals. This can be problematic, as many of these individuals experience poverty. Affordable housing stock is limited and those with illnesses may experience additional constrains as they attempt to quickly locate suitable and affordable housing (Forchuk et al., 2011). This may lead to increased or prolonged use of emergency shelters.

Experiences of childhood trauma are important to consider when investigating contributions to long-term homelessness. Individuals who have histories of childhood trauma are more likely to have their first experiences of homelessness at much younger ages. They are also more likely to suffer from extreme forms of substance abuse disorders (Tsai et al., 2011). However, once enrolled in supportive housing programs, these individuals are just as successful as those who did not experience childhood trauma. Tsai et al.'s (2011) findings suggest that childhood trauma contributes to both homelessness and substance abuse. However, they find that supportive housing is still beneficial in promoting long-term stability.

Our literature search indicates that the majority of present health research focuses on the negative health implications and increased risk of injury in the homeless or underhoused populations. However, a recent study of residents of caravan parks found that worsening or poor health led to limited housing options for some of the residents of these parks (Newton, 2011). Acute physical injury, leading to loss of income and limited housing options, often prohibits individuals from reentering the workforce, leading to an inability to regain sustainable housing. This study indicates that it may be important to consider physical injury and poor health as both contributors to and consequences of precarious housing and homelessness.

Similarly, the literature on acquired brain injuries (ABI) and cognitive disabilities is mostly focused on these ailments as resulting from homelessness. Few studies have investigated these as leading to housing precariousness (Spence et al., 2004). However, some evidence exists that persons with ABIs and cognitive disabilities are at greater risk of becoming homeless than others (Backer and Howard, 2007; Spence et al., 2004). In their literature review, Spence et al. (2004) argue that there is an increased amount of cognitive disability within the homeless population and this may act as a pathway into housing precariousness as a result of negative impacts on social integration. Additionally, schizophrenia, substance abuse, progressive

neurological disorders, ABIs, and developmental disabilities are all associated with increased risk of becoming homeless (Backer and Howard, 2007). The limited research on ABIs and cognitive disabilities suggests the need to further investigate the role of these as both causes and outcomes associated with homelessness.

Criminality is also a contributor to homelessness. However, the extent to which it contributes to long-term homelessness is still unknown. In analyzing the shelter use population in New York City, Metraux and Culhane (2006) found that almost a quarter of shelter users had a history of recent incarceration. Additionally, roughly 17% of this population accessed shelters directly from jail. Travis et al. (2001) attribute a large proportion of the residential instability in recently released offenders to problems with reentering society. Recent evidence is beginning to suggest struggles with reintegration are associated with chronic or long-term homelessness (Baldry et al., 2006). This is problematic, as not only does institutionalization contribute to residential instability and shelter use, these outcomes often lead to criminal recidivism and subsequent incarceration (Baldry et al., 2006). Residential and economic instability, associated with release from jail, contributes to homelessness. However, additional research is required to discover the full long-term implications of incarceration on this specific population (Metraux and Culhane, 2006).

Multiple and prolonged periods of homelessness lead to an increased risk that one will remain homeless or become part of the long-term homeless population. Johnson and Chamberlain (2008) frame this phenomenon using the concept of social adaptation. As individuals remain homeless, they are more likely to adapt to an unhoused way of living. In his sense, being unhoused becomes the new normal as individuals become more engrained in street culture and living unhoused. They form social connections and learn to adapt to life on the streets or in the shelter system.

Other researchers frame exposure to homelessness, leading to prolonged homelessness, as contributing to deep or meaningful engagement in street life and culture. In their study of street youth, Auerswald and Eyre (2002) found that youth became engrained in street culture throughout the process of finding ways to meet their basic needs. These findings suggest that the longer one remains homeless, the more disengaged from mainstream society he or she becomes. One of the norms associated with street culture is distrust of traditional systems and services designed to assist homeless persons (Wasserman and Clair, 2010). This leads to disengagement with those perceived as authority, service providers, and mainstream institutions.

One of the most fundamental causes of both long and short-term homelessness is the lack of affordable housing in Canada. Canada has the second smallest social housing sector of any Western nation which results in limited options for low-income households in increasingly expensive rental markets (Hulchanski, 2002). The high cost of both rental and privately owned properties has placed many low and moderate income households in core need of affordable housing (Laird, 2007). Researchers argue that Canada's social housing system is not extensive enough and investment in housing stock and rent supplements is needed to prevent households from becoming homeless (Bryant, 2003; Hulchanski, 2002).

COMPLEX NEEDS

As noted in the previous section, a variety of different inequities, health concerns, and economic and environmental factors contribute to long-term homelessness. However, prolonged homelessness can also contribute to the development of ill health, social maladaptation, mental health and addictions concerns, criminality, and chronic social disengagement. Our literature review of both academic and grey literature reveals that the traditional pathways into homelessness are also consequences of chronic or long-term homelessness. We briefly discuss some of the consequences or outcomes associated with remaining unhoused and highlight the literature that discusses the systemic implications of long-term homelessness.

The longer individuals remain unhoused, the worse their general health and wellbeing becomes. Prolonged emergency shelter use is associated with increased risk of disease (Frankish et al., 2005). Due to overcrowding, individuals occupying emergency shelters are considered high risk for catching airborne diseases such as influenza, tuberculosis (TB), and bronchitis (Badiaga et al., 2008; 2009). When these illnesses remain untreated, the risk of developing serious and life threatening conditions increases.

Perhaps more alarmingly, unsheltered individuals experience heightened risk of developing chronic or acute illnesses, including human immunodeficiency virus (HIV), hepatitis B, and hepatitis C (Badiaga et al., 2008). However, these blood borne viruses are more common among those sleeping rough, as rates of intravenous drug use tend to be higher in this population. Research shows that the emergency shelter population experiences

higher rates of airborne than blood borne illness. However, these illnesses can result in serious health implications if not treated in a timely and comprehensive fashion (Badiaga et al., 2008).

In addition to developing periodic and acute illnesses, those who remain unhoused for longer periods of time are at increased risk of physical injury (Barrow et al., 1999). In their study of homelessness in Toronto, Hwang et al. (2008) found that 30% of homeless persons with brain injuries acquired them after becoming homeless. These injuries often result from victimization and trauma related to mental health concerns, drug use, drug seeking activities, alcohol consumption, and seizures (Padgett and Struening, 1992; Svoboda and Ramsay, 2013). Those who have experienced brain or head injuries are at an increased risk of sustaining future injuries and time between injuries decreases with each subsequent injury (Svoboda and Ramsay, 2013).

Although mental health illnesses are often seen as being contributors to long-term homelessness, these illnesses can develop or worsen as individuals remain unhoused. Feelings of hopelessness, uncertainty about the future, fear of victimization, and isolation from mainstream society contribute to depression, anxiety, and a variety of other mental health concerns (Villanueva, 2004). According to Martins (2008), homeless individuals often feel invisible to health care providers and others who are not marginalized within society. This results in increased feelings of social disconnection and isolation (Votta and Manion, 2004). In addition, this may result in the misuse of health care services, which is associated with diminished experiences of health, mental health, and wellbeing (Martins, 2008).

As previously noted, the longer one remains unhoused, the more engrained he or she becomes in a culture that normalizes street life, values, and cultures. In other words, those who remain homeless for longer periods of time begin to adapt to homelessness as a way of life (Johnson and Chamberlain, 2008). According to Thompson et al. (2006), street culture emphasizes distrust toward those who are viewed as being in positions of power or authority. This distrust stems from past negative experiences with traditional social systems and authority figures, as well as from the stigma homeless individuals experience. This suggests that these individuals may be more difficult to engage with using traditional social service provision outreach models, as they belong to a culture of distrust.

Engaging those who have become distrustful of social service and health care agencies and authority figures is extremely difficult (Caton et al., 2007; Fisk et al., 2006; Park et al., 2002; Zerger, 2002). According to Zerger

(2002), engagement refers to a period of time directly following initial contact with a social agency, institution, or worker. It is during this period of time that an individual chooses his or her level of involvement with a program. Resistance to engaging during this period often results in unsatisfactory outcomes, as the individual is not connecting and using the resources available to him or her. Engaging persons experiencing homelessness in programming designed to improve their housing outcomes can be extremely problematic for service providers.

Those who experience homelessness are at an increased risk of victimization (Kushel et al., 2003; Lee et al., 2010). However, homelessness is also associated with increases in criminal activity and incarceration (McNiel et al., 2005). In particular, homelessness is associated with increased involvement in non-violent criminal activity (Fischer et al., 2008). Criminal activity in the homeless population is often associated with mental health illness. However, Draine et al. (2002) argue that poverty is a better explanatory factor for crime in this population. Coping with extreme poverty is offered as an explanation for increases non-violent criminal activity in the homeless population.

Persons who have been homeless for longer periods of time can experience extreme difficulties and barriers when attempting to find housing independently. In studying homeless persons with mental illnesses, Mojtabai (2005) uncovered multiple practical barriers to finding housing, arguing that even when they have the money to do so, these individuals lack the resources needed to secure housing. These resources may include proof of income or employment, previous landlord reference letters, and good credit scores. Homeless individuals are often stigmatized by landlords and their inability to provide proof of stable housing and economic histories acts as a significant barrier to finding housing.

Housing stability is important to overall health and wellbeing. Further, research supports the argument that obtaining stable housing is important to achieving stability in other areas of life (Bratt, 2002; Jakubec et al., 2012; Tsemberis et al., 2010). In their review of literature on housing stability and health of individuals with severe mental health illness, Kyle and Dunn (2008) argue that housing stability is essential to obtaining and maintaining good health. Research suggests that maintaining stable housing is important to health and wellbeing, especially for those who experience mental health illness.

SERVICE USE

As previously noted, the cost of homelessness in Canada is extremely high (Gaetz et al., 2013; Graham and Schiff, 2010). In addition to direct costs, such as operating emergency shelters and providing case management support, there are multiple indirect costs associated with the complex needs of the homeless population. This section presents findings associated with service use patterns. Specifically, our literature review points to increased use of Emergency Departments (EDs), Emergency Medical Services (EMS), and police services. These programs are publically funded and are expensive to operate.

The homeless population accesses ED services more frequently than those who have stable housing (Kushel et al., 2001; 2002; Witbeck et al., 2000). Specifically, frequent use of EDs is associated with homeless persons who experience severe housing instability, victimization, substance abuse concerns, mental illness, and physical illness (Kushel et al., 2002). Comorbidities, or the experience of simultaneous multiple physical illnesses, also increase ED use in homeless populations (Kushel et al., 2001). Pearson et al. (2005) found that homeless persons access EDs four times as often as the general population and their visits are usually longer in duration. These findings suggest that poor health and diminished wellbeing are associated with increased ED use in the homeless population.

The literature on service use of persons experiencing homelessness suggests that mental health and addictions concerns contribute to more frequent ED visits (Kushel et al., 2001; Oates et al., 2009; Witbeck et al., 2000). Persons with mental health and addictions concerns are also disproportionately represented in the long-term homeless population (Johnson and Chamberlain). This suggests that the long-term homeless population is more likely to frequently access ED services.

In addition to more frequent use of ED services, the homeless population is also more likely to use EMS (Ku et al., 2010; Oates et al., 2009). In comparing 300 homeless patients to 300 housed patients, Pearson et al. (2005) found that 51% of homeless patients arrived at EDs via-ambulance, compared to 29% of non-homeless patients. Similarly, Oates et al. (2009) found that homeless persons were more likely to arrive at EDs via-ambulance, despite similarities in triage urgency. These findings suggest that homeless persons are more likely to use EMS for transportation to EDs.

Unhoused individuals experience higher rates of police contact. In interviewing 160 shelter users in Toronto, Ontario, Zakrison et al. (2004) found that 61% had some form of police interaction in the preceding 12 month period. Additionally, they found that homeless individuals were distrustful of police officers, with only 69% willing to call the police when emergency situations occurred. However, other researchers suggest that unwillingness to call the police during emergencies may stem from a culturally-based fear of retaliation for snitching (Huey and Quirouette, 2010).

The homeless population experiences higher rates of imprisonment, and longer incarceration periods than the housed population (Larimer et al., 2009; Zakrison et al., 2004). Homeless persons who experience frequent imprisonment have higher rates of mental illness and are often incarcerated for nuisance crimes (DeLisi, 2000). Additionally, they are more likely to have extensive criminal histories, and to have been incarcerated in the past for weapons, drugs, and alcohol related charges (DeLisi, 2000). These findings suggest that criminal justice system and police service use varies between the unhoused and housed populations.

The findings of our literature scan suggest that homeless persons use services, such as Emergency Departments, EMS, and criminal justice services, differently and at higher rates than housed individuals. Recent research has also shown that securing stable housing for these individuals, provided through Housing First programming, can decrease service use in the hard to house population (Gulcur et al., 2003). The following section of our report is dedicated to introducing the main components of Housing First models and synthesizing the evidence on the outcomes associated with these models.

TREATMENT FIRST & HOUSING FIRST APPROACHES

Continuum of Care (CoC) models are traditionally used to assist persons at risk of or experiencing homelessness in North America. In 1995, CoC emerged as the main approach to rehousing persons experiencing homelessness in the United States (Mott et al., 2012). These models became popular in Canada in 1999 with the introduction of the Federal government's establishment of the National Homelessness Initiative (Klodawsky, 2009). In the literature, Treatment First (TF), CoC, and Treatment as Usual (TAU) are often used

interchangeably to discuss programming that falls under the traditional mandate of CoC models. However, as the focus of our report is to assess the usefulness of Housing First for the long-term homeless population, and CoC models were designed to assist all persons experiencing homelessness, we specifically discuss their applicability to housing the population of interest in this report.

CoC models or approaches to addressing homelessness emerged in both Canada and the United States as part of the mandate for communities to develop coordinated housing action plans (CMHC, 2003; Klodawsky, 2009). According to Burt (2002: i), CoC is defined as:

> [A]…local or regional system for helping people who are homeless or at imminent risk of homelessness by providing housing and services appropriate to the whole range of homeless needs in the community, from homelessness prevention to emergency shelters to permanent housing.

In other words, CoC models are designed with the goal of addressing the needs of all individuals experiencing housing precariousness and homelessness. These programs are said to assist individuals with gaining access to services and programs. They are also praised for assisting service providers, institutions, and governments in coordinating with one another to provide a range of supports and services (Burt, 2002).

The fundamental components of CoC are geared towards providing people with emergency housing services and transitioning individuals into permanent housing. According to the CMHC (2003) the key model mechanisms are: 1) outreach, intake, assessment, and referrals to assess need, 2) provision of emergency shelters with appropriate services, 3) transitional housing to help people move towards independent living, and 4) offering permanent supportive housing for persons with disabilities who are unable to live independently. These components illustrate the broad nature of CoC programs, as they are designed to assist a wide spectrum of persons experiencing housing precariousness and homelessness.

Treatment first programming has been traditionally used in Hamilton, Ontario to address the needs of the homeless population (Austen and Sirko, 2003). Treatment as usual or treatment first programs fall under the mandate of CoC models. These programs require individuals to access treatment for addictions and mental health. Housing is dependent on participation in treatment. Once enrollment in treatment is established, individuals begin the process of moving through different types of housing. The level of support lessens as

individuals “graduate” from each housing stage. The ultimate goal of treatment first is for the individual to display ‘housing readiness.’ Whether or not someone is deemed to be housing ready is usually determined by a clinician and is based on substance use abstinence and improvement in psychiatric condition (Gulcur et al., 2003; Kertesz et al., 2009; Pearson et al., 2007; 2009). Once housing readiness is achieved, an individual may be placed in an independent housing unit.

CoC and treatment first approaches to rehousing may be useful for rehousing persons who experience shorter periods of homelessness. However, they are heavily criticized by Housing First advocates who are usually focused on providing housing for those experiencing longer periods of homelessness (Kertesz et al., 2009). In other words, the population of persons experiencing housing precariousness is not homogeneous. Different sub-populations exist within this larger population. Specifically, CoC models are said to fail to meet the needs of persons who are unable or not ready to participate in mental health or addictions treatment (Tsemberis et al., 2004). Additionally, treatment first programs are often ineffective for meeting the needs of individuals who do not thrive in highly structured and restrictive environments, as they require individuals to adhere to multiple rules and regulations (Pearson et al., 2009; Tsemberis et al., 2004).

Treatment first is also criticized from a social justice standpoint. Specifically, requiring housing readiness suggests that individuals must prove that they are suitable for or deserving of housing (Tsemberis et al., 2004). This is contradictory to the claim that housing is a basic right for all human beings (Tsemberis, 2010). Additionally, treatment first removes the elements of self-determination and choice from treatment (Kertesz et al., 2009). Requiring abstinence and mental health treatment forces participants to comply with societal norms regarding appropriate behaviours and lifestyles (Padgett et al., 2006). This removes the elements of self-determination and choice in both housing and treatment. Those who are unable to comply with the conditions of these programs often remain homeless.

The Housing First model is beginning to replace traditional approaches to rehousing for the long-term homeless population who experience addictions, mental illness, and concurrent disorders in both Canada and the United States (Gaetz et al., 2013; Tsemberis, 2010). This model was introduced in the 1980s (Goering et al., 2011). However, it gained popularity when it was implemented in New York City through Pathways to Housing in 1992 (Padgett et al., 2011). Mainstream use of this model began in the early 2000s in the United States and

eventually spread into Canadian cities (Gaetz et al., 2013; Tsemberis, 2010). Housing First is praised for allowing individuals to maintain control over their own lifestyles and treatment decisions, as there is no requirement that participants access treatment or abstain from substance use (Pearson et al., 2009).

Housing First is considered an evidence-based approach to addressing homelessness (Pearson et al., 2009). Implementation of this approach often varies between communities and service providers. However, researchers have clearly outlined the key principles of Housing First models. In the Canadian context, Gaetz et al. (2013) argue that Housing First involves the providing immediate access to housing, assisting with social and community connections, providing individualized support, offering consumer choice, and being oriented toward recovery. Tsemberis (2010) includes these elements within his description of Housing First. However, he adds that Housing First programs should separate housing supports from treatment. Additionally, Pearson et al. (2009) build on this, suggesting that Housing First programs should engage with participants through outreach, use harm reduction methods, and provide support to assist participants with maintaining housing. The most important underlying theme in all of these models is that housing is not dependent on accessing treatment and abstaining from substance use.

Studies that evaluate the effectiveness of Housing First for participants focus on understanding outcomes across five domains. These domains are: 1) substance use and psychiatric symptoms, 2) housing retention and tenancy satisfaction, 3) cost effectiveness, 4) service usage, and 5) quality of life and wellbeing (Woodhall-Melnik, 2014: Under Review). Generally speaking, research evidence illustrates that Housing First programs improve outcomes for the long-term homeless population.

Enrollment in a Housing First program is associated with improvements in self-reported perceived quality of life (Bean et al., 2013; Patterson et al., 2013). Additionally, Housing First program participants experience reductions in stress levels (Watson et al., 2013). Collins et al (2012) and Watson et al (2013) attribute stress reduction and feelings of relief to finding stable housing and obtaining housing with fewer barriers. Despite improvements in quality of life, current research finds no difference in tenancy satisfaction between Housing First and CoC participants (Robbins et al., 2009). This suggests the need to further investigate tenancy satisfaction as a quality of life measure for Housing First participants.

Housing First is associated with increased residential stability (Collins et al., 2013; Desliva et al., 2011; Montgomery et al., 2013; Palepu et al., 2013; Robbins et al., 2009; Stefancic & Tsemberis, 2007; Tsai et al., 2010; Tsemberis et al., 2004; 2012). In other words, enrollment in Housing First programs allows individuals to maintain stable, independent housing for longer periods of time. In addition to this, Housing First is associated with reductions in homelessness and the ability to house individuals faster (Greenwood et al., 2005; Gulcur et al., 2003; Tsemberis et al., 2004). Housing First participants also experience higher rates of program retention (Pearson et al., 2004; Padgett et al., 2011). This is indicative of a program structure that encourages longer term participant interaction and involvement with service providers (Stanhope et al., 2009).

Evaluations of Housing First programs indicate a general decrease in the use of the criminal justice system, emergency shelters, EDs, addictions treatment services, and impatient hospitalizations (Bean et al., 2013; Desilva et al., 2011; Gilmer et al., 2009; Hanratty, 2011; Padgett et al., 2006; 2011; Parker, 2010; Srebnik et al., 2013; Tsemberis et al., 2004). Research also suggests that Housing First participants experience increases in their consumption of more "appropriate" or planned, and preventative health services, such as use of primary care physicians and outpatient mental health services (Bean et al., 2013; Gilmer et al., 2009; Parker, 2010). Srebnik et al. (2013) argue that Housing First programs decrease costs associated with long-term homelessness, resulting from reduced expenditures on emergency health and criminal justice system use. However, Gilmer et al.'s (2009) association between cost reductions and Housing First program involvement was not statistically significant. These findings suggest that increased use of planned and preventative services may decrease cost. However, additional research is required.

Our review of the academic literature on substance use and the prevalence of psychiatric symptoms generated mixed findings. Research indicates that Housing First participants experience improvement in regards to experiences of psychiatric symptoms (Greenwood et al., 2005; Tsemberis et al., 2012). However, in comparing Housing First participants with individuals enrolled in CoC programs in New York, Tsemberis et al. (2004) found no significant difference in psychiatric symptomology between the two groups. Contradictory findings also exist for alcohol and substance use, with some studies finding that Housing First is associated with decreased use and others finding no significant relationship between the two (Collins et al., 2012; Padgett et al., 2006; Tsemberis et al., 2004; 2012). Our literature review suggests the need for additional research on mental health and addictions outcomes in Housing First participants.

Generally speaking, the evidence base that has provided the foundation for establishing Housing First programs suggests that these programs are beneficial in improving housing stability, quality of life, and service use outcomes for their participants. However, Kertesz et al. (2009) caution policy makers and service providers against overgeneralizing the findings of these studies. In other words, they suggest that different communities have different needs and the standardized application of Housing First models may not apply in all contexts. With this in mind, this study focuses specifically on the application of Housing First for men experiencing long-term homelessness in Hamilton, Ontario. The following sections provide the context required for conducting research within this specific location.

CONTEXT: HAMILTON, ONTARIO

To date, the majority of studies examining the Housing First model have yielded positive findings that affirm the usefulness of programs following this approach. However, in discussing the application of Housing First models in the European context, Atherton and McNaughton Nicholls (2008) argue that programs must be tailored to local contexts. In other words, to automatically assume that programs established through evidence-based practice in other areas will be successful in locations with different political climates, service providers, and populations, places researchers at risk of committing the error of overgeneralization. With this in mind, the following section provides context on the city of Hamilton, the Transitions to Home Program, and factors associated with homelessness and service provision. In order to accomplish this, we draw on information found within grey literature, Statistics Canada data, as well as data from our Key Informant interviews.

Hamilton is a large, mostly urban area, located within South Western Ontario. The city is comprised of multiple smaller townships including Ancaster, Dundas, Flamborough, Glanbrook, Hamilton, and Stoney Creek (City of Hamilton, 2013a). According to the 2011 National Household Survey, there are 708,175 residents in Hamilton, occupying 282,185 private dwellings (Statistics Canada, 2013). 31.7% of households rent their accommodations, with an average rent of $701 which is $100 less than the provincial average (Statistics Canada, 2007).

Hamilton, Ontario is a unique city with a rich history of industry, which developed as a manufacturing hub with a specific specialization in steel production (Ward, 1937). The majority of Hamilton's manufacturing plants were located in the north end of the city (Ward, 1937). The post-WWII era brought about a high demand for steel (Hedican, 2012). For years the city's two large steel plants, Stelco and Dofasco, played a large role as major employers, contributing to economic growth and prosperity (Holmes, 1991). Many of the participants in this study discussed their experiences in Hamilton in the 1960s and 70s. A T2H participant stated:

> And it was kind of strange here in Hamilton in the late '70s when I graduated high school. University or college was not a possibility, you know it was out of the question and I didn't have the discipline or the wherewithal, I had other things to do, I had people to confer, you know this Jesus complex. But here in Hamilton you could start down in Burlington Street and James and you could walk the length of Burlington Street and if you got to the end of the street by the end of the day and you didn't have a job that paid twice the amount of money there was something wrong with you, you know like there was good work …Yeah just all kinds of little mom and pop factories all the way up Burlington Street right that always needed somebody and you just walked in and you had your piece of paper with a little bit of information and you'd get a job right which drives me crazy today, absolutely crazy. You know the people that I live with, people that are in your study we have snowballs chance in hell of going out and getting a decent job.

This participant referred to a time when semi and unskilled work was readily available in Hamilton. During this time, it was easier for individuals to find work and earn a living wage. In the early 1980s, Canada entered an economic recession, resulting in large job losses in the manufacturing sector (Holmes, 1991). The 1990s brought about continued job loss in Hamilton's north end. Stelco laid off thousands of employees and several large manufacturing plants closed their doors, severely damaging Hamilton's once booming economy (Hedican, 2012; Torjman et al., 2002). Hamilton's main industry continued to suffer, with Stelco filing for bankruptcy protection in 2004. Hedican (2012) argues that this impacted over 20,000 working class families, resulting in many mortgage foreclosures and rental evictions in the north end. Hamilton has since established itself as an innovative leader in health care and social service provision. However, poverty continues to be a persistent problem for the many low and semi-skilled labourers who were displaced from their jobs in Hamilton's manufacturing sector.

In addition to the job loss and economic hardship associated with the decline of Hamilton's once booming industrial sector, changes to mental health treatment models in Ontario may have influenced housing outcomes for people who experience mental health illness and homelessness concurrently. In 2003, the World Health Organization released a report advocating for desinstitutionalization, stating that mental health services should be provided in the community. They argued that large scale psychiatric services are not appropriate environments for treatment. However, they also argue that persons being discharged from institutional care or those who are treated within the community require more adequate supports:

> In developed countries, the process of deinstutionalization during the last three decades has led to reductions in the populations of mental hospitals and the closure of many of these institutions. However, this has not been accompanied by sufficient provision of community-based services, which are often inadequate and unevenly distributed (World Health Organization, 2003: 4).

From a health promotion perspective, deinstitutionalization provides individuals with greater choice in treatment. However, to be effective, the process of deinstitutionalization must include steps to provide quality care and adequate resources within the community (World Health Organization, 2003).

Researchers have argued that deinstitutionalization without the provision of adequate services has resulted in increased rates of homelessness among persons experiencing mental illness (Collins, 2010; Lamb, 1984; Perlin, 1991). The Hamilton Psychiatric Hospital (HPH), which was a large institution that provided inpatient treatment, began the process of deinstitutionalizing care in the 1960s (Frankel, 2003). This resulted in the increased use of Residential Care Facilities (RCFs) in many cities that experienced bed closures, including Hamilton. However, despite increased RCF usage, research suggests that deinstitutionalization led to increased homelessness for those experiencing mental illness (Collins, 2010).

Hamilton is an extremely diverse city with clear geographical inequities. In identifying priority neighbourhoods in which to investigate inequality, the Social Planning and Research Council of Hamilton (SPRCH, 2012) noted that eight neighbourhoods in central and east-central downtown experience the highest levels of poverty and inequality. The majority of these neighbourhoods encompass or are in close proximity to Hamilton's north end. In this background, we provide information on two specific neighbourhoods, Beasley and Jamesville, as these neighbourhoods are hubs for the majority of men's homelessness services. The Wesley and Good Shepherd

centres are located in the Beasley neighbourhood, Mission Services borders the Beasley and Jamesville areas, and the Salvation Army booth centre is located in the Jamesville neighbourhood.

BEASLEY PROFILE

The Beasley neighbourhood experiences large amounts of social inequities. According to the SPRCH (2012), roughly 60% of residents in this area live below the low-income cut off line, indicating a very impoverished neighbourhood. The vast majority (79%) of Beasley residents are renters and 49% spend more than 30% of their household income on rent (SPRCH, 2012). Education levels in this neighbourhood are quite low, with 34% of adults between the ages of 25 and 64 reporting no completed education. Generally speaking, these statistics suggest low socioeconomic status in the Beasley neighbourhood.

In addition to social inequities, this neighbourhood also experiences health disparities. A higher proportion of Beasley residents (27%) live with mobility issues compared to the general Hamiltonian average (21%). Additionally, ED use is quite high within this neighbourhood, with an additional 480 visits per 1,000 residents (SPRCH, 2012). The average age of death is 71.9 years, which is 3.3 years younger than the rest of Hamilton. However, these rates may vary within this neighbourhood.

The Beasley neighbourhood is home to two of Hamilton's providers of men's homelessness services. The Wesley centre provides day use facilities and a hot meal program for those in need. The main centre also houses the case management staff for the T2H program, allowing the staff to easily meet with clients and perform outreach in a neighbourhood that is highly impacted by poverty. The Good Shepherd centre also operates within the Beasley neighbourhood. This organization provides multiple services to Hamilton's low-income population. However, of most importance to this report is their overnight men's shelter. This shelter has 54 overnight beds and also provides a hot meal program.

JAMESVILLE PROFILE

The Jamesville neighbourhood is geographically larger than the Beasley neighbourhood. Due to the large catchment area of this neighbourhood, there are substantial variations experienced across the area. The SPRCH (2012) argues that the north end of this neighbourhood experiences more inequity than the south area and that the inclusion of the south end in this catchment area artificially skews the population statistics for this neighbourhood. Nonetheless, we present the findings at the neighbourhood level, arguing that these statistics represent the best available approximation of the population residing in this area.

Similar to the Beasley neighbourhood, the Jamesville area also experiences socioeconomic and health inequities. Generally speaking, home ownership rates in Jamesville are moderately low, with 53% of residents renting their dwellings. Of these renters, 43% live in accommodations that are considered to be unaffordable based on their household income. 35% of Jamesville residents live below the poverty line (SPRCH, 2012).

Using average age of death as an approximation of health, one could argue that Jamesville does not experience health inequities (75.9 years of age). However, the SPRCH (2012) argues that this varies significantly by neighbourhood area. They estimate that the south area of the neighbourhood's average age of death is closer to 80 years of age, whereas the north end may be as low as 67 years. Additionally, ED usage in this neighbourhood is quite high. For every 1,000 residents, Jamesville experiences 300 additional ED visits when compared with the rest of Hamilton (SPRCH, 2012). This suggests increased service consumption in this area and decreased health and wellbeing in the north end of the community.

Like the Beasley neighbourhood, Jamesville houses two organizations with the mandate of providing shelter and services to men who are experiencing homelessness. Mission services is located on the boarder of Beasley and Jamesville and provides emergency shelter services, with 58 beds, and a hot meal program. In addition to this, they provide a variety of other services, such as treatment-based transitional housing programming for men with addictions concerns. The Salvation Army also provides emergency shelter services for men and a hot meal program. Their shelter has 82 overnight beds, with the purpose of providing shelter for those in need.

It is particularly important to note that the demographics in both of these neighbourhoods are presently fairly dynamic. According to the SPRCH (2012), Jamesville has a higher than average young adult population. In recent years, this area has become increasingly attractive to youth, artists and young entrepreneurs, resulting in the beginning of neighbourhood revitalization. Additionally, rapid transit, a large commuter transit station, and neighbourhood revitalization associated with the 2015 Pan American games are planned for these areas (City of Hamilton, 2013b; 2013c). Grube-Cavers and Patterson (2013) found that close geographic proximity to rail transit results in gentrification. Additionally, in studying neighbourhoods in Toronto, Ontario, Mazer and Rankin (2011) found that neighbourhood gentrification can result in the displacement of rooming housing tenants. These tenants are traditionally low-income and lack the financial resources to pay the high market rents traditionally associated with neighbourhoods that have gentrified. If these neighbourhoods continue to experience growth, they may improve. However, gentrification may occur, further marginalizing and potentially displacing low-income women, men, and families in these neighbourhoods.

MEN'S HOMELESSNESS SERVICES

In the late 1990s, social programming in Ontario underwent reforms under the leadership of former Premier Mike Harris and his common-sense revolution (Hackworth and Moriah, 2006). These reforms resulted in the devolution, from the provincial to municipal levels of government, of the responsibility for administering many social programs. As a result of these changes, public funding for homelessness programs in Hamilton is managed and administered by the Housing Services Division of the municipal government. The municipal government receives transfer payments from the Federal government through the Homelessness Partnering Strategy (HPS), and the Provincial government through the Community Homelessness Prevention Initiative (CHPI) which is administered by the Ministry of Municipal Affairs and Housing (MMAH). CHPI recently replaced the Community Homelessness Prevention Program (CHPP) which was administered by the Ministry of Community and Social Services (MCSS). The municipal government allocates block funding to shelter operators within the city (City of Hamilton, 2008b; 2013d).

There are three men's emergency overnight shelters in Hamilton. These shelters are operated by faith-based, not-for-profit organizations and have the cumulative ability to provide emergency overnight accommodations for up to 194 men. There are two coordinated bodies designed to facilitate communication amongst the three shelters, the T2H program, and other stakeholders such as Mental Health and Street Outreach. These committees are convened and chaired by the City of Hamilton. Shelter Standards gathers managers and supervisory-level staff and the Hamilton Emergency Shelter Integration Coordination Committee (HESICC) operates with the purpose of gathering directors and executive directors of the organizations.

In addition to the emergency shelter system, there are a variety of other services operating in Hamilton's downtown core which are designed to assist men, women, and families experiencing homelessness, mental health, and addictions concerns. Examples of these services include, Mental Health Street Outreach, various food banks and clothing programs, the Housing Help Centre, the Hamilton Police Services Social Navigator Program, and the Crisis Outreach and Support Team (COAST).

THE BEGINNING OF A HOUSING FIRST MODEL IN HAMILTON: HOSTELS TO HOMES PILOT

The City of Hamilton began working with models that incorporated Housing First principles in 1999 through the introduction of the Housing with Onsite, Mobile and Engagement Services (HOMES) program. This program, administered by the Good Shepherd, provided secure housing and supports for individuals experiencing homelessness and mental health illness. Supports associated with this program were provided to individuals living in any of the four HOMES sites, as well as to individuals who were enrolled in the HOMES program and were housed within privately owned apartment buildings (The Good Shepherd, 2007).

In May, 2007, Hamilton was selected to participate in the Hostels to Homes (H2H) pilot project (City of Hamilton, 2008a). This pilot was funded by the Ministry of Community and Social Services (MCSS) with the aim of testing Housing First programs in six municipalities in Ontario. Hamilton's pilot was slated to be a collaborative program which required the input of all of the emergency shelter providers to deliver housing to persons who had resided in emergency shelters for more than 42 days (City of Hamilton, 2010). However, the

program was run through the City of Hamilton. In 2007, H2H had the capacity to house 80 persons. Funding for an additional 40 program participants was granted in 2008 (City of Hamilton, 2008a).

The original aim of H2H was to stabilize emergency shelter use in the city. Specifically, the City of Hamilton (2010) was interested in minimizing long-term shelter use, in an effort to use the shelters to house on a shorter-term or infrequent basis. This pilot was deemed to be successful, as 145 persons were housed, with 109 remaining housed at the end of the pilot. In 2008, the City estimated that H2H contributed to a numerical decrease of 13,000 shelter nights (City of Hamilton, 2010). In 2009, H2H was credited with $43,000 in cost savings (City of Hamilton, 2010).

H2H used an Integrated Mobile Case Management team to provide participants with housing and services support. The City of Hamilton (2008) noted that this support was mobile in the sense that participants received support in a variety of locations, including their housing units, over the phone, and in the community. Between May 2007 and October 2008, scattered site housing was provided to 82 participants in 32 different building locations using the City's Housing Allowance Program (City of Hamilton, 2008a).

According to the City of Hamilton (2010), H2H contributed to decreased demand for men's shelter services. In response to this, the Blueprint for Emergency Shelter Services was created. This blueprint discussed the surplus of beds in Hamilton and outlined the closure of Wesley's overnight shelter and created the Shelter Standards group as a mechanism for promoting consistency amongst service providers. Another substantive change included the integration of HIFIS in the emergency shelter system. This allowed case workers at different shelters to share real time client data with one another. Additional changes included allowing individuals to stay in shelters during the day time and removing requirements that individuals be sober to enter a shelter. Prior to this, Wesley Urban Ministries' shelter was the only option available for clients presenting as intoxicated (Swanson and Clinton, 2010).

In addition to changes to the shelter system, the approaching end of H2H pilot program funding prompted the City of Hamilton to work in tandem with Wesley Urban Ministries and the other members of HESICC to create the T2H program. In 2009, Wesley Urban Ministries became the service provider for Housing First services in Hamilton. Between October 2009 and June 2010, T2H was partially funded using the remaining H2H pilot funding. Subsequent funding sources have included HPS, the Community Homelessness Prevention Program

(CHPP), the Community Homelessness Prevention Initiative (CHPI), and the Delivering Opportunities for Ontario Renters (DOOR) fund (City of Hamilton, 2009; 2013d).

TRANSITIONS TO HOME: PROGRAM DESCRIPTION & STRUCTURE

As noted above, the T2H program was originally designed with the intent of maintaining Housing First services in Hamilton with the conclusion of funding for the H2H pilot program (City of Hamilton, 2010). Similar to H2H, the mandate of T2H is to assist in providing housing to the long-term shelter use population. The following section draws on grey literature, as well as information generated through key informant and case management interviews to describe the T2H program and its structure.

Wesley Urban Ministries, hereafter referred to as Wesley, is a locally-based, not-for-profit organization which was designed to meet the needs of a variety of groups experiencing social inequities within the City of Hamilton. Wesley operates three service divisions: Housing and Homelessness, Child, Youth and Family Programming, and Neighbourhood and Newcomer Services. The Housing and Homelessness division, led by a Director, is responsible for Wesley's Special Care Unit or Managed Alcohol Program, the Wesley drop-in day use centre, and the T2H program.

T2H is run as a partnership program between Wesley and the local men's shelters. However, the administration and staffing for this program are maintained through Wesley. According to Wesley (2013), T2H have five program anchors. These are:

1) To assist long-term shelter users and people living on the streets in moving directly into housing without requiring substance abuse or mental health treatment

2) To provide ongoing case management support with no time limits, using mutually agreed upon case plans

3) To employ harm reduction strategies

4) To ensure that program participants are legal tenants with leases

5) To ensure a separation between housing maintenance and participation in services

From 2009 to 2011, T2H provided Housing First services for men and women. In 2011, Supporting Our Sisters (SOS), managed by the Women's Housing Planning Collaborative and funded through HPS, took over service provision for women experiencing long-term homelessness. Currently, T2H's client base is male. However, some of the women who were originally enrolled in the T2H program continue to access T2H's recreational programs and maintain contact with case managers. Additionally, according to one case manager, they continue to reach out to T2H for tenancy support.

T2H uses a mobile intensive case management team, with a specialized clinical team, to provide services to program participants. In addition to management staff, which includes a director, manager, and program supervisor, Wesley employs case managers to engage with potential and existing participants and to offer assistance to participants on an ongoing basis. According to the case managers interviewed for this research, the typical process of working with a client involves meeting with clients, who are typically referred through the emergency shelter system, discussing program mandates, completing enrollment paperwork, adding participants to the Rent Geared to Income (RGI) waiting list, applying for income support if necessary, and formulating a case plan. T2H has recruited a few participants through Hamilton's Police Services Navigator. However, to date, the proportion of individuals recruited in this fashion is negligible. Processes for engaging with potential participants are discussed in detail in the results section of the report.

After participants enroll in the program, the T2H team begins the process of assisting them with finding and obtaining housing. T2H works with a variety of private market landlords to house participants. However, scattered site, independent housing units are frequently difficult to quickly obtain. As a result of this, T2H provides an opportunity to move to scattered site congregate houses for the majority of participants who enter the program. T2H operates with the understanding that congregate housing may not be the best option for every participant. Participants have declined this form of housing for multiple reasons, including fear that addictions may be triggered in an environment where others may be using drugs and alcohol. Although it is not a requirement that participants enter into congregate housing, one case manager argued that these housing arrangements allow participants to adjust to living outside of the shelter system. Additionally, this case manager also noted that placing participants in congregate housing allows them to observe any potential difficulties a

participant may experience in living independently and attempt to problem solve with the individual to uncover potential coping strategies. When independent units are available, they are offered to participants.

Participants are provided with access to housing with few barriers or requirements. In order to secure housing, participants are required to apply for Rent Geared to Income (RGO) Housing. Additionally, they are asked to meet with their case managers on a regular basis. Generally speaking, these meetings can serve therapeutic or social functions for participants. Meetings generally involve reviewing goals that are captured within participants' case plans. These goals vary, however, common goals noted in the case manager interviews included applying for income support, assistance with finding housing, employment or education goals, obtaining valid forms of personal identification, seeking assistance with mental health and addictions concerns, and accessing services and medical care.

In addition to regular meetings, participants are able to access their case manager when needed. They often do so by calling their case manager or by locating them within Wesley's day use centre. Case managers provide assistance with a variety of concerns that often exist outside of their clients' case plans. Examples of common tasks mentioned in the case manager interviews include assisting clients with housing and personal concerns and crisis, attending legal and medical appointments as an advocate or support person, and assisting participants as they complete daily tasks such as grocery shopping. Participants are provided with assistance for emergencies 7 days a week and 24 hours a day, as case managers have a rotating on call schedule.

T2H also employs a specialized clinical team. This team includes an addictions case manager who assists participants in achieving any goals related to harm reduction or cessation they may have, and a recreation therapist. The recreation therapist is responsible for planning activities for T2H participants. Some of the activities offered to participants include bowling and baseball leagues, swimming, gym passes and workouts, outdoor exercise activities, holiday parties, and a weekly drop-in group lunch. T2H has also has a housing worker on staff. This person is responsible for assisting case managers in determining housing options for their participants and acts as an advocate for landlords housing program participants. This position is unique to the T2H program and allows the landlords to connect with the program while attempting to resolve tenancy issues with participants.

METHODS

In designing this study, we sought to understand both the general impacts of the T2H program on participant outcomes as well as the experiences of individuals enrolled in the program and those who qualified for the program but had not engaged with T2H staff. In order to do this, we designed a multi-stage mixed methods study. This research program was designed to be a community-university alliance between Wesley Urban Ministries, who served as the community agency and program service provider, and McMaster University. It was overseen by a research advisory committee which consisted of Wesley staff, a participant representative, an employee of the City of Hamilton, and representatives from McMaster University. The following section describes the qualitative and quantitative research methods used in this study.

QUALITATIVE INTERVIEWS

Sample

In order to learn about the T2H program and to explore the experiences of its participants, the research team interviewed a total of 41 respondents including key informants [n=5], T2H case managers [n=10], T2H participants [n=16], and a comparison group of men who had accessed emergency shelters for more than 30 days in the past year and were not participants in the T2H program [n=10].

Key Informants [n=5]

Key informants were identified as senior social service managers in Hamilton, Ontario who were known to possess expert knowledge of the T2H program and issues of homelessness in the area. These individuals were purposively sampled based on their knowledge of the T2H program. They were selected from a mix of professions and organizations in order to provide a multi-faceted perspective of the issues at hand. These interviews were used by the researchers to gain a better understanding of the program including its publicly perceived benefits and challenges.

Case Managers [n=10]

These respondents were members of the T2H case management and clinical teams. The purpose of these interviews was to gain an understanding of the strengths and challenges associated with administering the intensive case management model within the T2H context from the case managers' perspective. Specifically, case managers were asked about the processes clients go through, how they work with their clients, and about the specific kinds of opportunities and barriers they saw their clients facing. These interviews were designed to gain insight into the psychological, structural, social and physical factors leading to success and challenges within the T2H program.

T2H Participant Interviews [n=16]

These respondents were participants in the T2H program. Program tenure varied for each participant. However, all of the respondents were actively involved with a case manager at the time they were interviewed. The purpose of these interviews was to collect narratives of participants' experiences within the T2H program and to understand their subjective understandings of what they saw as leading to their own homelessness. Secondary goals of these interviews were to understand participants' housing trajectories, their experiences with mental health, physical health, and addictions, and their experiences with using and navigating the social service system. We also assessed their baseline functioning. The process for assessing functioning, using the Multnomah Community Ability Scale, is outlined below.

Non-T2H Participant Interviews [n=10]

These respondents were experiencing long-term shelter use in Hamilton, Ontario. However, they had not accessed the T2H program. Similar to the T2H interviews, we aimed to better understand contributions to long-term homelessness, housing trajectories, experiences with mental health, physical health, and addictions, and experiences with using and navigating the social service system. However, the main goal of these interviews was to gain an understanding of the qualitative reasons that lead men not to access the T2H program as well as to understand any perceived barriers to full program utilization. The Multnomah Community Ability Scale was administered prior to interviews to assess functioning.

Recruitment

Recruitment emails inviting voluntary participation in this research were sent out to the publicly listed email addresses of the key informants. We contacted 7 potential key informants and 5 agreed to participate in this study. The Director of Housing and Homelessness at Wesley assisted in providing contact with the case management staff by emailing letters to his staff on behalf of the research team. Case managers were asked to contact the researcher directly to set up an interview time and to ask questions about the research. An information letter outlining the details of the study was attached to each recruitment email.

In order to recruit T2H participants for this study, the case management team was provided with copies of the recruitment letter to distribute to their clients. Participants were asked to contact the researcher directly to ensure confidentiality. Recruitment posters were also displayed asking for voluntary participation in the study at Wesley's day use centre. This centre is frequently accessed by program participants and those who access overnight shelters in Hamilton. These posters were intended to recruit homeless non-participants using the centre to the study. In addition to this, the researcher hand delivered recruitment letters to potential study participants in the Wesley drop-in centre and at local service agencies. Permission was granted by each local service agency accessed. T2H participants and the shelter use participants were compensated for their participation. Each respondent was provided with a $25 Giant Tiger gift card and 2 bus tickets for transportation to and from the interview location.

Data Collection

Face-to-face, semi-structured interviews of approximately one hour in length were conducted with each respondent. The lead researcher conducted all interviews. Key informants were interviewed in their offices. To ensure confidentiality, case managers were interviewed off-site in a private room of a municipal building. Interviews with T2H participants and non-participant men who had experienced long-term shelter use were conducted by the lead researcher, accompanied by a male research assistant. These interviews were conducted in a private meeting room secured by the research team.

The Multnomah Community Ability Scale was administered prior to the beginning of each T2H participant and long-term shelter use interview. The scale is designed to assess the baseline functioning or ability of a

participant across a variety of domains. Questions are asked about physical and mental health, social connections and skills, adaptation to daily life tasks, and participation in deviant behaviour. The purpose of administering this was to compare the mean scores in each category for each participant type to assess whether there were differences between the T2H group and the comparison group. A teach back exercise, which is described below, was administered prior to beginning each interview. This was used to ensure that participants comprehended the consent form and were able to provide informed consent.

Analysis

Detailed notes were taken using a laptop during all interviews. These were recorded by the lead researcher during interviews with key informants and case managers, and by the research assistant during interviews with T2H participants and the non-participant comparison group. With respondent consent, interviews were audio recorded. The key informant and case manager interview audio recordings were used to verify the accuracy of the quotes that were transcribed in the research notes. 20 of the 26 interviews with the T2H participants and comparison group were transcribed. 6 of the interviews were not transcribed as they were not audio taped or the audio quality on the recordings were low.

Interview transcripts and notes for those that were not transcribed were cleaned to remove identifying information and uploaded into the NVivo qualitative analysis software package. The research team used the software identify key themes that emerged in the interviews, which they then used as a framework to code and analyze the data.

Ethical Considerations

Careful consideration was given to potential ethical issues associated with conducting this type of research. Particular attention was given to issues of consent, managing risk and confidentiality. These three areas and the

strategies employed to address them by the research team are addressed in this section. This research received approval from McMaster University's Research Ethics Board.

All recruitment materials for this study indicated clearly that participation in the study was voluntary. Copies of the study's information letter were included with all recruitment letters and made widely available at the Wesley day centre. Respondents were told at all levels of recruitment that they were free to stop the interview at any time, and that they did not need to answer any question they did not want to or that made them feel uncomfortable. In the case of key informants, consent was straightforward and was obtained by reviewing and signing a consent form. Special consideration was given to ensuring the proper conditions for obtaining informed consent from case managers, T2H participants and comparison group.

To ensure all interviews with case managers were obtained on a voluntary basis, each respondent was asked to contact the lead researcher directly. As the lead researcher was employed by both McMaster University and Wesley Urban Ministries, she had met the majority of the case managers at work and they were aware of her employment with the organization as well as with the research project. Case managers were informed that lead researcher was not connected with the administration of the T2H program or its staff, that their job performance was not being evaluated by the lead researcher, and that only the lead researcher would know whether or not they agreed to take part in the study. Further, they were informed that their participation was voluntary and confidential and were assured that their choice to participate would not be shared with other co-workers or management.

Given the significant psychological, structural, social and physical barriers faced those who have experienced long-term homelessness, it was necessary to assess for capacity to consent before attempting to obtain signed consent. In order to do this, the lead researcher read through the consent form with each respondent, stopping to ask for questions at multiple intervals. The Research Ethics Board at McMaster University also recommended that each respondent should complete a teach back exercise. This consisted of three questions that were asked after the consent form was read. These questions were designed to assess the participants' knowledge of the

study, and to confirm that they understood that participation was voluntary and that they could leave the study at any time. If these questions were answered appropriately, the researcher obtained signed consent.

QUANTITATIVE ANALYSIS

The quantitative data used in the analysis for this study were derived from two secondary sources: T2H Client Outcome Tracking System (COTS) and HIFIS. The T2H program uses case management software, called T2H COTS, to track the progress and status of its participants. This database was designed and managed by an independent company located in Hamilton, Ontario. As this database contains large amounts of quantitative and qualitative information about the status and needs of program participants, the research team decided that it was not ethically appropriate to access this database. The lead researcher contacted the independent company and requested access to a variety of reports that described the housing status and program involvement of participants. Raw data were anonymized by the independent company and provided to the researcher in Excel spreadsheets. These data were then cleaned to remove any ambiguous or erroneous data and categorical data were recoded into numerical data. These data were transferred into STATA statistical software, version 12 and analyzed. In order to assess the outcomes associated with participation in the T2H program, descriptive analyses were conducted.

The second dataset used for this study was derived from the Homeless Families and Individuals Information System (HIFIS) which is managed by the City of Hamilton. This system is used by all overnight shelter case workers in the city, with the exception of those providing services for women who have experienced violence, to track the identities of individuals who access shelters and number of nights stayed. Although the primary purpose of this database is to assist in tracking shelter clients, the data collected on age, gender, and number of nights spent in shelters can be reliably used for research purposes. There are data sharing agreements in place for all HIFIS users and the terms of this agreement protect the privacy of the clients who are listed in HIFIS. The research team submitted a proposal to the Housing Services Division at the City of Hamilton and they were tasked with preparing and analyzing the data in compliance with their data sharing agreements. Reports on shelter use for T2H participants and a general profile of men who accessed emergency shelters since January,

2010 were provided. The City was provided with a list of T2H participants' names by Wesley's Director of Housing and Homelessness, which they then used to assess whether or not an individual in the HIFIS database was a T2H participant. Each participant record was matched with his record in HIFIS using name and date of birth. The data are reflective of only those participants who were able to be matched. If a record was unable to be matched, there was an error in the participant's name or date of birth, or they were not listed in HIFIS.

The City of Hamilton is acknowledged as the analyst for all tables derived from HIFIS in this report. While matching the participants' names with the HIFIS data, a separate variable was created to indicate whether or not an individual was actively enrolled or in maintenance with the T2H program. Descriptive analyses were then performed using SPSS to provide a general profile of participants and the male shelter use population, and to assess the shelter use of T2H participants.

RESULTS

As noted in our methods section, the data collected and analyzed to discuss the outcomes and experiences associated with participation in the T2H program were generated from multiple sources, using multiple techniques. In this section, we attempt to synthesize these data in a logical fashion in order to assist in describing the impact of the program. This section begins with a description of the T2H and long-term shelter use populations in Hamilton, Ontario. We then provide a brief description of the characteristics of the sample of participants who participated in interviews.

POPULATION & SAMPLE CHARACTERISTICS

All data collected through HIFIS in Hamilton may be used for research purposes. However, the original intent of using HIFIS in this municipality was to assist shelter case workers and management in tracking clients across the various emergency shelters in Hamilton. As a result of this, limited data are collected on shelter users.

Clients have the option of supplying additional information which is stored in the HIFIS system. However, as this information is optional, it is not collected for every client. The analysis of the HIFIS database provided us with two reliable indicators. These were age and number of shelter nights. Table 1 provides the average age of shelter users and T2H participants, recorded on the date of their first emergency shelter stay. The age of the average male emergency shelter user in Hamilton is 39.6 years at time of first shelter use. The findings suggests that on average, the T2H population is 4.7 years older at time of first visit than those who have accessed emergency shelters but have either not qualified for or not accessed the T2H program.

Table 1: Age in Years at First Emergency Shelter Visit by Population

Population	Average Age at Time of First Visit Since January 4, 2010
T2H Participants	44.0
Men's Shelter Users	39.3
Total	39.6

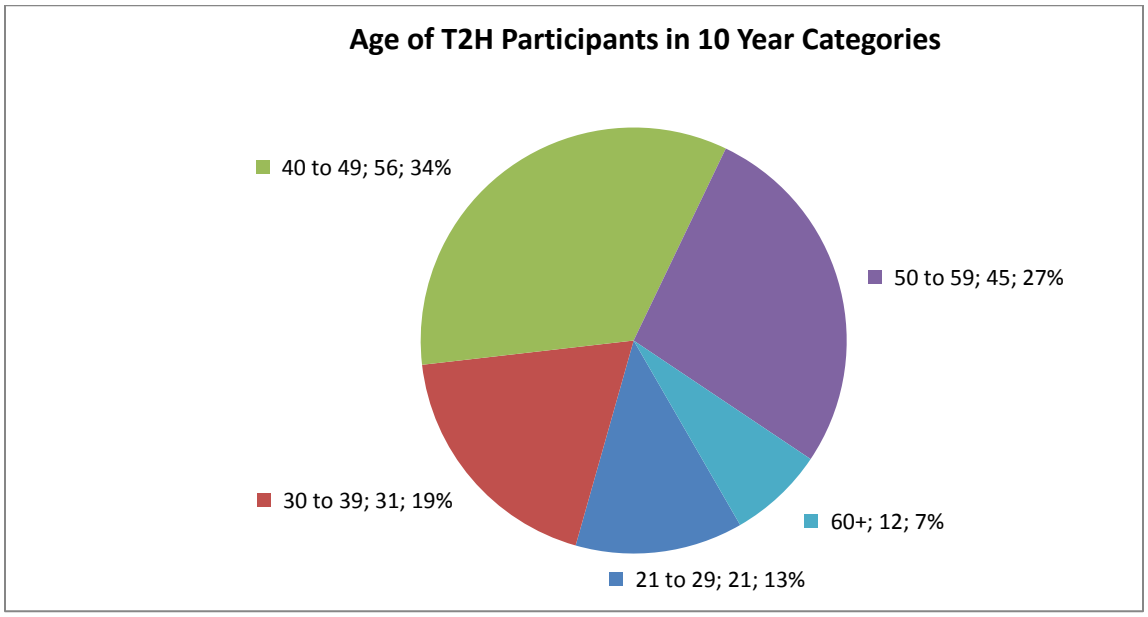
Source: HIFIS Database. Analysis conducted by the City of Hamilton

In addition to average age, the HIFIS data were used to provide a ten year age breakdown of the T2H participant population. These data are described in Figure 1. This analysis illustrates that the majority of participants are middle aged men between the ages of 40 and 59 (61%). A smaller proportion of program participants are between 21 and 39 years of age (32%), and only 7% of program participants are 60 years of age or older. Figure 2 compares the ages of T2H participants with the shelter use population in ten year categories. Generally speaking, the shelter use population is younger than the T2H population. However, T2H is not mandated to serve youth, which accounts for some of the categorical variations illustrated. Regardless of this, the data indicate that the proportion of middle aged T2H participants is higher.

The T2H COTS data provided the program status of persons who have had contact with the T2H program based on their level of involvement with the program. For clarity, we have divided these statuses into two larger

categories: inactive and active. Those who were included in the inactive category were no longer maintaining regular contact with the program. This included those classified as "on hold," "closed" and "maintenance." On hold refers to persons who made contact with the program for a brief period of time and have not established case plans and therefore, were not actively enrolled in the program. These individuals did not continue their involvement with the program. Additionally, closed typically refers to persons who have died or those who will not make contact with the program in the future. Persons who are placed on maintenance are those who have established a case plan and who have discontinued their participation in case management. Those who are on hold and on maintenance may make contact with the program and receive program or case management assistance in the future. Active refers to persons who are actively participating in case management with the T2H program.

Figure 1: Age of T2H Participants in 10 Year Categories



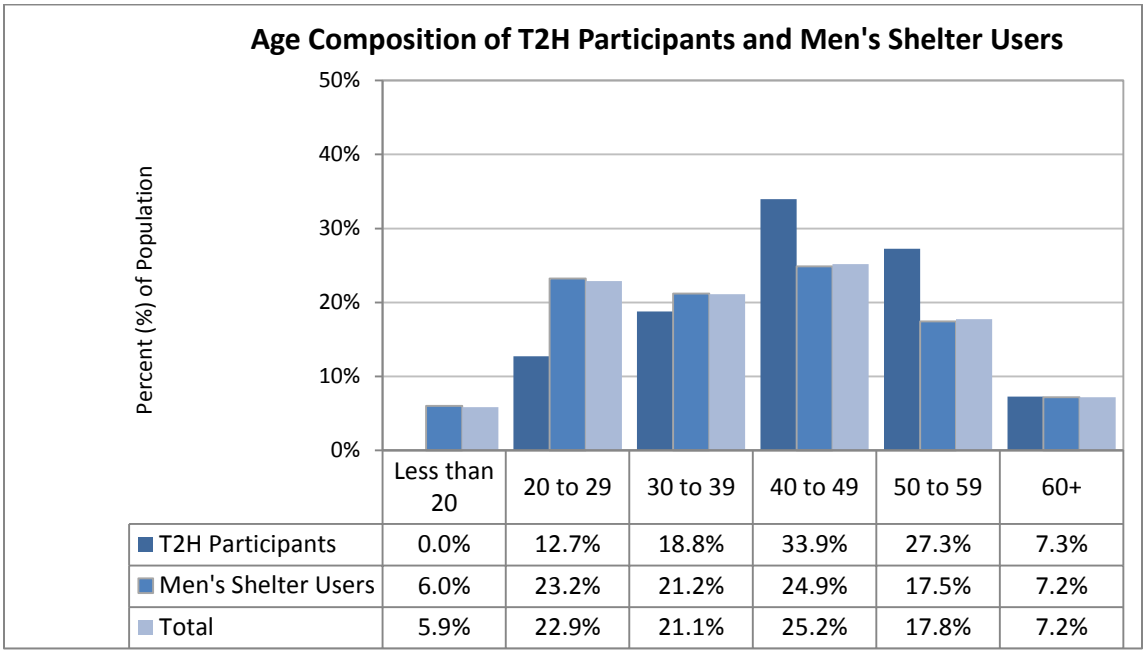
Source: HIFIS Database. Analysis conducted by the City of Hamilton

In order to capture the experiences of participants who were involved with the T2H program and of those who qualified for the program but did not engage with the program, we interviewed 16 T2H participants and 10 men who were experiencing long-term shelter use. The average age of both sets of qualitative samples are provided

in Table 2, along with age ranges. The average age of T2H participants and the range of age for T2H participants were both higher than the mean and range ages of those sampled who were not enrolled in the program.

Prior to discussing life experiences and housing trajectories, we began by administering the Multnomah Community Ability survey. A full discussion of the procedures used for this is provided in the methods section. Our findings indicate moderate levels of functioning or ability in both samples. The mean scores for each category are provided in Table 3. T2H participants experienced slightly higher levels of self-reported physical and mental health, and social skills. However, they expressed slightly lower levels of daily life adaptation skills, and reported participating in more maladaptive behaviour. However, the differences between these samples were marginal and not significant due to small sample sizes (N) and relatively small variations in observed difference. Our baseline findings indicate that the participants interviewed from each of the two samples illustrated similar levels of ability or functioning.

Figure 2: Age Composition of T2H Participants and Men's Shelter Users in Ten Year Categories



	Less than 20	20 to 29	30 to 39	40 to 49	50 to 59	60+
T2H Participants	0.0%	12.7%	18.8%	33.9%	27.3%	7.3%
Men's Shelter Users	6.0%	23.2%	21.2%	24.9%	17.5%	7.2%
Total	5.9%	22.9%	21.1%	25.2%	17.8%	7.2%

Source: HIFIS Database. Analysis conducted by the City of Hamilton

Table 2: Average Age & Age Ranges for Qualitative Sample for T2H Participants and Non-Participants

Sample Group Type	Average Age in Years	Age Range in Years
T2H Participants	50.94	39-63
Non-Participants	43.3	24-59

Table 3: Adjusted Multnomah Community Ability Scores by Participant Group

Category	T2H Participants' Adjusted Mean Score (Range 1 to 5*, N=16)	Non-Participants' Adjusted Mean Score (Range 1 to 5*, N=10)	Observed Difference
Physical & Mental Health	3.38	3.06	0.32
Daily Life Adaptation	3.33	3.74	0.41
Social Skills	3.68	3.59	0.11
Behaviour	3.48	4.08	0.60

*A score of one indicates low functioning or difficulties in the categories and a score of 5 indicates high functioning or no difficulties experienced

HISTORIES OF TRAUMA

The majority of participants' interviewed had experienced some form of childhood trauma. Individual experiences varied greatly and included childhood mental health concerns and youth suicide attempts, experiences of physical, sexual, and emotional abuse, trauma resulting from living with a substance dependent caregiver, childhood or youth institutionalization, experiences of housing instability and extreme poverty, expulsion from high school, adoption or placement in the foster care system, and leaving home at an early age. For some participants, experiences of trauma were multifaceted. One respondent stated:

> Me and my mom—we're getting along now, like she's good now. But, when I was younger, she just, she just treated me different. Like everybody in the neighbourhood kind of seen it. She never did but like they seen how my brothers would get all the stuff and I would get like nothing. They just see how my

> parents are treating me different and stuff and my mom would always like she'd get mad at me, like you remind me of him [his biological father], you're just as crazy as him and like flip out on me. And she made me go to church cause—nobody else had to go to church in my family but she made me go to church 'cause she wanted to get the evil out of me. I didn't really finish, I got kicked out of --I got kicked out of one high school, expelled when I was at the other high school I got expelled and kicked out of every school in Ontario. Then I went to my friend's, my friend's car, I lived in his driveway for a bit. Then his mom found out I was staying in the car and she let me live1 with her for a bit.

This individual experienced multiple forms of trauma in his childhood and began drinking and using drugs at the age of 13. His biological father had left his household and he reminded his mother of his father, and in turn she was abusive toward him. Additionally, he was expelled from high school and left home, moving from place to place. This man's story is just one example of the multifaceted forms of youth trauma captured in this study.

Early exposure to trauma or youth placement in unstable environments appeared to have a lasting impact on all participants' ability to independently secure and maintain a stable home environment. One of the case managers discussed the lasting implications of living in chaotic or traumatic situations:

> Some people are afraid to be stable because they have never been stable before and chaos is comfortable for them. They think "I better boot a hole in the window to get things back on track" …[T]ake a guy who's been in a system with people his whole life, then you put him all alone in his own unit and he can't deal with living alone and you bring over the wrong people, chaos happens, then the supers calling, etc. If all you know is chaos, you think you can't survive if things are going well because you've never known things to be going well.

This quote suggests that experiences of trauma over the life course can lead one to expect or normalize chaos, as it becomes a familiar life factor. These findings that respondents experienced early exposure to instability and trauma suggest the need to provide individuals with the opportunity to access counseling or appropriate supports. Access to social workers is provided to the shelter use population and case managers assist T2H clients in finding supports that they may need. However, there are often waiting lists for mental health and counseling services.

HEALTH, MENTAL HEALTH & SUBSTANCE USE

Many of the respondents interviewed for this study experienced difficulties with physical health, mental health, and substance use, regardless of whether or not they were actively enrolled in the T2H program. Some of the common physical health problems experienced included diabetes and hypertension, chronic pain, back and musculoskeletal injuries, methadone treatment for opiate replacement, and seizures. Individuals expressed that some of these ailments developed or worsened with age. Others noted that physical pain and injuries occurred at work, resulting in long-term unemployment, and continued to worsen. Accidents were also associated with pain stemming from injuries. One participant discussed the role of chronic pain in his life:

> I said it's pinched nerves. All of a sudden I'll be walking down the road and I'll get a sharp pain in my hip, my whole leg will go out from me. The one time I almost fell in the traffic but I aimed for a pole and I managed to hit the pole instead of landing in Main Street. Now if I'm carrying something, let's say for a moving company or anything like that who's going to be on the top and bottom helping me carry stuff? I can't trust my leg I wouldn't expect you to, it could fall on you, you know.

Pain, resulting from a back injury, had caused this participant frequent discomfort. For him, this pain was debilitating and prevented him from completing daily tasks and from performing physical labour.

Mental health was a concern for many of the participants in this study. The range of mental health concerns captured was quite broad and included many diagnoses, from situational depression to schizophrenia. Some of the individuals had experienced mental health concerns since childhood. One participant discussed contemplating suicide at the age of 13:

> I was 13 years old and my parents left and I turned the gas stove on without lighting it up and I was just sit on the chair and just wait for the gas. And then, then I, 20 minutes later I changed my mind so I shut it off, opened the window. I bust out. So then I just clean up after me and went to see my mom to tell her that I don't feel well and I'm sick so she says go home. Then I go to school. But that's what's after my parents and everybody left and it's like and a month later my best friend killed himself the same way. So, well, we were like 13 years old. And then the thing is that my parents knew that when he died that they talked to me. They said, you know, what if you have any problems, you can always come to us and talk about it. And don't deal with it like that. And, but to me it was like don't talk to anybody. It, for me it was, like, don't talk to anybody.
>
> You kind of, all my life you kind of was thinking that you, maybe you, like, want to kill yourself but I, on one hand, it, you know that you will not have to deal with it if you are dead, that's, everything is gone for you. And that's it. It's over with. But my parents were still alive

> and it would hurt them. It would, you know, so…I was hanging around, hanging around and then I know when my mom died, I was, like, oh.

For this individual, a hospitalization resulting from a suicide attempt in adulthood contributed to his experiences of housing instability. One individual was unable to secure stable housing as a result of hording behaviour which was connected to his diagnosis of obsessive compulsive disorder. Although some individuals experienced mental health concerns since youth, others' states declined as they continued to experience housing instability. Mental illness was a contributing factor to loss of housing and continued housing instability for some of the respondents in this study.

Many of the participants interviewed in this study had some history of problematic drug or alcohol use. A respondent described his drug use patterns using the following words:

> I stayed at Sally Ann and at first I was in the basement for a while and I was using drugs then so my day would consist of leaving the Sally Ann, going and stealing all day, getting my drugs and then going back to Sally Ann with my drugs…doing the whole thing over the next day.

This individual described his activities around the time that he first entered the emergency shelter system. His days consisted of finding ways to purchase drugs, buying drugs, and doing drugs. At the time of the interview, he was receiving methadone treatment.

Despite chronic histories of substance use, some individuals were able to successfully begin treatment and employ harm reduction strategies. For example, a non-T2H participant abstained from using injection drugs, as he was concerned about the harm of catching a blood borne illness. A T2H participant discussed participating in recreational activities through the program as a way to encourage himself not to use during the day. Others were able to work toward abstaining from certain types of drugs and alcohol. One participant attributed his ability to cope with his addictions to his ability to employ strategies of self-reflection:

> Oh, God no, like I said I had to ask a couple a dark questions …Go into some dark corners and through help and guidance with some smart people that I met along the way, I actually learned my problem was trust and abandonment. Those were the two underlying causes of it all. A lotta dark questions, a lotta scary answers. And like it started with not lying to the person I see in the mirror. Cause with the amounts of coke and Valium that I was doing …The doctor … My family physician at the time and I'm sure he's long since passed, was like you've got a choice, do what you're doing and die or get some help… Geez. But you have to know what's good for you, cause a lot of people can't do that work, they can't look inside those corners of their brain, so that's … But if you're just absorbed in self, those aren't even thoughts, those are just like

> fleeting moments, they're like oh better push that one to the back before I actually think about that again.

This participant had been able to reach out and access supports for his treatment. However, he attributed his ability to cope with his addiction to his capacity to be self-reflective. His healing began when he was able to begin to understand the impacts of his childhood experiences of trauma on his daily behaviours and addictions.

PATHWAYS INTO HOMELESSNESS & EXPERIENCE WITH SHELTER USE

The situations surrounding loss of tenancy or permanent residence captured in this study were quite diverse. Some of the situations captured included marital or relationship breakdown, economic hardship, injury resulting in job loss, inability to maintain a familial home after parental death, excessive spending on drugs, alcohol, hotel rooms, and the sex trade, incarceration and subsequent enrollment in halfway houses, and inability to manage physical or mental health concerns. The responses to experiences of housing loss were quite diverse and represent the level of diversity in needs experienced by these individuals.

All of the individuals who participated in this study had experienced long-term shelter use. Additionally, many of them experienced housing instability from an early age. In discussing housing histories, we asked each respondent to describe his first night in an emergency shelter. A few of the individuals seemed unfazed by the experience. However, many of the participants' experiences were traumatic. When asked to describe his first night in a shelter, one individual described feeling that his life was over:

> Over time [after my mother died] I got used to … I got used to being on my own and then … and then when I first moved into a shelter it felt kind of … you know, my life is done. Like I've gone from … in a period of two years gone from living at home with my mother in a nice house to living with a bunch of men sharing a bathroom and … yeah. Like why am I … like turn out this way. It's like… then I start blaming God saying 'how could you do this to me and like how could you take my parents away?' and that. So it's like … that time … that's the first time I feel like the whole world against me.

For this man, as well as for others interviewed, moving into a shelter was a highly emotional event. Similar to this participant, others mentioned feeling weird about sleeping in a dorm room with other men who they did not know and desired a renewed sense of privacy and security.

The majority of those who entered the emergency shelter system with trepidations eventually became desensitized to their new environments. As they became familiar with the system and its requirements, residing in the shelter was normalized:

> Well I guess the first night it was kind of weird, but I got used to it pretty quick. Well, just different and, I don't know, kind of just new.

Another participant said:

> It was a little scary watching all these drunks and crack heads. Then you see a cruiser out there about three times a day and wonder who they're coming for. But after that it didn't bother me, ever since.

Although many individuals were wary of entering the shelter system, the majority seemed to quickly adapt to their surroundings.

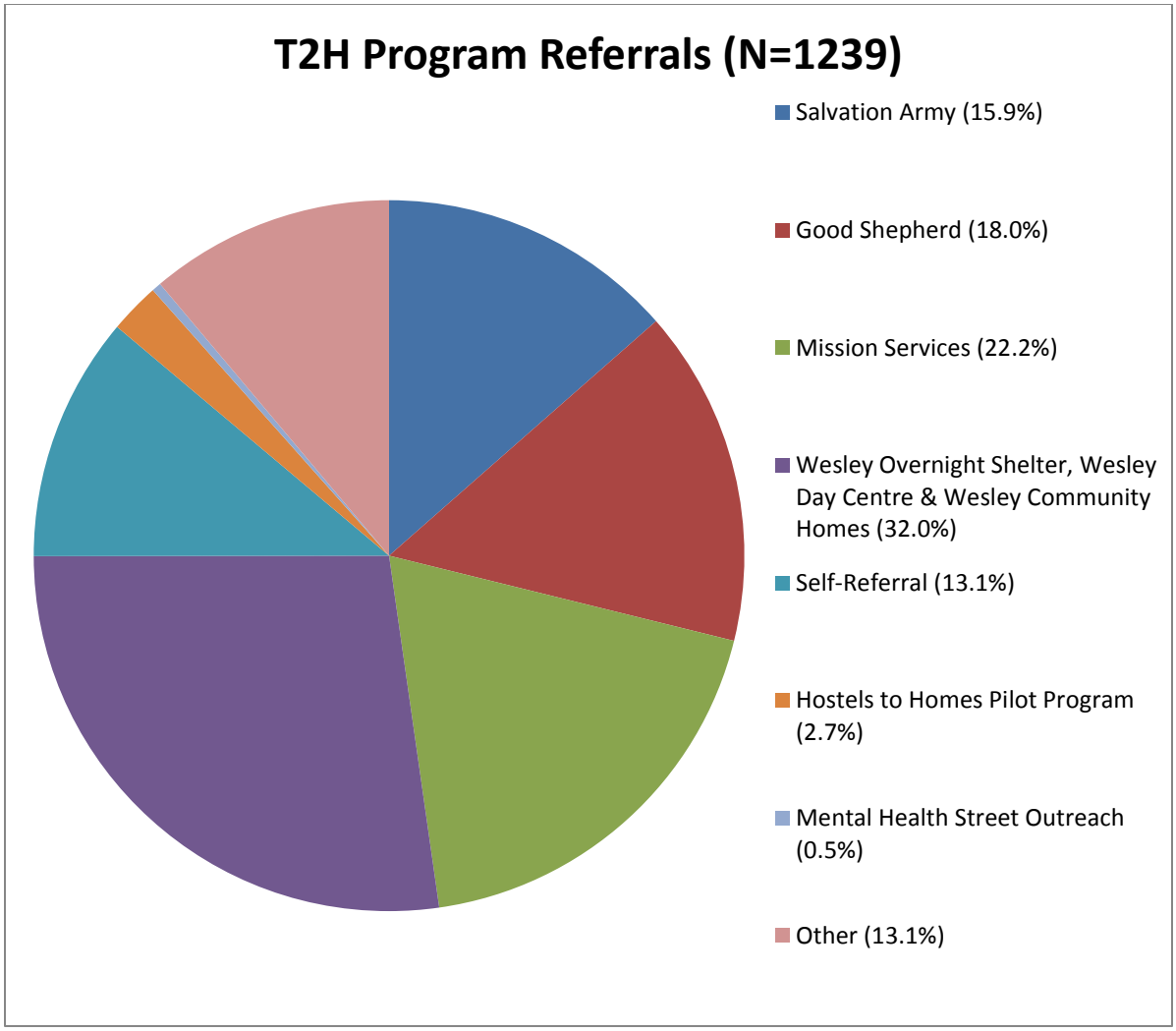
Our findings surrounding shelter use, health, substance use, pathways into homelessness and experiences of trauma suggest that individuals who currently reside in or have stayed in emergency shelters may require access to specialized supports that assist them with healing and forming new trajectories of stability. The subsequent sections of this report discuss the housing stability of T2H participants and the experiences of both participants and non-participants in accessing diverse services.

T2H PROGRAM REFERRALS & ENGAGEMENT

The T2H program was designed to be a collaborative effort amongst Wesley Urban Ministries and the three men's shelters in the City of Hamilton. As the program is designed to house men who have stayed in emergency shelters for 30 days or more, case management staff are required to provide outreach hours at the shelters. In analyzing the T2H program data, we found that the majority of referrals come from Wesley programs and the men's shelters. Figure 3 displays the percentage of total referrals by source. Other Wesley programs provided the highest proportion of program referrals (32.0%). However, cumulatively the men's shelters acted as a point of referral for 56.9% of all referrals, with 15.9% from Salvation Army, 18.8% from the Good Shepard, and

22.2% from Mission Services. Additional referrals were provided by Mental Health Street Outreach, word-of-mouth sources resulting in self-referrals, the hostels to homes pilot project, and through a variety of other social service agencies.

Figure 3: Percentage of Total Program Referrals by Source



BARRIERS TO RECRUITMENT & ENGAGEMENT

In interviewing men who had qualified for the T2H program but had not accessed it, we asked respondents why they had not connected with the program. The majority of respondents indicated that they had not heard of the program or were not aware of the supports that T2H offers. Others had heard about the program through their informal networks and were unsure of how to connect with a worker or were working with a different service provider. One participant was unsure of whether or not he had met with a case manager from T2H, as he had accessed a large variety of supports.

Our key informant and case manager interviews indicated that there have been ongoing struggles with performing client engagement. Members of different organizations' views varied significantly, making barriers to engagement a very complex issue to discuss. Obtaining program funding in the social services is often a very competitive endeavor. This resulted in competition amongst different programs and service providers. One of the key informants discussed this stating:

> The funding system is created in a way that everyone is so worried that their agency isn't going to be needed anymore that they compete for funding. All of our services are needed; we are all strong in different ways. Instead of making it a competition, we can work together to draw on each of our strengths. We can build teams built on strengths. If we could get funding where people aren't so worried about their own jobs and agencies I think you would find more willingness to collaborate because you are not threatened and worried about duplication of what you are doing and getting your funding. Then we wouldn't be trying to do everything.

The City of Hamilton's (2009) Blueprint for Emergency Shelter Services called for the development of mechanisms designed to facilitate collaboration amongst service providers. Three groups were established: HESSIC, the Women's Housing Collaborative, and the Street Youth Planning Collaborative. Each group oversees a different sub-population and has a Housing First program available for their client groups. However, despite these efforts, our findings shows a need to continue to work toward greater collaboration in service provision. According to this individual, competition for funding has resulted in siloed agencies that are forced to compete with one another to ensure the longevity of their own agencies. This results in lost opportunities for collaboration and may contribute to the barriers to engagement that case managers' experience.

Miscommunication between and amongst agencies may also result in missed opportunities to appropriately engage with clients. One of the case managers described this:

> Theoretically people shouldn't be unaware of the program. I do see some issues with communication in terms of—that's not just other providers, it's us as well—there's been changes in the program over the years that go along with the availability of housing, there's misconceptions about what we do, there's people who want to work with us so the shelters will let them stay longer if they work with us, I don't know if the message that goes out to folks from the referral sources is 100% accurate. We need to be better about working with that system and being consistent with them.

The T2H program was designed to be a collaborative effort amongst the men's shelters. HESICC and Shelter Standards were designed to increase collaboration and communication amongst providers. Although the key informants in this study noted that these governing committees have been useful in beginning to work toward collaboration and in fostering effective communication, they also argued that communication could and should be improved.

The majority of case managers interviewed expressed concerns with engagement. One of the case managers stated:

> Another frustrating part for me personally is the engagement hours. I find it's a waste of our time. At first, going to engagement, we would go there and there would be referrals from the shelters, we would find them, meet with them, then move forward. Right now, we go to the engagement and there's nothing. Somehow I think there's a political thing attached to it. T2H was supposed to be a collaboration with the shelters, so our presence needs to be seen, but some of them don't want us to be there and you can feel it. Sometimes you go there and you feel like it's 2 hours of your time you can't get back. Some try to get us involved. My supervisor always says, mingle, talk to people. The clients are not there during the day. Like [one shelter], you go for 2 hours, you sit in the basement with a few people there sitting there watching TV. They have no interest in moving anywhere, but I find it a waste of our time. It really bugs me. It's a drain on you. To be there for 2 hours and do nothing, you want to do something because you don't want to sit there useless. Some places the staff are very friendly and some places they won't communicate with you. [At another shelter] the guys are very welcoming and you can participate in [handing out] the juice and it makes the time go faster…doing the milk line, I get to see the people and I know a lot of people and I can say hi and check in. I can explain why I am there and it gets the communication going.

The relationship between the T2H program and some of the other service provision agencies may also present challenges to engagement. One key informant stated:

> I guess T2H has become a bureaucracy in itself. They have their own computer system, and referral process. I don't think the folks around the table envisioned that. It's taken on a life of its own and I'm not so sure. I think that there, the relationship hasn't been a great relationship. There was a bit of a rocky road that we went through. One of the things was—they are only going to take people have been in the shelter for 42 days cumulatively and the staff has to confirm, why don't you ask them. They get access to HIFIS, we don't get access to T2H COTS. They've set themselves a bit higher over the shelters, we are the experts and the shelters are not, we do case management. That doesn't endear them a whole lot.

This key informant was concerned about the relationship between T2H and the men's shelters. According to another key informant, access to the T2H COTS database has been offered to the shelters. However, they have yet to establish use of the system. This could be indicative of miscommunication between different service providers. Reestablishing effective communication and relationships between all of Hamilton's homelessness service providers may assist in opening future avenues for more effective forms of client engagement.

The broad sentiment that more engagement and client outreach is needed to connect with all homeless individuals was expressed in our interviews. A senior social services manager stated:

> We need more outreach to homeless clients. I envision a more responsive service for those with undiagnosed conditions and a better understanding of the connections between conditions and housing. I also envision reinventing what services are provided in each area. They need to do an orientation drop in that gives useful information for services where clients can take away information and they can continue through this access point. Services should be more comprehensive…we need to move beyond the silos.

Introducing clients to the various forms of available assistance should be done in a comprehensive and accessible way. There are multiple programs and agencies working together to provide homelessness and housing services. According to this respondent, it would be beneficial to clients to have assistance in locating services and navigating the supports available, as well as offering additional supports that are not currently available.

HOUSING STATUS

In order to capture recent housing trajectories and experiences with housing, we analyzed data from multiple sources. Not only were our qualitative respondents asked about their experiences with housing and their current living environments, we also accessed the T2H COTS database and the City of Hamilton analyzed current

HIFIS information to determine current rates of housing stability and instability, operationalized using current housing status. The following section reports on the housing status of active participants, as well as on those who are in maintenance or on hold or closed.

T2H classifies participants as being in maintenance if they decide that they no longer require active case management. These individuals have often been successful in maintaining housing and the majority can be informally referred to as program "graduates." Persons are classified as being on hold or closed if they have made contact or have been referred to the program in the past and have failed to maintain contact with the program. This can happen for a multitude of reasons, including but not limited to moving to a different municipality or deciding to withdraw from the program. Table 4 provides a breakdown of T2H's inactive referrals and Table 5 illustrates the length of involvement with the program. As of December 20th, 2013, 680 individuals were classified as on hold or closed and 174 individuals were placed in the maintenance category.

Days spent in contact with the program varied significantly, with some individuals having very short periods of contact that equated to less than a full day and others sustaining program involvement for over 3 years. It is important to note that our count of individuals who had contact with the program and then left included the women who were T2H clients and who were moved to SOS's program. It is likely that many who had long-term contact with the program before leaving were women who now receive support from SOS. The report on inactive referrals provided by the administrators of the database included 49 ambiguous cases, wherein it was not clear as to which category these cases should be placed. These cases were removed from our analysis.

Table 4: Program Status of Inactive T2H Referrals (N=854)

Status	Number of Individuals	Valid Percent
On Hold or Closed	680	79.62%
Maintenance Follow-up	174	20.37%

Table 5: Length of Program Involvement for Inactive T2H Referrals in Days (N=854)

Average Length	Standard Deviation	Minimum Number of Days	Maximum Number of Days
207.90	280.08	0	1415

Generally speaking, the housing outcomes of inactive T2H referrals were mixed. Housing status of inactive referrals was recorded by case managers at the time of last contact with these individuals. A sizable percentage of referrals (22.48%) continued to experience homelessness. However, larger proportions of inactive referrals began to experience some form of housing stability with 31.15% accessing temporary housing, and 35.01% moving to permanent housing.

Table 6: Housing Outcomes of Inactive T2H Referrals (N=854)

Housing Status	Number of Individuals	Valid Percent
Remained Homeless	192	22.48%
Moved to Temporary Housing	266	31.15%
Moved to Permanent Housing	299	35.01%
Unknown	97	11.36%

Not surprisingly, the housing outcomes for those who were classified as maintenance were more positive than for those who were on hold or closed. These findings are displayed in Table 7. The percentage of individuals who remained homeless was much higher in the on hold or closed group (29.70%) than in the maintenance group (2.30%). Additionally, a much higher percentage of individuals classified as being in maintenance (74.71%) had obtained permanent housing. These findings suggest that those who are able to successfully move through the T2H program are more likely to obtain stable housing than those who have left the program.

In addition to measuring housing outcomes by inactive referrals' status, we also measured whether or not length of contact with the program improved housing outcomes. These findings are displayed in Table 8. Our findings

suggest that the majority of inactive referrals had one year or less of program involvement. This is not surprising, as the majority of these cases were classified as being on hold or closed. Increased length of program involvement is associated with improvements in housing outcomes. Rates of homelessness decreased with program involvement. Specifically, the rate of homelessness for those who had 2 or more years of program involvement was 0.00%. Additionally, an increase in permanent housing was observed for those who had 1 to 2 years (73.33%) of program involvement and for those with 2 or more years (80.95%) of involvement.

Table 7: Housing Outcomes of Inactive T2H Referrals by Status (N=854)

Housing Outcomes (% (N))	**Status**	
	On Hold or Closed	Maintenance Follow-up
Remained Homeless	29.70% (188)	2.30% (4)
Moved to Temporary Housing	36.18% (229)	21.26% (37)
Moved to Permanent Housing	26.70% (169)	74.71% (130)
Unknown	7.42% (47)	1.72% (3)

As of December 20th, 2013, 160 individuals were listed in the T2H COTS database as being active T2H participants. The classification of active refers to individuals who are currently meeting with case management staff on an ongoing basis and are receiving assistance with finding and maintaining housing. In addition to on hold or closed, maintenance, and active, the data provided included a wait-list classification. As of the aforementioned date, 9 persons or 0.73% of all referrals were on the T2H waiting list.

Table 8: Current Housing Status of Inactive Participants by Length of Contact with Program

Housing Outcomes (% (N))	Contact Time Spent with T2H Program		
	0 Days to One Year	366 Days to Two Years	<Two Years
Remained Homeless	26.80% (189)	3.49% (3)	0.00% (0)
Moved to Temporary Housing	33.62% (237)	20.93% (18)	17.46% (11)
Moved to Permanent Housing	26.24% (185)	73.33% (63)	80.95% (51)
Unknown	13.33% (94)	2.33% (2)	1.59% (1)

The housing outcomes associated with participation in the T2H program for active participants were positive. The findings of our analysis of the T2H COTS database are presented in Table 9. We found that 74.38% of active participants were living in permanent housing and an additional 24.38% had secured temporary accommodations. Less than 1% of all active participants were listed as homeless. This suggests that housing stability is associated with program involvement.

Table 9: Current Housing Status of Active Participants (N=160)

Housing Status	Number of Participants	Valid Percent
Remained Homeless	1	0.63%
Moved to Temporary Housing	39	24.38%
Moved to Permanent Housing	119	74.38%
Unknown	1	0.63%

Generally speaking, the housing status of active participants remained constant, regardless of recruitment year. Our findings, displayed in Table 10, indicate that those who entered the program in 2010 (86.15%) experienced slightly higher rates of permanent housing than those who entered in 2011 (81.25%) and 2012 (82.61%). However, decreases in homelessness were observed for all cases, regardless of year. The data provided for 2013 represent shorter periods of involvement with the T2H program.

Although none of the participants recruited in 2013 experienced homelessness, rates of permanent housing were much lower and temporary housing rates were higher than those recorded for participants recruited in earlier years. We argue that these rates are representative of their shorter program involvement. Upon entering the T2H program, individuals are generally moved to congregate "shared accommodations" housing, which is classified as being temporarily housed. Individuals are able to refuse offers to live in shared accommodations. However, this option is provided as a mechanism for housing people when single unit availability is limited. Participants reside in shared accommodations until appropriate single unit housing can be located.

Table 10: Current Housing Status of Active Participants by Year Enrolled in T2H Program (N=160)

Housing Status (% (N))	**Recruitment Year**			
	2010 (N=65)	2011 (N=32)	2012 (N=23)	2013 (N=40)
Remained Homeless	1.54% (1)	0.00% (0)	0.00% (0)	0.00% (0)
Moved to Temporary Housing	12.31% (8)	18.75% (6)	17.39% (4)	52.50% (21)
Moved to Permanent Housing	86.15% (56)	81.25% (26)	82.61% (19)	45.00% (18)
Unknown	0.00% (0)	0.00% (0)	0.00% (0)	0.63% (1)

In order to assess the total moves of those who have been involved with the T2H program, we accessed T2H COTS' records on all recorded moves from all persons referred to the program between January 2010 and December 2013, regardless of current program status. Table 11 provides all moves toward stable housing for active and maintenance participants, as well as for those who were classified as being on hold or closed referrals.

Table 11: Movement toward Forms of Stable Housing by Type, Tracked by History of Recorded Moves (N=1291)

Type of Housing Location	Number of Occurrences (N)	Percentage of Total Moves (%)
Moved to Regular Housing	209	16.19%
Accepted Social Housing Offer	67	5.19%
Returned Home	12	0.93%
Moved to Long-term Care	6	0.46%

Note: only moves that were clearly indicative of movement toward stable housing were included in our calculations. Other moves included movement toward temporary accommodations, moves associated with service use, and movement between and to shelters. Additionally, some moves were ambiguously categorized within the data provided.

EXPERIENCES WITH HOUSING

The T2H participants who were involved in this study appeared to experience fewer barriers in accessing housing than those who were not engaged with the program. Common concerns surrounding housing included a lack of affordable housing, inability to provide landlords with references and first and last month's rent, confusion surrounding where to look for housing, and a lack of clean and pest free or appropriate rental housing. A non-T2H participant described the barriers he faced in obtaining housing:

> It needs people like yourself who are willing and able to sit down on the phone with me on the other side of the desk, you with a perspective landlord on the line and you explaining it to them. Like I say, you're more experienced on the phone than I am. It needs people like you to give us a little push. You know how I got the house that I'm in now?

> I'm walking down [a street] and I saw the advert on the window. Phones it up and I get this little Chinese girl on the phone. Kind of broken English but I could make it out. And I said well, what are you asking for rent? The rent is 370 month and I went click… if it's any good I'm moving. So would you like to come and see it? Minding, I'm right outside your front door. So we went in, up the stair and up. I got a full kitchen and my bedroom two-thirds the size of this room. I mean not so tall but it's about two-thirds, complete bathroom which I thought I'm not too stable in the shower but I got a bath. It's cheaper. Boom, I'm moving. Signed the lease right there.
>
> I went from there directly down to ODSP and I showed the girl it, wow. This just happened, I says, half an hour ago. So I've got her shocked and stunned right there. She phones up the YMCA. Now, by the time I went from the ODSP office to the YMCA, [a worker] is at the top of the stair. I'm getting a big hug from her, congratulations, you're moving. Well, that's what she wants. She says that you have to go down to [an agency]. That's where it started going downhill. I showed him the lease that I'd already signed up; name, address, code, the whole bit. And this was in the middle of May. And he said okay, we'll call you with an appointment for an interview. Three days later I got a phone call, come in for an appointment and maybe it's slipping away at this point. After the interview … well, within the next two weeks I got to submit this to my supervisor, they will okay it, meanwhile go out and get yourself a cot for a bed, whatever you need to get started, but I'll make an appointment for you in two weeks. Two weeks later I've got an interview. Boom, did that. We'll call you when your cheques come in. Now we're into June. I had the sense … and I didn't know it but I had the first and last. I had it tucked away. Now, they came up eventually two weeks later. Honest to God, this was so disappointing. But I had the foresight of mind to have that first and last in my pocket. If I hadn't the foresight to have that first and last in my pocket, where was the help?

This man indicated that assistance with finding housing and speaking with landlords would have helped him in securing housing. Additionally, he noted the importance of having access to first and last months' rent, as landlords often demand this payment when a lease is signed and it can take a while to process government cheques for these payments.

All of the T2H participants who were involved in this study were housed. We asked each individual questions about his housing and questions surrounding perceptions of housing stability and instability. Generally speaking, the participants were happy that they had obtained their own housing units. They often spoke of the enjoyment and safety they experienced from being able to close and lock their doors, and sit at home and watch television. One T2H participant defined stable housing as:

> A safe place to re-establish…Coming from an environment where … I mean you're on the fringes of everything, not just society, everything … no social insurance number, no present resident address, none of the ID you need to get any kinda quality help, healthcare, whatever it be, you still need a spot. And

> you need a spot where you can lock the door. So that you can start piecing this back together …like all of it back together, your ID, relationships, getting a hold of yourself. And if you have a spot that you can say I'm not letting anybody in my spot today, that promotes some sort of stability where you've got like … you got your dog house, right, some people call it a man cave whatever it be, but it's yours. It's a place to start and it's only you that can screw it up.

For this individual, having stable housing provided him with the opportunity to stabilize his life. He was able to begin the process of re-establishing or starting over in his life. Many of the T2H participants interviewed in this study described stable housing in similar terms, discussing the relief that comes with having one's own space.

Many of the individuals interviewed for this study experienced problems with housing quality and pest management. For those who had obtained independent housing, the quality of the housing was often discussed as being mediocre. A large concern was pest management and bed bugs. One T2H participant stated:

> The perception I had is that 'You just dump people in a' – because I know, I've heard stories and they're true, where they hook you up with a place and then you go in and like it's infested with bed bugs. Now I've come to realize also that many, many places in this city are – and I don't know what the answer is. I don't know what the answer is because there's a – but you have to have dedicated people who are not willing to stop, who just want, you know. And I'm not talking about myself because I'm not that person but the people who – and I don't even really demand that from them. I can't expect what I can't do, you know what I mean?

The T2H program offers bed bug management support and education for participants and landlords. For example, program participants are able to request a free bed bug cover from the program. Additionally, case managers assist clients in preparation for pest spraying and the housing worker supplies landlords with information surrounding how to deal with bed bugs. Despite this, bed bugs continue to be a persistent problem in downtown Hamilton and some T2H participants have had problems stemming from the presence of these pests.

SERVICE USE

Unfortunately, due to issues related to accessing appropriate and available forms of data, we were unable to measure increases and decreases in service use for T2H participants. However, the data included in T2H COTS included a list of moves into a variety of different housing types for all active participants and for inactive

referrals while they were considered active in the program. The total number of recorded moves was 1291. From this report, we extracted moves that indicated service usage. Each occurrence represents a move, not an individual. Table 12 presents our findings. Overall, the proportion of overall moves that indicated some form of service usage was fairly low. Accessing an emergency shelter (16.42% of all moves) represented the largest percentage of moves into a service provision location. Movement into other types of service provision locations, such as jails and hospitals, represented a much smaller percentage of total moves. These data suggest that those who have contact with the T2H program experience relatively low rates of residence in service provision locations. However, these data prompted further investigation of shelter use patterns of T2H participants.

Table 12: Recorded Service Use of T2H Participants, Tracked by History of Recorded Moves (N=1291)

Movement into Service by Location Type	Number of Occurrences (N)	Percentage of Total Moves (%)
Released from Custody	11	0.85%
Incarceration	28	2.17%
Long-term Hospitalization	12	0.93%
Moved to Long-term Care	6	0.46%
Entered Residential Treatment	19	1.47%
Completed Treatment Program	4	0.31%
Returned to Shelter	212	16.42%

The City of Hamilton's HIFIS data, displayed in Table 13 and Figure 4, indicate that T2H participants have accessed emergency shelters for longer periods of time. Additionally, they have a higher average number of episodes of use. These data do not account for date of entry into the T2H program. Therefore, they indicate that the individuals who became participants in the T2H program have experienced long-term homelessness at some point since January 4th, 2010. These data suggest that T2H is serving the population that they were intended to

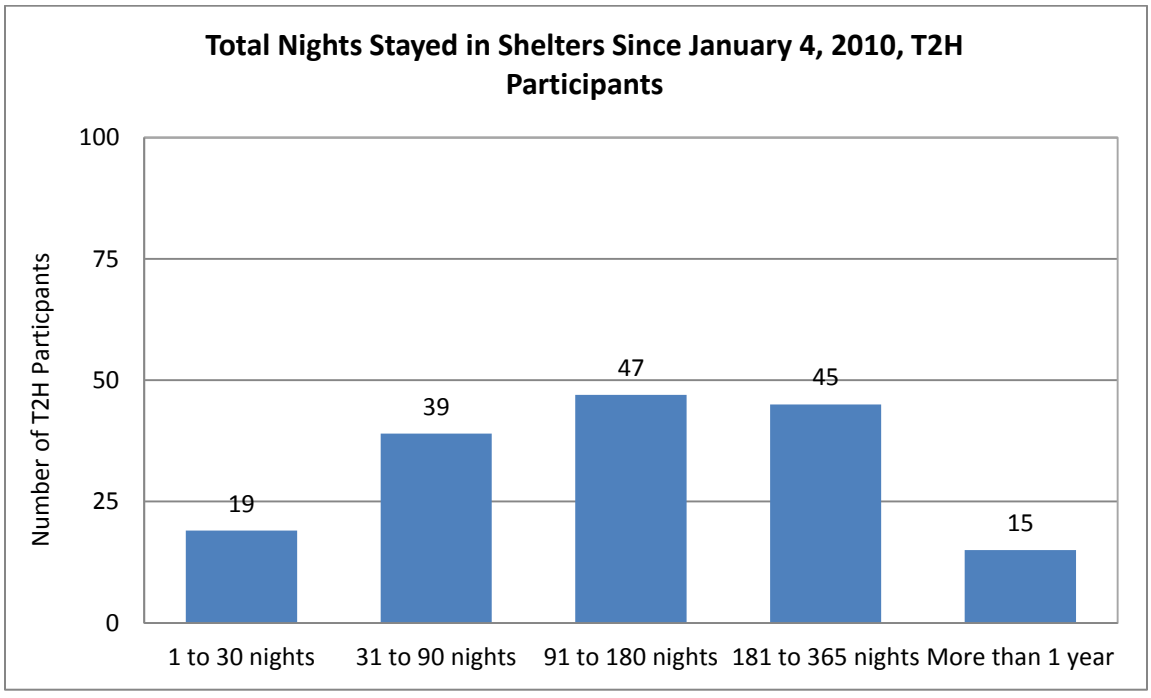
serve. The data suggest that the T2H program not only serves those who experience long-term shelter use, they also assist those who have experienced multiple episodes of homelessness. Additionally, clients enrolled with T2H are often able to extend their shelter stays slightly past the usual maximum while they wait for housing to become available in the community.

Table 13: Duration and Nights Spent in Emergency Shelters

	T2H Participants	Men's Shelter Users
Average Nights Stayed Since January 4, 2010	176.1	47.7
Average Number of Stays	16.8	6.4

Source: HIFIS Database. Analysis performed by the City of Hamilton

Figure 4: Total Nights T2H Participants Spent in Emergency Shelters Since January 4th, 2010



Source: HIFIS Database. Analysis performed by the City of Hamilton

Data from the HIFIS database were analyzed for participants by recruitment year to discover whether or not shelter use decreased for T2H participants after they connected with the program. These data are displayed in

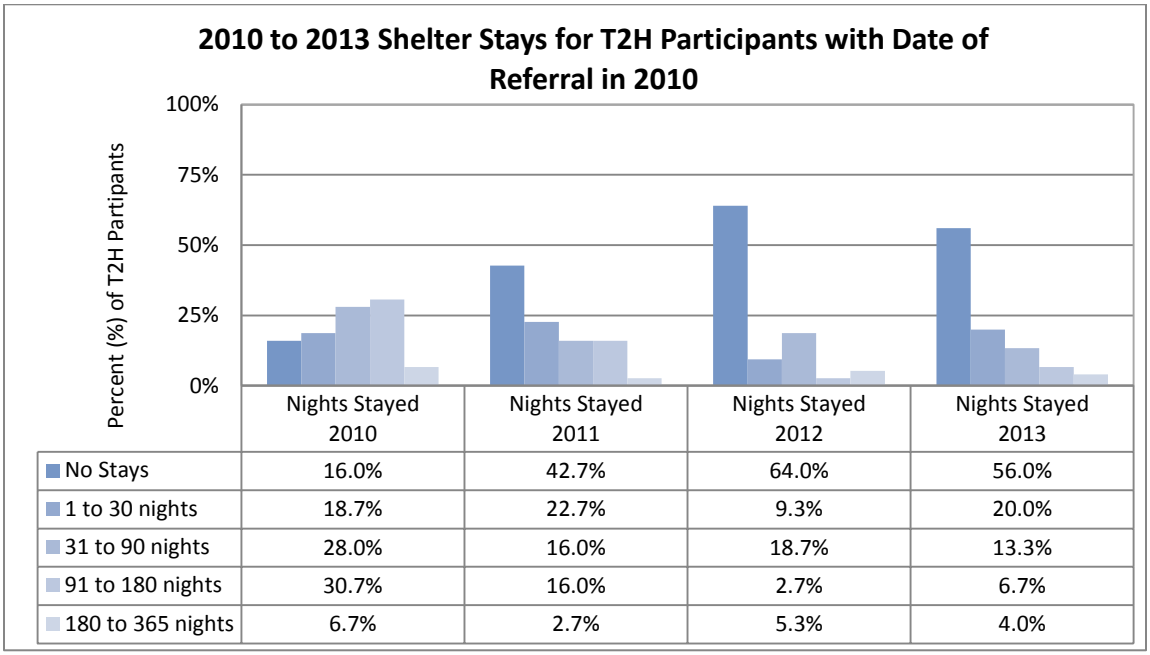
Figures 5, 6, and 7. For those recruited to the program in 2010, we observed an increase in individuals experiencing no nights spent in shelters from 2010 (16.0%) to 2012 (64.0%). However, we observed a slight decrease in no stays in 2013 to 56.0%. In 2013, a higher proportion of individuals accessed emergency shelters for 1 to 30 nights, suggesting that the slightly higher percentage of T2H participants who were accessing emergency shelters in 2013 did so on a short-term basis. These data show a decrease in T2H participants' long-term shelter use after enrollment in the program.

For those recruited in 2011, the percentage of individuals who did not stay in emergency shelters steadily increased from 15.6% in 2011 to 65.6% in 2013. Between 2011 (3.1%) and 2013 (6.3%), a slight increase in the percentage of individuals who accessed emergency shelters for 180 to 365 nights was observed. However, generally speaking, the 2013 rates of long-term shelter use, categorized as occupancy for 31 nights or more were lower than those observed in 2012. Additionally, the 2013 rates of 180 to 365 night occupancy were lower than those observed for 2011.

Participants who were recruited to the T2H program in 2012 also experienced decreased shelter use. The HIFIS data suggests that there was a large increase in the proportion of individuals with no nights stayed between 2012 (9.5%) and 2013 (66.7%). For this group, there was a decrease in all categories of long-term shelter use, defined as 31 nights or more. There was a slight increase in short-term shelter use between 2012 and 2013. In 2013, 37 of the men listed in the HIFIS database had been referred to the T2H program. However, as these individuals are recent referrals, data measuring emergency shelter use outcomes is not yet available.

In addition to accessing publically available supports and services, all T2H participants are provided with case management support. When participants enroll in the T2H program, they agree to meet with their case manager on a regular basis. The case managers described the services they provide to their clients which include assistance with finding housing, obtaining identification, applying for income support, attending appointments and meetings, assistance with daily life tasks, working on the participants' identified goals, and assisting participants in navigating the social services system.

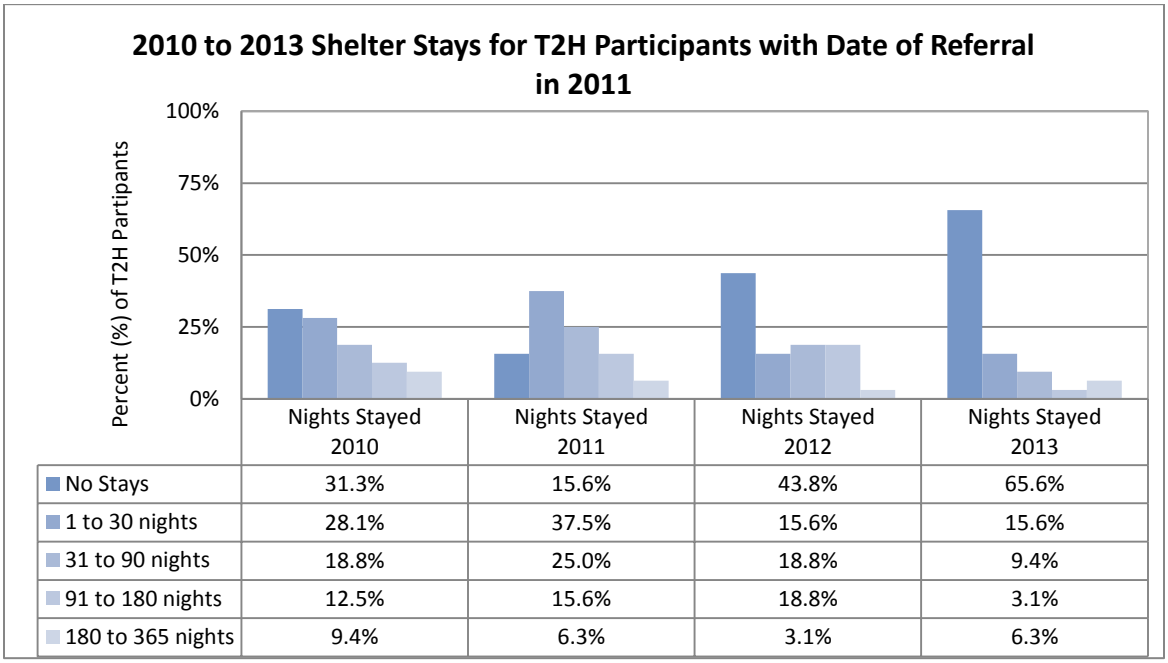
Figure 5: Shelter Stays for T2H Participants who were Referred to the Program in 2010



	Nights Stayed 2010	Nights Stayed 2011	Nights Stayed 2012	Nights Stayed 2013
No Stays	16.0%	42.7%	64.0%	56.0%
1 to 30 nights	18.7%	22.7%	9.3%	20.0%
31 to 90 nights	28.0%	16.0%	18.7%	13.3%
91 to 180 nights	30.7%	16.0%	2.7%	6.7%
180 to 365 nights	6.7%	2.7%	5.3%	4.0%

Source: HIFIS Database. Analysis performed by the City of Hamilton

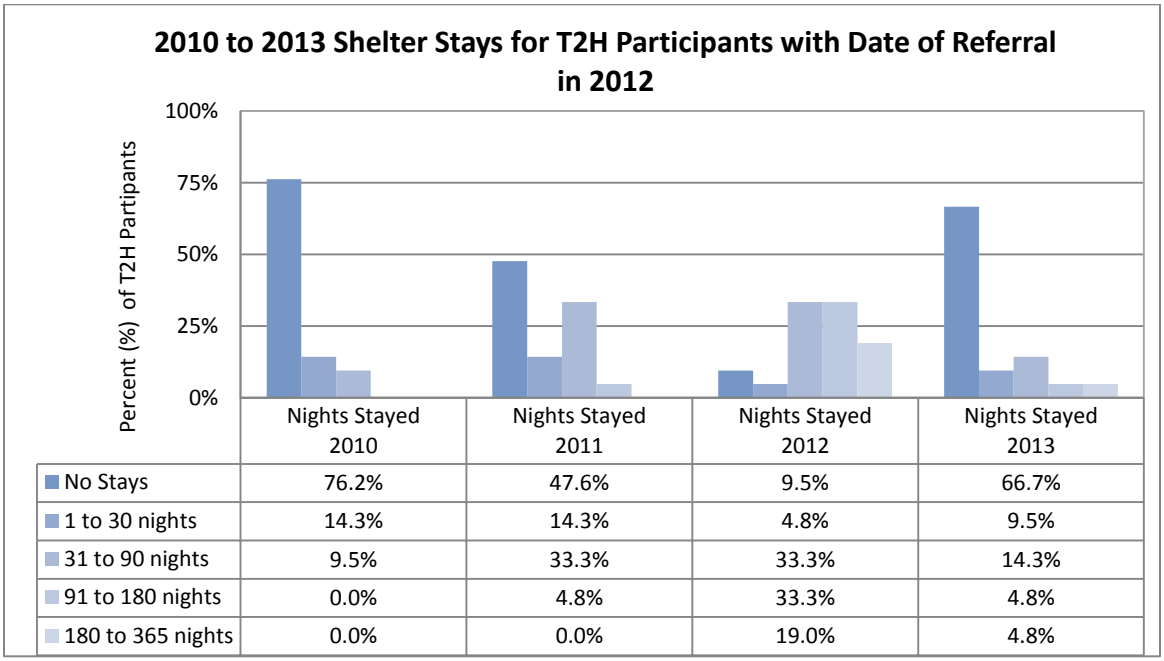
Figure 6: Shelter Stays for T2H Participants who were Referred to the Program in 2011



	Nights Stayed 2010	Nights Stayed 2011	Nights Stayed 2012	Nights Stayed 2013
No Stays	31.3%	15.6%	43.8%	65.6%
1 to 30 nights	28.1%	37.5%	15.6%	15.6%
31 to 90 nights	18.8%	25.0%	18.8%	9.4%
91 to 180 nights	12.5%	15.6%	18.8%	3.1%
180 to 365 nights	9.4%	6.3%	3.1%	6.3%

Source: HIFIS Database. Analysis performed by the City of Hamilton

Figure 7: Shelter Stays for T2H Participants who were Referred to the Program in 2012



	Nights Stayed 2010	Nights Stayed 2011	Nights Stayed 2012	Nights Stayed 2013
No Stays	76.2%	47.6%	9.5%	66.7%
1 to 30 nights	14.3%	14.3%	4.8%	9.5%
31 to 90 nights	9.5%	33.3%	33.3%	14.3%
91 to 180 nights	0.0%	4.8%	33.3%	4.8%
180 to 365 nights	0.0%	0.0%	19.0%	4.8%

Source: HIFIS Database. Analysis performed by the City of Hamilton

In addition to the formal supports provided by the case managers, some of the meetings served a social or therapeutic function for participants. In meeting with their case managers, clients were able to feel less isolated and were able to talk about their lives. One case manager described the social function of some of her meetings:

> I meet a few people to touch base and see how they are doing, they are pretty stable in their housing right now, but socially they like to talk to somebody about what they do with their days. I like to see each client every two weeks at least. There are two I see weekly because they have anxiety issues, but because they have a relationship with me, they will come out for coffee. I do lots of coffee meetings.

This case manager discussed the importance of meeting with her clients. She did note that the primary purpose of most of her meetings was to work with clients on their goals. However, she was willing to meet with her clients to provide them additional social supports which they may need to continue to have stable tenancies.

Each case manager had a slightly unique approach to service provision. However, they were all focused on allowing their participants to identify their own goals and needs. They were also focused on performing an advocacy role and assisting their clients, rather than performing tasks for them. One case manager stated:

> I find that most people with addictions, you can't come on too strong and you have to allow them to be in charge with their goals and of the pace they want to move. I say you talk to me whenever you feel like it or want to talk to me, no pressure. If they miss an appointment I say no big deal. You have to be willing to miss appointments if they aren't ready to meet with you that day. You have to build a working relationship, go for coffee and develop an initial assessment. I focus on recovery, developing a recovery plan.

In discussing her interactions with clients, another worker said her job involved:

> Just being there, I have a hard time of thinking of fancy words for that. Oftentimes they are anxious and uptight so it can be something as simple as attending the PAWS (People and Animal Welfare Solutions) clinic, giving them whatever resources we can help them with, even as simple as printing out a map. Venting, they like to vent, they just want someone to listen. Empathy, just knowing that someone's in their corner another big thing is advocacy.

These case managers saw their roles as being very supportive while still encouraging program participants to attempt to problem solve and become involved in advocating on their own behalves.

All of T2H participants we interviewed were happy with the case management support that they received, and many referred to their individual case managers as "strengths" associated with the program. For these participants, their case managers were able to assist them with finding stable housing and supported them with a plethora of other concerns as they worked toward rebuilding stable livelihoods. One participant stated:

> [My worker], she's my guardian angel, yeah. She's like, I always say to her in a nice way, not in a, you know that she's like my baby sister that I never had. But she's my guardian angel. [My worker] used to come in to the [shelter], and then one day I started talking with her and then we started talking about different things and whatnot. And I got myself out of there and I was renting a furnished apartment. But then I started going downhill again and isolating and I wasn't taking my meds properly. And then I had a hospitalization, bad psychosis and I lost my place and I ended up back at the shelter. And that's when I found, she recommended, she said "Well listen, why don't you try this?" And then I did. I've been there now two years three months. Now it hasn't been a perfect ride by no means but, nevertheless, I've had a lot of push and a lot of support.

This individual accessed the T2H program through approaching a worker at a shelter. She has been able to assist him in securing stable housing. Although he has experienced multiple events of housing instability, contact with a case manager has assisted him in working toward maintaining a stable home. The only concern

surrounding case management that was expressed by a participant was related to succession planning. This participant stated:

> But the worker turnover rate is brutal. It's brutal and again speaking for myself, with the trust, abandonment issues, the whole having to go through one worker and then a week later get bounced to another one and have her for eight months and then she's off on maternity leave.

Some participants may become very connected to their case managers. This may present problems when a worker takes vacation, moves on to a new position, or takes time off for maternity or sick leave. Participants usually have some exposure to the other case management staff. However, this exposure may be limited or very informal, resulting in barriers to engaging in a trusting relationship when clients are moved to other workers' case loads.

Program participants also have the option of accessing addictions support and therapeutic recreation programming. Wesley employs a full-time recreation therapist and a full-time addictions case worker to work with T2H participants. Recreation programs include gym programming, swimming, a winter bowling and summer baseball league, weekly drop-in lunches, summer outdoor programming, cooking classes, breakfast groups, skating, and movie days. In addition to this, the recreation therapist provides individual recreational therapy to individuals in accordance with their case plans. Addictions supports are tailored to the individual needs of each participant and are often focused on harm reduction. However, participants may choose to work toward abstinence and supports and referrals are provided for assistance with cessation. Those who access these services tend to do so for support with alcohol, drug, and nicotine use. Recreation and addictions programming are optional and T2H participants are not required to access these services.

Our analysis of the T2H COTS data indicates that over 176 participants have accessed some form of recreational programming during their tenures in the program and 85 participants have accessed addictions support. These findings are displayed in Table 14. The total hours of therapeutic recreation provided by the program between January 1st, 2010 and December 20th, 2013 was 2,667 with an average of 15.15 hours spent with each participant. 1,035 hours of support were provided by an addictions case worker with an average of 12.18 hours spent with each participant.

Table 14: Transitions to Home Internal Program Service Use by Type

Type of Service Used	Number of Participants (N)	Number of Service Provision Hours
Therapeutic Recreation	176	2,667
Addictions Support	85	1,035

Not all of the T2H participants interviewed in this study accessed therapeutic recreation and addictions support services. As housing is not dependent on treatment, participants are not required to access specialized resources. However, these resources are available to the T2H clients who choose to access them. Many of the participants interviewed attended the drop-in lunches and some of the larger social gatherings, such as the summer barbeques or the Christmas parties. However, most who did not actively participate in recreation programming claimed that they were not interested in attending. Others experienced anxiety in social environments. One participant stated:

> And there's a lot of times when [my worker] has told me "Oh there's picnics and there barbecues" and there's this and that. And a lot of times, to be honest with you, I don't feel comfortable in those kind of settings. And it's not just that but I take a lot of very sedative medicine and sometimes I can't get myself out of bed. But when it comes to social situations I feel, I don't know, I feel out of place. But I've always kind of felt that way, even since I was young and even when I was with my wife who'd go to parties or dances, and I always kind of, I didn't feel sociable. Like I almost felt like I didn't belong. So it's just the way I've always kind of been. I've always kind of been somewhat of a loner.

For those who did regularly participate in recreational programing, they found it to be quite beneficial. These participants discussed forming social relationships through programming, using activities as a way to fill their time and assist with mental health and addictions concerns, and using recreation as a way to improve their overall health and experiences of wellbeing. One individual described how participating in recreational and volunteer activities could assist him with his sobriety:

> But, you know, the summer programs and stuff like that are excellent. I mean, if you want to participate they're there. And I've done it, but it's a long way to get to the baseball field from my end of town especially if you're not driving. But, you know, the social side of it, I like to get myself involved with it more. Maybe as a volunteer type of thing, you know, that's something

> I'd have to bring up with certain groups. I mean, even if it's the food banks and stuff like that. I'm bored, I need something to do, that's why, you get bored and there's nothing to do and the next step in boredom is drinking. That's where you end up and I don't want to end up that way again, so.

Another participant was able to use the recreational programming to make new friends who assisted this individual in overcoming a fear of leaving home after dark:

> Yeah. But me and my friend, who will--I'm afraid of the dark so I don't go out at night, so my brain says okay. It gets dark at about 7:30 right now. I better--wherever I am I better start heading home around 5:00 or 6:00 because I can't be out. But I can be out with my friend. I can be out with [him]. Me and [him] have an appointment, I don't know what you call it. We're friends. We're going to a movie Tuesday night. It starts at 8:10 p.m. Really? I have to leave the house when I really want to be going home? [He says] you'll be okay. You'll be with me. You've got some guns (in reference to muscles), so yeah. So I'm going to get on a bus and we're going to go all the way up to the top of the mountain to go watch a movie. But he's my movie buddy. He's my swimming buddy, my movie buddy, my workout buddy.

For this individual, recreational programming was an important avenue for meeting other people who could assist in overcoming crippling fears that contributed to problems in completing daily life tasks.

Similar to recreational programming, participants are not required to access addictions supports. The T2H addictions case manager uses a harm reduction framework to provide the level of assistance to an individual that they request. One participant discussed his experience in obtaining harm reduction assistance for his addictions:

> Now, I have talked to the addictions counselor, I suffer from an ailment where a group of muscles in the right side of my neck is not working and the left side through flexing is pushing the throat cavity off to the side. I'm a singer and any time I get a chance to sing there's so much closure in the throat that I've actually found that if I drink alcohol it will open it up. Now my doctor has said yes that's true, my girlfriend is a non-drinker, she's actually scared of alcohol but she's been with me when I have played and she's seen me have those two beers and I walk out exactly the same person. Now there's more of a fear factor, how long could I do that on a steady basis, I don't think I could do it very long because I love booze you know. But any other time I'm completely sober. So I'm being more choosy on you know when I work, you know I don't try and work so often because of the fact of that invitation to addiction is there but it's … yeah it starts out as a necessity but it's also that opportunity it use it abusively.

This individual was not yet ready to completely abstain from drinking alcohol and found it useful to drink when he sang. He was able to access the addictions case manager and employed harm reduction strategies by only having two beers at a time. He also chose to limit the number of performances he participated in to control his drinking. Other respondents also discussed accessing the addictions case manager to cut back on or abstain from nicotine use, and drug and alcohol consumption.

PARTICIPANTS' AND WORKERS' RECOMMENDATIONS FOR THE T2H PROGRAM

During our interviews with the T2H participants, each respondent was asked what he thought would improve the program. The responses to this question were quite diverse. Some participants were unable to think of recommendations, whereas others provided multiple suggestions. Some of these included assistance with accessing healthy food, the provision of additional support groups and access to a clinical psychologist, the provision of resources for starting cooperative work projects, and increasing resources to provide quicker access to single site apartment units.

In addition to participants' perspectives, we also asked the case managers for their recommendations and goals for the program in the future. Many of the case managers suggested that the program and its workers be provided with additional supports and resources. One case manager stated:

> You have 11 case managers, but you only have 1 housing and 1 addictions worker, having 2 of each would be the ideal. Expanding some of the positions, maybe having a team member with a nutrition background, we have a lot of diabetes, HIV, Hep-C, you can get those in the community but a lot of our participants cancel, so having someone here to work one-on-one with the clients would be a bonus. I look at the ones with diabetes and all of the other issues, how do we keep them where they are healthy and not losing their limbs? You can only do a plan so much, but with one guy I told him if you have an abscess you have to go to the hospital right away. Nutrition is a big thing for them; the nutrition factor is not there all of the time. Right now we have the gardens so people are bringing in vegetables, potatoes and tomatoes and after the season you just get what's donated. It's a big thing nutrition.

This particular case manager suggested expanding the clinical team to include other specialized workers to assist individuals with medical concerns. She also suggested that having supports on site was important to this

population, as they are often unable or unwilling to access other supports within the community. In addition to this, other workers suggested expanding the program's capacity by providing more housing allowances which are used to quickly house T2H participants in scattered site independent units.

Many of the case managers who were interviewed for this study made recommendations for material resources and job conditions that would assist them in performing their job duties. Some of these included Wesley supplied cell phones, access to mobile internet sticks, and improvements in pay and work hours. One case manager discussed the importance of having appropriate information and resources:

> I do think training is important, it would be nice to have a package of resources available within, even if it's just through Wesley, I was saying with other programs in the community they give a nice little package to introduce themselves, not necessarily the gift cards, we have a huge influx of services, but I don't see the same as other programs where you leave from [another agency] with a whole booklet about what they do as well as other programs. So I don't think we do enough branding. Something else to offer… we are very at times, I want to say marginalized, it's very ridged in the budget, a little bit more flexibility there. If I see someone who's very hungry and he's a bit angry, to deescalate a situation to be able to buy him a sandwich. We are told to try to keep it to coffee for the sake of money. The bus tickets helps, instead of the pass because I can give them out, but I feel like I have to budget them more because I don't want to go ask for more.

According to this individual, supplying additional resources, such as food and information packages, would assist her in her efforts to engage with and assist individuals in the community.

In addition to recommendations for additional resources, case managers were asked to describe their vision for the future of the T2H program. The majority of respondents envisioned program expansion and increased capacity to assist in housing clients. The following quote provides insights into some of the workers' future goals for their program:

> I'm hoping that we will be able to house more people, we will be able to obtain more funding, and um be able to help more people maintain their units. I would like to see us to get our own building, I don't know if it will be possible, maybe it's wishful thinking. Like the homes program. You have a whole building and you manage, case manage, all of the people in the building.

The idea of offering a single or congregate site Housing First building with on-site case management support was presented by this case manager, as well as by a key informant, as a way to address the shortage of affordable housing and participants' need for individualized supports. In both cases, this idea was presented as an ideal dream for the future, one which would require access to substantial resources.

DISCUSSION & RECOMMENDATIONS

Our findings indicate that the T2H program has had success in stabilizing tenancies and improving outcomes for its clients. The qualitative and quantitative data point to the multiple successes of this program. However, we also discovered that there are areas in which improvements can be made. This section discusses our findings and provides general recommendations for continued program success.

The age of T2H clients is slightly older than the general shelter use population in Hamilton. This could mean that those who experience long-term homelessness tend to be older. Additional research is required to determine whether or not this is the case. However, it could also mean that younger men are not frequently engaging with the program. T2H is currently not mandated to work with youth. However, focused engagement with men in their late 20's and early 30's may improve access to T2H for younger men.

The HIFIS data indicate that T2H is meeting its mandate of providing to services to the long-term emergency men's shelter population. However, our qualitative results indicate that more creative forms of engagement may be necessary to recruit and maintain contact with those who are not active in the program. This could include the provision of a specialized worker on the case management or clinical services teams who is specifically responsible for researching and determining best practices for engagement with this population. Currently, the T2H shelter outreach hours are distributed among the members of the case management team. T2H maintains a presence in each of Hamilton's men's shelters for 4 hours a week. Providing additional specialized worker support could increase the program's physical presence in the shelters and provide additional opportunities to engage with potential clients.

In addition to the creation of program innovations to increase engagement, our qualitative findings indicate that there is a general need to continue to find ways to reduce organizational divides. The City of Hamilton has begun to work towards this by establishing Shelter Standards and HESICC. However, as all agencies compete for limited resources, we suggest that all of Hamilton's men's housing services providers continue to work together, in tandem with the City of Hamilton, to find ways to problem solve, share resources, and break down organizational barriers and divides.

As housing stability increased with longer periods of involvement with the program and emergency shelter use decreased, we recommend the continued use of a Housing First model to actively house the long-term male homeless population in Hamilton. A small proportion of total referrals (N=9) were on a waiting list for the program suggesting a slight need for increased program capacity.

In discussing the T2H program with non-participants who qualified to be enrolled in the program, we discovered that the majority of our sample had no or limited knowledge of the program and its benefits. Additional resources for and creativity in engagement may assist in informing potential participants about the benefits of the program. The case managers and key informants suggested that information sessions about resources available in Hamilton and accessible literature on the program may assist in engaging new participants.

The T2H COTS data indicate that a high percentage of recently recruited 2013 participants are residing in temporary housing. This may be a result of participants' placements in shared accommodations while they wait for a housing allowance and single unit to become available. Additionally, the case managers interviewed discussed the importance of providing more housing allowances to assist in quickly housing individuals. Our data indicate that there is a need to increase the number of housing allowances available and to continue to work with landlords to house program participants. The position of housing worker is a unique role. This individual is able to assist and advocate for landlords by assuming some of the risk associated with housing participants. We suggest that T2H continue to build positive relationships with their landlords. We also suggest that the benefits of housing participants, for example participants are able to request that their rent be paid directly to the landlord from benefit cheques at the first of every month, be shared with Hamilton's landlords who are not currently participating in the program in order to secure additional leasing capacity for the program.

Our interviews with the case management team indicate a need to increase program resources. Some of these resources include assigned mobile telephones and portable internet sticks for use when engaging in the community, access to additional bus passes, and useful and accessible literature about the program to provide to potential clients. Additionally, some members of the T2H team had envisioned the creation of a single site Housing First building, containing independent apartment units as well as shared program space where case management supports can be provided at the request of clients. With additional research and resources, this

vision may be feasible in the future. We recommend that any moves toward the creation of a single site building include strict adherence to Housing First model fidelity. This will assist in maintaining the key principles of the program.

Social services work in general has a high turnover rate. Our interviews with the case managers indicated that program participants may become attached to working with their particular service worker. However, human employment factors such as worker illness, maternity leave, contractual expiration, and employee turnover are often unavoidable. This presents problems when program participants need to be moved to other workers' case loads, suggesting the need to find innovative ways to engage and familiarize participants with secondary workers who can also become familiar with the clients' needs and build trusting relationships. However, at the present time, resources do not allow workers to have primary and secondary clients, as many of the case managers are currently carrying full case loads.

In asking T2H participants and non-participants about their housing histories, it became clear that the majority of these individuals had experienced some form of trauma in early life. One of the case managers noted that experiences of trauma over the life course seem to result in individuals' taking comfort in living in and reverting to chaos. Additionally, our interviews suggest that with increased exposure, individuals begin to normalize shelter life. All T2H participants have stayed in an emergency shelter or were homeless for at least 30 days. This suggests the need to provide individuals with access to counseling, adjustment, and community reintegration resources. At the present time, participants are able to access a social worker who is supplied through the City of Hamilton. However, there is a waiting list for this service and there is a need for additional counseling supports.

Almost all of the respondents who had experienced long-term homelessness also experienced some form of youth or childhood trauma. Trauma generally occurred in the family home, as a result of familial experiences of poverty, parental drug or alcohol use and/or mental health concerns, and abuse. Trauma also occurred after individuals left or were removed from their homes. This was associated with entry into institutionalized living or foster care and experiences of housing instability. We also observed that many participants dropped out of high school at a young age and began living in unstable circumstances. As communities work to end homelessness, they must also strive to prevent housing loss and instability. Our research suggests a strong need

to provide low-income and at risk families, children, and youth in Hamilton with access to appropriate resources to assist in promoting stability. The experiences of the men in this study illustrated a strong connection between youth trauma and subsequent experiences of housing instability. In order to move from reacting to homelessness to preventing it, resources must be spent on stabilizing families who experience high levels of need.

Our interviews suggest that T2H participants faced fewer barriers in accessing housing than those who were not enrolled in the program. Program assistance with locating housing, filling out paper work, accessing appropriate incomes supports, housing allowances, and immediate access to first and last months' rent provided T2H participants with advantages while seeking housing. The experiences of individuals who were not enrolled in the program speak to the usefulness of providing Housing First assistance for those experiencing long-term homelessness.

In addition to assistance with finding housing, many of the T2H participants sampled discussed the importance of therapeutic recreational programing in establishing stable tenancies. Access to recreation provided participants with a mechanism for connecting with others in the program who has also experienced social disengagement and were working toward securing stable tenancies. For others, recreation served as a form of harm reduction, taking the place of drug or alcohol consumption. The participants expressed that recreational programming allowed them to heal and form new bonds.

Our research suggests that the condition of some of the housing stock in downtown Hamilton requires improvement. Specifically, individuals who were attempting to access housing without program support discussed not being able to find appropriate housing units that were clean and in good repair. Many participants, regardless of whether or not they were in the program, had experienced issues with or were concerned about pest control. Getting rid of beg bugs is extremely difficult and expensive. Although the onus for physically ridding an apartment unit of bed begs lies with landlords, it is the tenants' responsibility to ensure that they have properly prepared their belongings in their units for spraying and pest control. The T2H program provides participants with supports with this. Additional education and resources to assist both landlords, tenants, and all residents in Hamilton may prove useful in pest control.

As the widespread use of Housing First models in North America is relatively new, little is known about what happens to participants once they achieve stability and maintain it for prolonged periods of time. The T2H

program tracks the outcomes of participants who no longer need frequent case management support. These individuals are listed as being in maintenance and are able to contact the program and access a case manager if they require assistance in the future or if a crisis arises. This is considered a sustainable "graduation" model, as it allows case managers to take newer clients on their case loads. However, it also provides graduates with the ability to access support if potential triggers for instability occur in the future. In order to further assess the continued value of this model, additional research should focus specifically on understanding the experiences of maintenance individuals.

LESSONS FOR OTHER COMMUNITIES

One of the original aims of this research was to examine the T2H program to determine best-practices or key programming components that other communities can use when introducing their own Housing First programs. The T2H program used an Intensive Case Management model. However, we believe that these recommendations can be adopted for communities that wish to use Assertive Community Treatment model. Through our research, we found that there were six factors that we suggest communities keep in mind when thinking about Housing First. In this section, we list these components in an accessible way, in attempt to assist policy makers in developing their own programming. We suggest the following:

1) Housing First programs should offer a comprehensive and customizable range of supports: In our research, we found that onsite addictions supports and access to recreational therapy assisted participants in rebuilding stability in their lives. Although participants do not have to access these supports, we found that having them available was highly beneficial. For example, in offering therapeutic recreation activities, the T2H program was able to assist participants with harm reduction and forming new social connections with other program participants. Due to the trauma our sample reported experiencing, we do suggest that easy and quick access to social workers and psychologists be provided to all participants who identify the desire to see a clinical counselor.

2) Housing First programs should be designed to meet the needs of the local community: T2H was designed to be a collaborative effort by Wesley Urban Ministries and Hamilton's men's emergency shelter providers. This allows for recruitment and consultation with the emergency shelter providers. Our findings showed that the majority of program participants were recruited from emergency shelters. We suggest that other communities work in collaboration with other service providers, agencies, and local government to design, implement, and run their programs.
3) Housing First programs should develop creative and appropriate engagement strategies that best suit their needs for connecting with their local populations who experience housing precariousness.
4) Housing First programs should find ways of building strong relationships with landlords: The T2H program employed a housing worker who was responsible for working with case managers to assist their clients in finding housing. This worker was also responsible for acting as a liaison between the program and landlords. This provided landlords with an avenue to voice any concerns. This worker was also able to assist case managers and landlords in understanding the rights of landlords and tenants. Having a designated person to work with landlords may be useful in other communities.
5) Housing First programs should be aware of staff turnover rates and implement successful succession planning strategies: T2H participants discussed the difficulties they experienced when they were required to switch workers. Building trusting relationships between workers and those who have experienced trauma and long-term homelessness can be challenging. Our findings suggest that finding ways to ensure that participants are comfortable working with different staff members may be important to continued engagement.
6) Housing First programs should have a post-intervention maintenance model to assist those who no longer require active support: The T2H program has worked with individuals who have obtained stable housing, met multiple life goals, and no longer needed intensive case management support. These individuals were placed in a maintenance category, wherein their case managers would occasionally call to see if supports were needed. Additionally, participants were able to call their case managers at any point if they felt they needed support or were in crisis. Graduate participants were also able to continue to access recreational programming.

CONCLUSION

Through our attempt to explore and understand the outcomes and experiences associated with participation in Hamilton's Housing First program, we have found that enrollment in the T2H program was associated with decreased shelter use. Additionally, we found that the men enrolled in the program generally expressed experiencing increased stability in housing and daily life. The sample of T2H participants interviewed for this study also experienced fewer barriers while attempting to access housing. Various components of this program, including access to case management staff, addictions supports, recreational programming, and assistance with finding and maintaining housing contributed to these positive experiences.

Our findings also suggest the need to continue to adapt the program within the context of Hamilton's homelessness and housing policy landscape, to continue to ensure that T2H is able to engage with and successfully house individuals experiencing long-term homelessness. Our qualitative data indicate that new models of engagement should be explored. Additionally, expanding program capacity to quickly house individuals in single site units may prove useful in rapidly establishing secure tenancies.

In addition to our findings which specifically relate to the T2H program, we found that greater emphasis needs to be placed on engaging with all levels of government and potential landlords to increase appropriate, affordable housing stock by building, renovating, or allocating existing units as affordable. Our findings also suggest that funders and service providers should continue to work toward supporting low-income families to promote experiences of stability in children and youth.

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