FIXED-SITE PERMANENT SUPPORTIVE HOUSING: UNDERSTANDING OPERATIONAL AND ENVIRONMENTAL FACTORS THAT CONTRIBUTE TOWARDS POSITIVE OUTCOMES FOR RESIDENTS OF FIXED-SITE PERMANENT SUPPORTIVE HOUSING IN THE FRASER HEALTH AND INTERIOR HEALTH REGIONS

by

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MAJOR PAPER SUBMITTED IN PARTIAL
FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SOCIAL WORK

In the
School of Social Work & Human Services
Master of Social Work Program

UNIVERSITY OF THE FRASER VALLEY
Summer 2019

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Degree: **Master of Social Work**

Title: **Fixed-Site Permanent Supportive Housing: Understanding Operational and Environmental Factors That Contribute Towards Positive Outcomes for Residents of Fixed-Site Permanent Supportive Housing in the Fraser Health and Interior Health Regions**

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Abstract

Homelessness is a historical issue that has plagued many countries over time, and there have been a variety of responses to it. Homelessness is conceptualized as living without stable, permanent, or appropriate housing, is increasingly experienced by individuals who struggle with mental health issues, addiction, and poverty, and can result from both personal and systemic factors (Cronley, 2010). One measure to address increases in homelessness in Canada is the utilization of Permanent Supportive Housing (PSH). PSH is loosely defined as subsidized housing partnered with ongoing supportive services and often operates on Housing First (HF) principles (Byrne, Fargo, Montgomery, Munley & Culhane, 2014). Many PSH developments work with people who have varying levels of complexities on their lives, including mental health, addictions and histories of trauma.

This study looked at operational and environmental factors that contribute towards positive outcomes for residents in PSH by having operators (management or lead staff member of operating organization for PSH surveyed) of developments in the Fraser Health and Interior Health regions complete a 25-question survey to share their experiences and insight. The participants identified positive outcomes and challenges in the areas of staffing, programming, and environmental designs. Understanding how PSH developments operate, and what considerations are needed to promote resident safety and independence will assist social workers and other human service providers as we journey towards providing services and reducing homelessness.

Keywords: homelessness, supportive housing, housing first, housing continuum, addiction, mental health, recovery approach, social workers.

Acknowledgments

I would like to sincerely thank the faculty at the University for the Fraser Valley for guiding me through my learning journey. This process has helped me gain a deeper understanding of education, understanding, and how I can shape and respond to the many things that life throws at a person. I would especially like to thank Dr. Anita Vaillancourt for her dedicated support throughout this journey as my supervisor, consultant, and cheerleader. I would also like to thank Dr. Leah Douglas for providing feedback as my second reader.

I also want to say a special thank you to the participants of this study that took the time to share their wisdom on a challenging topic. The work you do is never ending, often going without reward, but makes all the difference in the world to many.

Dedications

I would like to dedicate this paper to my amazing wife Jessica and two daughters Hannah and Holly. You have endured many evenings and weekends without a husband and father so that I could complete a Diploma, Bachelor Degree, and Master's Degree. This paper marks the end of a long journey. You have been a cornerstone in my life, remaining unmovable, and without you, I would not be writing this. While there have been many sacrifices, strength and resiliency has been forged out of those times.

Thank you, God for allowing me the opportunity to finish this. You know the journey it has been. In my greatest weakness, your strength has been made perfect (2 Corinthians 12:9-10).

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Acronyms and Symbols

Acronym	Definition of Acronym
CMHC	Canadian Mortgage and Housing Corporation
HF	Housing First
HPS.	Homelessness Partnering Strategy
MEH	Multiple Exclusionary Homelessness
NHI	National Homelessness Initiative
PSH	Permanent Supportive Housing

Introduction

Homelessness is a historical issue that has plagued many countries over time, and there have been a variety of responses to it. In recent years, Canada has seen a drastic increase in homelessness. Gaetz, Dej, Richter, and Redman (2016) report that in the early 1980s, a small number of largely single men experienced homelessness, whereas today more than 35,000 people experience it on a given night, and on average, 235,000 people experience it in a given year (p. 12). Homelessness is defined as "the situation of an individual, family or community without stable, safe, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it" (Gaetz et al., 2012. p. 01). A lack of safe, appropriate housing poses significant barriers to stability, and without it, it is very difficult for individuals to pick up the broken pieces of a life and get back on track (Gaetz, Scott & Gulliver, 2013).

The utilization of Permanent Supportive Housing (PSH) is one measure to address increases in homelessness in Canada. PSH is loosely defined as subsidized housing partnered with ongoing supportive services and often operates on Housing First (HF) principles (Byrne, Fargo, Montgomery, Munley & Culhane, 2014). It aims to help people who have struggled to attain or maintain independent living find safe, appropriate, client-centered housing and thereby exit homelessness, while concurrently working with internal or external services to address a variety of personal or structural issues. Further, PSH developments aim to be conducive to the safety and wellbeing of all who live and work in the surrounding community.

While PSH is continuing to be utilized as a viable response to homelessness and its associated complexities, there are many factors to consider when operating a site, such as organizational philosophies, staffing capacity, and the demographics of the residents who will reside there**.** PSH operators (management or lead staff member of operating organization for

PSH surveyed) need to address issues pertinent to staffing, policy creation and implementation, security, harm reduction, screening processes, and responses to challenging situations, such as working with people who use substances and live with mental health concerns. While research has been conducted on the ideologies and philosophies that direct PSH principles, minimal research has been done on actual internal operational and environmental factors. This research study therefore aims to provide a detailed and nuanced answer to the question: "What operational and environmental factors contribute towards positive outcomes for residents of fixed-site Permanent Supportive Housing in the Fraser Health and Interior Health Regions?" It is important to note that for the purpose of this study, positive outcomes include, but is not limited to: the stability of residents (e.g. positive interaction with staff and neighboring residents, program guideline compliance, minimal behavior challenges), resident engagement in programs, minimal emergency service attendance and a reduction in risky behaviors (e.g. criminal involvement, unsafe substance use practices).

The paper includes a literature review that discusses the history of housing in Canada, explores current knowledge on PSH, homelessness, and considers the former continuum of care approach and current HF approach to homelessness. It also includes the research methodology, recruitment processes, ethical considerations, findings and a discussion of the research, and a conclusion. The findings from the study provide insight into how the operators of multiple PSH developments balance the tasks required to manage sites occupied by people who live with various complexities and face multiple barriers to stability, such as mental health and/or substance use concerns. It is hoped that the findings will therefore inform best practices for the operators of fixed-site PSH.

Literature Review

Homelessness

Homelessness is conceptualized as living without stable, permanent, or appropriate housing. It is increasingly experienced by individuals who struggle with mental health issues, addiction, and poverty, and can result from both personal and systemic factors (Cronley, 2010). Manthorpe, Cornes, O'Halloran, and Joly (2015) use the term multiple exclusion homelessness (MEH) to refer to people who are homeless as the result of struggling with a variety of complex issues, which is the population this paper is focused on. Cronley (2010) suggests that those who experience MEH routinely encounter barriers to securing adequate housing, including economic factors such as job loss, housing market changes, or low wages. The long list of personal factors associated with MEH can be both the cause or the consequence of homelessness, and include:

> drug and/or alcohol dependencies; severe mental health problems; experiences of domestic violence; a history of having been 'cared for' by a local authority because of lack of adequate parenting; having been imprisoned; and participation in 'street culture' and 'survival activities' such as sex work, begging, street drinking and street-level drug dealing. (Manthorpe et al., 2015, p. 588)

As previously indicated by Gaetz et al. (2016), over 235,000 Canadians experience homelessness each year. Roughly 5,000 of these are described as being absolutely homeless or unsheltered, 180,000 make use of emergency overnight shelters, and 50,000 are provisionally accommodated. Additionally, according to Macleod, Worton, and Nelson (2016) one in five Canadians are at risk of homelessness because they spend more than 50 percent of their household income on rent. According to the 2018 Canadian Rental Housing Index, the number for residents of British Columbia is similar, with 21.3 percent spending more than 50 percent of their household income

on rent. Additionally, 7,655 individuals were identified as experiencing homelessness in BC, of which 63 percent were sheltered and 37 percent were unsheltered (2018 Report on Homeless Counts in BC).

Failing to provide housing to the homeless has a very high financial cost for taxpayers (Gaetz, 2012; Gaetz et al., 2016; Macleod et al., 2016). The direct costs include homeless shelters and services, and the indirect costs include increased use of health services, police services, and the criminal justice system. Taxpayers may also have to bear the cost of the direct negative impacts of homelessness in their communities, such as loitering in spaces meant for recreation (e.g. sporting, shopping); disarray resulting from people living on the street, and; fear of the danger perceived to be associated with homeless people. It is therefore important to consider the HF and PSH approaches, which mitigate the challenges of homelessness by providing immediate housing and necessary supports (Boyd, Cunningham, Anderson, & Kerr, 2016).

Housing History

Changes in provincial and federal government policies over the years have substantially contributed to the need for various types of housing and the incidence of homelessness. According to Macleod et al. (2016), federal government involvement in homelessness has fluctuated over the years. Prior to the 1930s, the view was that the market should regulate housing exclusively, with no involvement from the federal government. Subsequently, the Canadian Mortgage and Housing Corporation (CMHC) was partnered with the provinces to carry out the task of helping Canadians get into the housing market through loans and social housing, so provincial governments took a large responsibility for the housing sector.

Canada faced a new housing challenge in the 1960s, when a wave of deinstitutionalization released people who resided in psychiatric institutions into the community. This led to an increase in homelessness. The expectation was that the community would provide the released individuals with treatment and be responsive to their needs (Macleod et al., 2016). A variety of philosophies were developed to address the needs of the released individuals, who suffered from psychiatric illnesses. Some of these philosophies aimed to help support people to avoid experiencing homelessness or remain housed and detailed the factors that support positive outcomes in residency in Permanent Supportive Housing. These included systems of care that offered housing in conjunction with compliance to psychiatric services and the continuum of residential care, wherein mental health consumers moved from more restrictive to more independent housing as their functioning improved.

In the 1990s, the federal government became aware of the dramatic increase of homelessness in Canada and its associated costs, and the HF approach was advanced (Macleod et al., 2016). While these philosophies may have had positive outcomes for individuals who were homeless or might have become homeless, the continuing increase of homelessness in Canada calls for additional philosophies or models to address it. It is also important to note that research conducted in the 1980s and 1990s suggested that people who lived with psychiatric disabilities preferred to live independently in their own house or apartment. However, during Mulroney's terms in the 1980s and 1990s, the federal government capped its funding for social housing and stopped allocating new funding to it (Macleod et al., 2016).

In 1999, the National Homelessness Initiative (NHI) was created, and it was operational until 2007. Through the NHI, the federal government invested over $1 billion dollars in communities throughout Canada to combat homelessness locally. In 2006, the NHI was replaced

by the Homelessness Partnering Strategy (HPS), which adapted and modified most of the former NHI policies and practices and retained the philosophy of community-based solutions (Homeless Hub, 2019).

Despite the structural and systemic factors that have clearly impacted housing and homelessness over the years, there are some who believe homelessness is only caused by personal factors, never environmental factors (Cronley, 2010). Cronley (2010) adds that paradigms of individualism and self-reliance support this view by emphasizing the belief choices and that actions enable individuals to solve their challenges and progress upwards in social status.

The Housing Continuum Model

The continuum model is a housing model with several settings that provide different levels of service and/or supervision, and different levels of restrictiveness, with the most intensive treatment, or supports, offered at the most restrictive settings (Ridgway and Zipple, 1990). Gabrielian, Hamilton, Alexandrino, Hellemann and Young (2017) report that during the early 1990s, many services for homeless people were delivered along a continuum, with consumers progressing from shelters, to transitional housing, to residential treatment, and then to independent housing once they became capable of living fully on their own. According to the continuum model, clients are matched to appropriate housing settings based on their level of functioning and need for restrictions or intensive programs (Ridgway & Zipple, 1990). Ridgway and Zipple (1990) further indicate that each setting along the continuum aims to represent a homogeneous group of people, all functioning at similar levels and requiring similar levels of support or service. When a client becomes stabilized in their respective setting, or phase, they then move to the next level of independence. Alternatively, if a client experiences a decline in

functioning, he or she can return to a setting on the continuum that offers more intensive programming (Ridgway and Zipple, 1990).

Although the continuum model has had some positive outcomes, Ridgway and Zipple (1990) suggest that it has failed to foster the development of services that adequately meet the residential needs of people living with complex needs and that few communities provide a complete housing continuum. Ridgway and Zipple (1990) add that because governments devote scant resources to independent living, many clients hit a wall when they are ready to 'graduate' to independence as there are very few settings to accommodate them in the last phase of the housing continuum. Tabol, Drebing, and Rosenheck (2009) argue that another major drawback of the continuum model is that when residents make progress, they are uprooted and moved to a new environment where they lose social supports. This could normalize residential instability. Further, Tabol et al. (2009) point out that because the continuum model assumes that residents will adhere to the very structure rules and guidelines required by various living situations, it does not honour individual choice, which is important to fostering self-efficacy.

Housing First

The HF philosophy was born in the 1970s as a result of deinstitutionalization, which led social service workers, as well as social workers, to realize that finding housing for people with severe mental health and addiction problems was imperative in order to ensure that they received appropriate treatment. The HF approach has since been utilized often to address the various complexities that characterize people who are homeless. However, the name 'Housing First' did not originate until the early 1990's with Tsemberis' work with Pathways to Housing (Gaetz et al., 2013). The HF model is oriented to working with a diverse range of clients and provides a variety of scattered or fixed site housing options that may shed light on the operational and

environmental factors that contribute towards positive outcomes in PSH residency. The HF philosophy is that everyone deserves housing, and that people who are housed do better and have a better chance of recovery from life and health issues (Gaetz et al., 2013). According to Somers, Moniruzzaman and Palepu (2015), HF entails the provision of housing prior to treatment being provided for personal struggles such as substance use or mental health concerns. Somers et al. (2015) further state that there are both personal and societal benefits to HF, as this approach gets people off of the streets, provides a level of personal stability and personal safety, and reduces the financial costs of homelessness to the community, such as the costs of outreach and emergency services.

While the HF model has proven to be an effective model for rapidly housing people, it is not a stand-alone model. Other models may work more effectively for some individuals, depending on their personal situations. HF thus plays an important role in addressing the large, complex puzzle of homelessness alongside other interventions, such as prevention, emergency services, and other models of accommodation and support (Gaetz et al., 2013).

Gaetz et al. (2013) describe the HF process as a "recovery-oriented approach to homelessness that involves moving people who experience homelessness into independent and permanent housing as quickly as possible, with no preconditions, and then providing them with additional supports as needed" (p. 2). The idea that housing is not based on meeting presupposed standards that are imposed on individuals, but instead on a collaboration with client-centered services, sets this model apart from the continuum model (Cornes, Manthorpe, Joly & O'Halloran, 2014). HF does not require adherence to programs or services, but instead utilizes the Recovery Model, which Wittman, Polcin, and Sheridan (2017) describe as building on the resilience and strength of individuals, families, and communities to achieve improved health and

abstinence (if desired). The model works to emphasize health, wellness, and quality of life, and lends itself to a wide array of applications such as education, prevention, substance abuse treatment, and linkages to various mental and physical wellness settings (Gaetz et al., 2013; Wittman et al., 2017). Cornes et al. (2014) add that the Recovery Model emphasizes values, attitudes, and philosophies, and as such, is extremely personal for each individual.

There are 5 core principles associated with the HF model, as indicated by Gaetz et al. (2013. p. 5):

1. Immediate access to permanent housing with no housing readiness required, which means that individuals are not required to demonstrate abstinence, the receipt of mental health treatment, or employment in order to access housing;
2. Consumer choice and self-determination, whereby clients are able to have some choice as to where the type of housing they live in and the services they receive;
3. Recovery orientation, focusing on wellness as a whole;
4. Individualized and client driven supports, which recognizes that every person receiving is unique and requires different attention and services, and;
5. Social and community integration, which aims to have clients integrate into community by engaging in meaningful employment, vocational and recreational activities to promote inclusion.

While the HF approach has great potential, it is not a panacea. MacLeod et al. (2016) point out that while it may be effective for some, it does nothing to increase the accessibility or availability of affordable housing. As such, it does not specifically address the specific operational and environmental factors required for positive outcomes in residency in fixed-site Permanent Supportive housing. While the HF approach can be useful for some, it does have its

challenges as it serves a diverse range of clients. Matching team supports to the needs of clients can be difficult, which is why individuals who utilize the model often works with diverse teams, such as Assertive Community Treatment (ACT) teams (Gaetz, Gullier, Richter & Marsolais, 2014). According to Olivet, McGraw, Grandin, and Bassuk (2009), another challenge associated with the model is that staff are working in 'low demand housing', which places specific requirements on residents wishing to access housing. Consequently, staff with varying backgrounds may have different expectations as to what a client should or should not have to do in order to be given supports. This will influence whether staff take any environmental and operational factors into account, and if so, which factors they focus on.

Permanent Supportive Housing (PSH)

PSH provides permanent housing and support services and often utilizes a HF approach that often does not require people who are homeless to be compliant with treatment methods in order to access housing and available support services. As such, it is often an attractive option for housing people who are experiencing homelessness (Corinth, 2017). Boyd et al. (2016) add that while many PSH programs utilize a HF philosophy, others have rules and guidelines regarding substance use and/or alcohol issues, in which case non-compliance may result in eviction from housing. This creates high barriers to accessing housing for people who are homeless and living with substance use challenges. Corinth (2017) adds that while PSH aims to work with people who experience many complexities, including homelessness, it is often focused on housing those who have experienced numerous or lengthy periods of homelessness. A variety of voluntary services are available to better support individuals maintain PSH, including: 24-hour onsite mental health, addiction workers and crisis workers; medical and legal assistance; housekeeping assistance; personal care assistance; skill training, and meal programs. These

services can help residents who have experienced homelessness to learn new skills and experience positive outcomes in their new housing (Boyd et al., 2016).

The federal government's 2013 renewal of the HPS prioritized permanent supportive housing as a method to address homelessness and the multiple complexities associated with it. Macleod et al. (2016) indicate that the policy shifts associated with the renewed HPS largely resulted from the At Home/Chez Soi project, a randomized controlled trial among chronically homeless people with mental illness about the utilization of HF supportive services. The study identified that when homeless people are housed, they have better educational, employment and social outcomes than people who remain homeless. Tabol et al. (2009) note an additional factor that contributed to the push towards a policy change for PSH: the growing conviction that the linear model of residential services based on transitioning through housing did not meet the needs of people who lived with mental health and substance use concerns because it was based on an adherence to treatment plans.

People who reside in PSH are working through a host of personal challenges, such as substance use, mental health, and trauma related issues. These challenges can be reflected in troubling behaviours, which have the potential to create many difficulties for operating a safe PSH development that supports residents towards positive outcomes in their lives. Olivet et al. (2010) indicate that PSH developments find it challenging to provide comprehensive yet flexible services to meet the complex and varying demands of residents with a wide array of needs − many of whom have been alienated by more traditional systems of care that were unable to respond to their needs. The challenges that PSH developments face include hiring an appropriately skilled workforce; training and supervising staff to ensure high-quality care, and; supporting staff to prevent burnout and turnover, which may result from funding limitations

(Olivet et al., 2010; Larkin, et al., 2016). Olivet et al. (2016) add that PSH staff may find it challenging to engage clients while they maintain appropriate boundaries, monitor the safety of clients and themselves, witness the traumatic life experiences of the people they serve, and operate in the absence of direct supervision. Larkin et al. (2016) suggest a lack of education about homelessness in many fields further inhibits PHS staff's ability to provide comprehensive services that can meet the individual and complex needs of PSH residents. Tsemberis, Gulcur and Nakae (2004) suggest that the inability to meet residents' needs results in fragmented care, which often prevents them from seeking services. This is especially problematic, given that they may have a history of unmet needs and have consequently lost trust in systems of care. To address the above issues, it is essential to identify the operational and environmental factors that contribute towards positive outcomes in residency in fixed-site PSH and ensure that these factors are present in the developments.

In addition to the operational requirements of PSH, it is important for those who provide housing to people who have experienced homelessness to ensure that the physical environment is of satisfactory quality and visually pleasant, and has an amenable social climate. Marcheschi, Brunt, Hansson and Johansson (2013) note that an amenable social climate is one of the more relevant factors that contribute to recovery from homelessness, addiction, and mental health issues. A settings' capacity to foster a residential 'homelikeness' – architectural and design elements that create a homelike environment – has been recognized as a primary indicator of a positive social climate. Marcheschi et al. (2013) reference the Swedish National Board of Health and Welfare (2010), which reports that a positive social climate has been associated with people's well-being and settings that are family-oriented/friendly, rather than institutional in

nature. Such settings promote greater community engagement among residents and between residents and services.

Although it is suggested that the success of PSH often hinges on a positive environment (Marcheschi et al., 2013), Whittaker, Flatau, Swift, Dobbins and Burns (2016) claim that many PSH developments are not homelike and are characterized by oppressive security measures that invade residents' privacy and impede their capacity to feel a sense of autonomy. According to Whittaker et al. (2016), these measures include the scrutiny of residents by case managers, the rigid screening of residents' guests, and institutional-like features such as glass barriers to staff offices and cameras in every corridor and stairway. In addition, the residents of fixed site PSH often have considerable interaction with emergency services, as they are housed in high-density, downtown neighbourhoods. It has also been suggested that living in such neighbourhoods exposes residents to a higher risk of criminal involvement (Whittaker et al., 2016). The aforementioned considerations highlight the importance of considering environmental factors when developing or operating PSH.

Location within community is another important factor to consider when housing people who have experienced homelessness. According to Keita, Hannon, Buys, Casazza and Clay (2016), locating low-income developments within higher income neighbourhoods deconcentrates poverty and reduces social isolation. Keita et al. (2016) reference Kawachi, Subramanian and Kim (2008), who point out that higher-income individuals often have more social capital (i.e., interpersonal trust, norms of reciprocity, involvement in civic organizations), which is beneficial for neighbourhoods. This claim is affirmed by Keita et al. (2016), who indicate that communities lacking social capital have less access to protective resources and lead to poorer mental health than communities with greater social capital. Popkin et al. (2004) add that a

growing body of literature associates social mixing and the implementation of an urban revitalization policy with reduced crime. Strategically placing housing for people who have experienced homelessness and its associated complexities within healthy communities may improve these individuals' chances of recovery to move beyond homelessness and attain a life of well-being and stability.

In sum, homelessness and solutions to address it, including the increase in its numbers, have posed challenges to stakeholders across the country for decades. This is in part because those who experience homelessness constitute a diverse population with a range of complexities, including mental health issues, addiction, a history of trauma, poverty, and isolation (Cronley, 2010). PSH is one option for combatting homelessness and its associated complexities, and often works in tandem with a HF philosophy to house people before addressing any of the complexities they experience. Fixed and scattered site PSH often collaborate with multidisciplinary teams to offer the comprehensive services that residents need (Byrne et al., 2014). As such, PSH can help those who have experienced prolonged homelessness get out of the cycle of poverty, deal with complex issues, and pursue a stable life path.

Gaps in The Literature

There is a growing body of knowledge and evidence regarding the personal positive outcomes experienced by many residents of PSH developments. There is also considerable research on the philosophies and ideologies that characterize or inform PSH practices. However, there is minimal research on the actual internal practices and how they interact with other external practices and systems leading to positive outcomes for residents of PSH (Byrne et al., 2014). As a result, there is a need for studies to focus on these practices. The general research question that guides this study addresses that gap: What operational and environmental factors

contribute towards positive outcomes for residents of fixed-site Permanent Supportive Housing in the Fraser Health and Interior Health Regions? The question aims to utilize operator experience and knowledge to answer the following questions:

- In order to provide appropriate housing and supports to residents of PSH, how are current practices and staffing models being utilized, and if necessary, what can be done to increase positive outcomes in residency?
- What environmental considerations are, or should be taken to facilitate positive outcomes in residency in PSH?

Theoretical Framework

Ecological Systems Theory

Ecological Systems Theory (EST) is the theoretical framework that guided this study. EST suggests that humans interact with different environmental systems that impact their lives and relationships within community and the community's capacity to change (Ecological Systems Theory, 2018). In utilizing EST, this study aims to answer the question of what constrains people with varying complexities (i.e. addiction and mental health issues) from accessing appropriate housing that meets their basic needs and supports them to work towards person-centered outcomes or to attain empowerment.

The EST framework suggests that there is a need for social service agencies to meet a variety of different concerns that pertain to homelessness. These different concerns need to be addressed by both front-line services and government policies at the micro, mezzo, macro, and policy levels (Larkin et al., 2016). With regard to systemic governmental change, it is necessary to understand that there are many factors which have contributed and continue to contribute to a

person's homelessness and that collaborative efforts between government and clients have the most positive outcomes for government programs (Larkin et al., 2016).

According to EST, the various systems that impact individuals' lives have many layers, such as the environment of the spaces they occupy, operational factors in which they operate, and the personal perspectives or beliefs of both consumers and professionals (Darling, 2007). Darling (2007) notes that that these systems fuel and steer development or positive outcomes and that changes or conflict in any one layer will have an impact on other layers. It is therefore important to ensure that stability is maintained in order to allow the institutions and organizations that comprise systems (e.g. mental health services, housing providers, personal/professional relationships, income supports) to fulfill their mandate and optimize the success of programs and services. Within the context of this study, systemic balance is a contributor towards positive outcomes in residency in fixed-site PSH.

While it is important to look at the various systems (e.g., financial, housing, health/mental health, substance use, personal supports) at play in the lives of people who experience homelessness in order to understand and address the issue, it is no less important to recognize that personal agency plays a large factor in a person's journey through life. It is therefore critical to consider an anti-oppressive approach when working with people who have experienced homelessness. Dominelli (2002) indicates that anti-oppressive practice aims to deconstruct oppression by becoming aware of how it works and creating non-oppressive relationships rooted in equality. According to Dominelli (2002) non-oppressive relationships contribute towards healthy collaboration and potentially positive outcomes for clients. As social workers, we are not neutral**,** but instead are active in the process helping our clients to achieve change. This requires us to work within and between systems to support those we serve to get to

a place of independence and autonomy (Baines, 2011; Green and McDermott, 2010). That process is relevant to this study because in order to maintain PSH that meets the needs of residents, it is imperative to consider how the various interconnected factors and systems (e.g. housing supports, mental health and addiction services, finances, personal and professional relationships) have the potential to give both PSH and the resident the best chance of attaining positive outcomes. Moreover, Ridgway and Zipple (1990) also suggest that it is important for clients to have the ability to control the levels of engagement they have with supports and services that impact their lifestyles and routines.

Ecological systems theory and the anti-oppressive approach inform this study because social workers must negotiate many factors and systems when designing PSH, or helping individuals who have experienced homelessness to attain housing and address any addiction and mental health issues. Different approaches and systems are required to address the myriad of factors and complexities that are pertinent to these individuals. Green and McDermott (2010) suggest that as social workers, we should be focused on the constant changing and mutually influencing interdependency between clients and the different systemic layers involved in the design and planning of services aimed at responding to the various complex factors that clients present and live with.

This study aims to explore relationships between those who work in the field of PSH, individuals who live in PSH developments, and the organizations and services that support those individuals in the pursuit of change. As a person who has experienced and successfully resolved homelessness and addiction, I hope that the frameworks and theories I present in this paper and the findings of my study will guide social workers, educators, and policy makers to create more

robust and complete systems that effectively serve the needs of the individuals who utilize those systems and help those individuals to achieve change.

Research Design and Methodology

The research question for this study is: *What operational and environmental factors contribute towards positive outcomes for residents of fixed-site Permanent Supportive Housing in the Fraser Health and Interior Health Regions?* The study was approved by the Human Research Ethics Board of the University of the Fraser Valley on December 19, 2017, before the data collection process began.

The study sought to gain information from the operators of fixed site PSH in the Fraser Health and Interior Health regions. In order to gain a more complete and comprehensive understanding of the research problem than achievable from either quantitative or qualitative approaches alone, a mixed methods design was chosen for the study. This study sought to gain information from the operators of fixed site PSH in the Fraser Health and Interior Health regions using qualitative questions to capture experiences and expertise in a variety of areas (programming, staffing models, and environmental designs), as well as quantitative questions to capture numbers (residents, units, budgets) in order to present a richer understanding of the research question. Given that operators have varying experiences managing PSH, this method was deemed best to capture relevant information about factors that have addressed the operational and environmental challenges posed by PSH and generated the best tenant outcomes. The integration of qualitative and quantitative data advanced a better understanding of the various complexities pertinent to operating fixed site PSH.

Recruitment

A sample of 15 to 20 participants who had experience and expertise managing fixed site PSH or were staff members at PSH were sought for this study from the Fraser Health and Interior Health regions of British Columbia to ensure an adequate sample size for the study. While there are a variety of differences between the two health authorities (e.g., community policies on housing, health authority priorities, cultural diversity differences), these regions share many characteristics that are comparable to those of the Fraser Valley, British Columbia region, which is where the results of this research will be used to support positive outcomes for residents in PSH. Similarities between the two health authorities include municipalities of similar sizes, a similar incidence of homelessness, and communities that have utilized fixed site PSH as a response to increased homelessness.

Convenience sampling was used to recruit the participants. Preestablished relationships in my role as a social worker led me to identify 22 potential participants who were operators of individual PSH developments across 18 separate agencies. The inclusion criterion for participation was that potential participants were operators (manager or staff member) at a fixed site PSH in the Fraser Health and/or Interior Regions of British Columbia. The exclusion criterion was not working at a fixed site PSH in those regions.

I contacted the potential participants through email communication to invite them to participate in the study. This communication contained a Request to Participate form (Appendix A), an Information Letter (Appendix B), and a link to the on-line survey that was administered for the study, which was located in the Fluid Surveys platform (Appendix C). Of the 22 potential participants contacted, three did not respond and one was excluded because that individual did not manage or work at a fixed site PSH. Eighteen participants agreed to participate and

completed the survey. All participants were informed that they were under no obligation to participate, that they could quit the survey at any time, and that completing less than 50 percent of the survey would result in it being excluded from the study. Of the 18 completed surveys, one was omitted as it was identified that the PSH was not a fixed-site development, but rather, comprised scattered units throughout the area the organization operated in. The remaining 17 surveys were included in the study. Three participants were followed up with by phone in order to provide further clarity on their survey responses.

Data Collection and Analysis

Qualitative and quantitative data were collected via a 25-question survey located in the Fluid Surveys platform. The survey was estimated to take 15-25 minutes to complete, with the time needed depending on the amount of information participants wanted to include. A thematic analysis of the survey results was subsequently conducted and identified themes and subthemes were inputted into Excel to organize and present as results. Quantitative information was collected and analyzed using the tools available through the Fluid Survey Platform. The survey results were stored on a password protected personal computer and an external drive, and locked in a secure office when not in use.

The organization and respondent information collected included how long the organization they worked for had been operating PSH; the amounts and types of residential services offered; budget categories, and qualitative data regarding various elements of facility operations, including staffing, programming, and environmental design. Of the 22 participants invited, 17 were surveys were completed and included in the results, with the remaining not completed or rejected due to not meeting participation requirements. Of the 17 included surveys, three required follow up phone call to obtain clarity on survey responses.

Ethical Considerations

This study was granted research approval from the Human Research Ethics Board of the University of the Fraser Valley (Appendix D). The study was deemed to be minimal risk as participants were professionals in the field and the survey posed little, if any possibility of physical, emotional, or legal harms**.** Consent was deemed to be implied by the completion of the survey, which was explained in the Information Letter (Appendix B) sent to participants. No participants were asked to identify the organization they worked for, which minimized confidentiality and anonymity issues. When participants gave information that identified them or their workplace in their answers to questions, those identifiers were removed to ensure anonymity.

Limitations

This study sought to gain a greater understanding of operational and environmental factors that contribute towards positive outcomes for residents of PSH. While much relevant and important data was collected, there were a variety of limitations that should be addressed in future studies. This study had a small sample size and for greater understanding, future studies should increase the number of participants. In addition to a small sample size, geographical constraints were present in that only two health authorities were utilized for sampling. Another limitation was that many of the participants were invited based on previous relationships and as, such there may have been potential for bias. This study utilized Excel rather than professional research software to collect and collate collected data and as such was an additional limitation.

Findings and Analysis

Findings

The online survey that participants completed sought to explore the various operational and environmental factors that contribute towards positive outcomes for PSH residency. The survey results demonstrated that participants have varying experiences of PSH and varying perspectives regarding how their developments are run – or could be run – in order to offer residents the best chance of positive outcomes.

The survey questions (Appendix C) included quantitative and qualitative questions regarding four facets of the housing development or operations. These include: a) descriptors (i.e. age, size, type of build); b) staffing (i.e. number of staff, type of staff, education of staff); c) environmental design (i.e. factors in the design of the building that promote wellness, safety, and inclusion), and; d) programming (i.e. services offered to support resident positive outcomes and resiliency).

Descriptors

The descriptive information collected in the survey pertained to how long the fixed-site PSH where participants worked had been in operation; the number of units in the participant's fixed-site PSH, and; the type of building that characterized the development. When asked about length of time the participants' organizations had been operating PSH. almost half (8 out of 17 participants) reported that the organization where employed when this survey took place had been operating PSH between seven and 10 years, and four participants reported the organization operating the PSH for 11 or more years. Only two participants' organizations had operated a development for less than one year. The types of developments reported by the participants when asked in the survey included a modular building (rapid rehousing initiative under the current

Provincial Government utilizing prefabricated buildings), three renovated motels, seven new buildings (on-site builds, often referred to as "stick built"), and six non-identified buildings. With regard to number of units, four participants reported that their PSH contained fewer than 19 living units and the remaining 13 participants reported that their PSH had between 20 and 50 or more units.

Staffing

The quantitative and qualitative questions asked about staffing included the total annual operating budgets, the number of permanent staff employed, types and professional designations of staff, changes that operators would prefer in the staffing models they utilize if budgets were unlimited. The survey questions also inquired about changes the operators desired in the services currently offered and barriers to residents accessing service.

As shown in *Table 1* below, seven of the 17 survey participants (41%) indicated that their PSH operated on an annual budget less than $500,000, and four participants (23.5%) indicated that their PSH had an annual operating budget of over $1million dollars a year. The remaining six of the participants worked in PSHs that had annual operating budgets between $500,000 and $899,000.

Table 1.

Annual Operating Budgets for Participants Permanent Supportive Housing

Response	Percentage	Count
$499,000 or less	41.2%	7
$500,000 to $599,000	11.8%	2
$600,000 to $699,000	5.9%	1
$700,000 to $799,000	11.8%	2
$800,000 to $899,000	5.9%	1

Response	Percentage	Count
$900,000 to $999,000	0.0%	0
$1 Million or more	23.5%	4

More than half of the participants reported that their PSH employed nine or less permanent full-time and part-time staff, whereas the remaining 48 percent reported that their PSH had more than 10 staff. Almost 12 percent of participants reported that their PSH employed more than 25 permanent staff members. As identified below in *Table 2*, 76 percent of the participants reported that their PSH employed housing/health care workers with diploma/certificate level accreditation, 65 percent reported that their PSH employed janitorial and maintenance staff, and 41percent reported that their PSH employed BSW social workers. None of the sites reported employing doctors, and only 5.9 percent (one participant) reported that their site, which had between 40 and 44 units and a budget of $700,00 to $799,000, employed a psychiatrist and/or a registered psychiatric nurse. Participants identified a number of "other" types of staff in addition to the listed options, and these included chaplains, support staff, life skills support staff, food preparation staff, and outreach workers.

Table 2.

Number of Staff Type Employed On-Site by Participants Permanent Supportive Housing

Staff Type	Percentage	Count
Housing/Health Care Workers (Certificate or diploma level)	76.5%	13
BSW Social Workers	41.2%	7
MSW Social Workers	17.6%	3
Registered Nurse	17.6%	3
Registered Psychiatric Nurse	5.9%	1
Counsellor	5.9%	1
Doctor	0.0%	0

Staff Type	Percentage	Count
Psychiatrist	5.9%	1
Maintenance	64.7%	11
Janitorial	52.9%	9
Clerical Staff	29.4%	5
Other	52.9%	9

When participants were asked about what changes they would like to see made to their staffing models if there were no budgetary constraints, they mentioned service-related changes pertaining to amount of staff (more), types of staff (more clinical), and the need to provide PSH residents with access to adequate services. If budgets were unlimited, participants' foremost desire was for their PSH to employ more staff (e.g. counsellors, addiction specialists, mental health workers, support staff, and administration staff) in order to more effectively address the complex needs of residents, including those involving their histories of trauma, mental health diagnoses, and addiction issues. This theme was repeated through the written answers. One participant wrote "More staffing… We have moms and babies - these families need a lot of support, and we would increase our service to these ones". Another stated "We would have more support staff on-site, like counselor, mental health worker, social worker. 24/7 staffing model as well". Yet another stated:

> With an unlimited budget, I would hire two more full time housing workers to help with the process of not only supporting residents in looking for alternative housing options, but to also provide living skills support and creation of a day program to ensure that residents are engaging in pro-social learning activities during the day. At the moment, we do not have enough staff to complete this as time is currently taken up with crisis resolution and conflict resolution.

When participants were asked about what changes to services they would like to see and barriers to services, they clearly indicated that a limited provision of diverse services and a lack of certain types of services posed a challenge to working with PSH residents. A majority of the respondents emphasized that a range of services is necessary to address the complex factors and issues that PSH residents experience or live with. One respondent wrote, "Clients struggle with accessing mental health services – transportation, forgetting appointments…" while another wrote, "Often our participants neglect their care and experience barriers to accessing community services, [so] bringing the services to people is a way of supporting this".

Participants also had suggestions for new PSH operators. A major theme was staff – particularly more staff (e.g., enough staff for shift overlap, and enough staff to be available 24/7). One participant indicated that it would be prudent for PSH operators to ask for more staff than they anticipated needing, because those staff would always serve a purpose. Quality of staff and staff teams were considered equally as important as "more staff". Participants wrote comments such as: "Ensure there is a mix of education, experiences and approaches", "Train your staff well, and invest in training", and "Hire people with at least 2 years of work experience in supportive housing".

Environmental Design

Environmental design questions were asked to gauge how well PSH developments utilized common or shared spaces, promoted wellness and safety, and facilitated the inclusion of residents. As indicated in *Table 3* below, participants identified common television rooms, physical recreation areas, common computer rooms, and common cooking areas as the most utilized spaces within their developments. Interestingly, only 13 respondents indicated that outdoor gardening areas were utilized at their respective sites.

Table 3.

Most Utilized Spaces in Participants Permanent Supportive Housing

Most Utilized Spaces	Number of Respondents	Percentage
Common computer room	3	(21.4%)
Common television room	2	(13.3%)
Common cooking/eating area	4	(26.7%)
Outdoor gardening area	1	(7.7%)
Outdoor common areas (picnic table, gazebo, etc.)	5	(33.3%)
Physical recreation area (outdoor or indoor)	1	(7.1%)

The two major themes identified in the responses to questions about common spaces were relationship/community development and operational functionality. Residents' community development needs were particularly highlighted in terms of building design rather than operational functionality. One participant stated "common areas are a great way for all to socialize", and another indicated "common areas are very well-used and provide tenants and residents a place to go outside their units…they also help to develop a sense of community because neighbors learn to use and share the space". Creating a sense of community and/or a better functioning community within the housing development was of primary importance to operators. Numerous participants identified that the upkeep of common spaces was important because it gave residents a sense of pride. One participant mentioned that "having the outdoor space for residents to engage with each other and staff is necessary. This promotes engaging in nature, growing vegetables and flowers and gives residents a purpose and pride in seeing the things that they can create". It is important to note participants indicated that residents considered common outdoor spaces to be more important and beneficial than common indoor spaces.

Participants were also asked about how improvements to the designs of their buildings could be achieved to promote safety and involvement in programs. While some participants reiterated the need for environmental design to promote inclusion, others indicated that there was a need to address the safety and security aspects of their buildings. One participant reported that they had "a TON of things put in, including having a CPTED (Crime Prevention Though Environmental Design) analysis done; a better camera system; better entrance/gate system; and, new fencing (not able to cut or break)". Another participant reported that "one of the items that we ran into was having an office that only had one door. For safety reasons, I would have liked to have had two exits". Finally, participants emphasized the importance of accessibility in noting that developments often don't have elevators, even though many residents have mobility challenges. One participant pointed to the challenge of matching people to live together, and wrote "in the design, shared-living suites have proven to be difficult, due to matching people with appropriate roommates… We would change to Bachelor suites or one-bedroom suites, as it would be easier to manage".

Programming

The programming section of the survey looked at site resident demographics, the complexities that site residents live with, opportunities for support in different areas, positive outcomes and challenges with the provision of supports, community partnerships, and changes that could be made to address gaps or barriers in service delivery to residents. Asking qualitative and quantitative questions allowed participants to expand on their thoughts and experiences regarding site programming.

When asked what the main concerns that residents of their building were experiencing, all of the participants stated that mental health issues were the primary concern, followed by

substance use, financial hardship, homelessness, criminal justice system involvement, and family dynamics/breakdown/conflict. Some participants identified issues of loneliness, complex health issues, and romantic relationship challenges as concerns. As shown in *Figure 1* below, participants stated that all of these issues posed challenges to staff who aimed to engage residents in services. Participants identified "other" categories as multiple barriers, death and dying, and historic negative experiences.

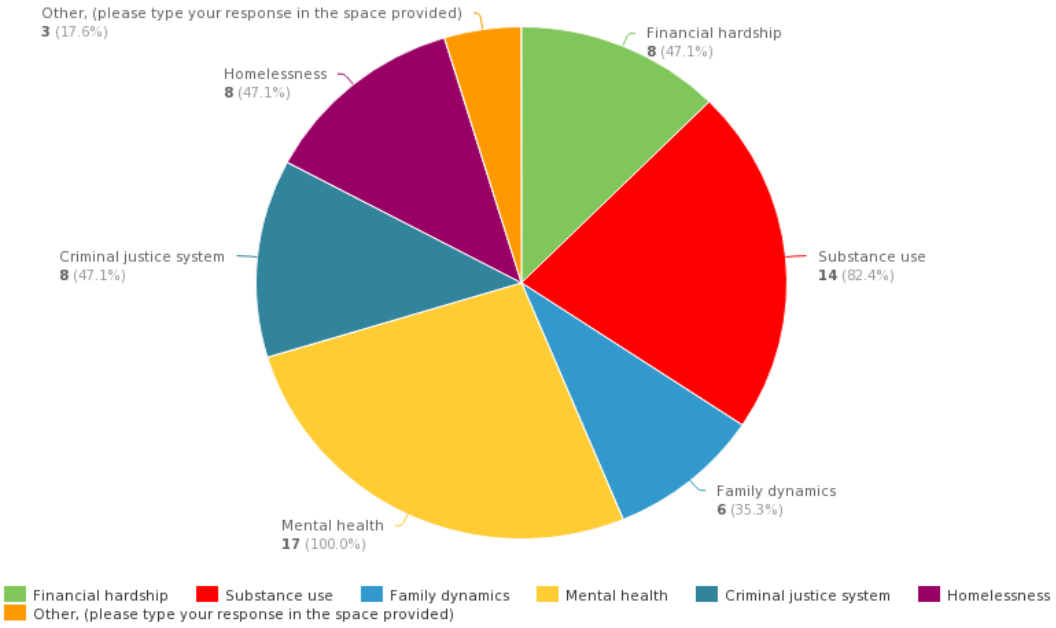

Figure 1. Barriers to Resident Engagement in Services at Permanent Supportive Housing

A variety of services are available to support residents of fixed site PSH developments to achieve stability. Over half of the participants reported that their PSH provided substance use services to residents and just under half reported that their PSH provided mental health services. Other services that respondents reported as being directly provided by the organization managing the site included medical and counselling services, employment services, parenting programs, life skills programs, and community integration services. It is interesting to note that 3 of the 17

participants reported that their PSH listed a number of services, but did not directly provide any of them.

Not all PSHs provide direct services to residents, in which case the consequent lack is met by community-based services that aim to ensure residents have the support they need. Participants were asked to identify which community-based services utilized space in their PSH to provide services to residents. Participants indicated that mental health supports and medical services were provided on-site more than any other community-based service, followed by substance use services, counselling, and financial services. Participants also identified a number of "other" types of community-based services that utilized space in their PSH, which included Work BC programs and legal advocacy. *Figure 2* below illustrates the types of community-based services that are provided on-site for PSH residents, and how many participants reported that their PSH provided space for these services.

Response	Chart	Percentage	Count
Substance use services		58.8%	10
Mental health services		70.6%	12
Medical services		70.6%	12
Other Counselling services		35.3%	6
Financial services		35.3%	6
None		11.8%	2
Other		17.6%	3
		Total Responses	**17**

Figure 2. Types of Community-Based Services Utilizing Space in Participants Permanent Supportive Housing

Services at PSH are made available to residents, but are not mandated. As a result, many of them may choose not to utilize those services. Participants reported that the primary barrier to

residents' accessing services was a lack of interest, which is a matter of personal choice. Additionally, eight participants reported the delivery method of programs as a barrier to residents' accessing services and seven identified times in which services were available as a barrier. Appropriate spaces for services and childcare for parents presented additional barriers to accessing services. When asked about optimal times to provide services to residents, just over half the participants reported that early evening was the best time, and the rest of the participants reported that early afternoon, mid-afternoon, and late afternoon were the preferred times. Mornings were identified as the least desired and utilized times for accessing services.

Participants were queried about the advantages and disadvantages of the service delivery model at their PSH – in other words, what they perceived as being effective in producing positive outcomes for residents in their PSH, or not. Staffing, or the shortage and lack of staff capacity, was clearly identified as not conducive to positive outcomes for residents. In contrast, participants considered their PSH's approach to resident care to be working well, as it was client-centered, collaborative, and supported residents to feel that the developments were their homes. Not surprisingly, participants strongly identified that clinical supports were the area most in need of additional programming and services, which aligns with much of the other data collected in the survey. One client indicated the need to "designate a portion of the units to deal with multiple barrier clients and have these clients adequately supported", and two others simply stated "clinical counselling" as a need. It is possible that participants' call for more staff could address this need. Further, participants noted that there was a need for constructive free time in PSH, as boredom was often a problem for residents. No problems or needs were listed with regard to the way PSHs approach their work with residents.

As has been shown, PSH developments can be a place where different factors and complexities result in the need for emergency services to be called. Participants were asked about steps to mitigate or reduce this need. They indicated that while there will most likely always be a need for emergency services to be called to respond to incidents at PSH, the frequency of those calls could be reduced by implementing a variety of measures. One participant wrote "debriefing and making sure that staff are trained in what constitutes a call to emergency services and what can be handled with staff training", and another indicated "rapport building between on-site staff and participants to create a safe environment for participants to engage in when in crisis". This pointed towards procedures and approaches for engaging residents, including peer support, a clear delineation of guidelines and expectations, client ownership, regular house meetings, and having a well-trained and competent staff to deal with in-house situations. Other participants emphasized that safety and security measures as imperative for averting the need to call for emergency services. One participant identifies safety and security measures as, "camera's inside and outside of our building - and locks - to keep our residents safe" and "fire extinguishers in the kitchen and training on how to use if needed…having accessible first aid kits and basic training with residents". Comprehensive and effective safety plans was also indicated as a measure to reduce the need for emergency services to be called at PSH.

In terms of promoting independence, respondents emphasized philosophy or approach, specifically with regard to client-centered care, than they did about specific programs or policies. While not all residents can or will transition out of PSH, participants indicated that staff relationships and supports were critical to supporting those who could make the transition. Available community programming was identified as another important means of supporting

residents to transition to independent housing, particularly the ongoing provision of accessible mental health, substance use, and health care services. Further, respondents indicated that PSH staff's willingness to maintain trusting and supportive relationships developed with PSH residents and support those individuals after they successfully moved out contributed substantially towards positive outcomes (e.g. maintaining housing, sustained positive relationships, minimal engagements with emergency services).

Finally, it is important to emphasize that supportive housing is a controversial idea in some communities, and some people do not want such housing to be provided in their neighbourhood. Consequently, there is a need for PSH providers to engage with the public to reduce the stigma associated with PSH and encourage the public to build relationships with the operator and residents of PSH if one is developed in the community. Participants reported two main categories for how they engaged the public: 1) doing outreach to the community and 2) allowing community to come in and see who they are. Outreach to the community includes sharing positive news through social media, news releases, and community events; providing education to groups and community members about who and what they as a PSH operator do/are; responding quickly to issues pertinent to PSH residents and collaborating with residents to prevent similar issues from reoccurring, and, in general, being available to answer questions and develop relationships with neighbors and community members.

Discussion

The major findings of this study suggest that staffing was biggest contributor to operating PSH and positive outcomes for residents. The study highlighted that it was staff members' philosophies, skill-sets, and approaches to working with residents that promoted program involvement, safety, and helped develop resident independence. Throughout the study,

participants reported that the quality of staff made the biggest difference when looking at the various layers involved in PSH. Further, they noted that positive outcomes for residents in PSH were facilitated by connections between residents and services; an appealing, functional building/apartment design, and; designating on-site spaces for serving providers.

As this study has demonstrated, PSH is more than just housing. When people get to a place in life where they need the assistance of PSH, on-site staff can make the housing more than just a roof over a head and help to transform people's lives. To that end, it is critical to recognize that all PSH developments are different. They have varying budgets, unit numbers, and building structures, and offer different levels of support. Various issues need to be addressed in order to create developments that successfully house diverse populations with varying needs. As each person who lives in a PSH is a unique individual with her/his/their own skills and abilities, PSH operators need to tailor support and services to the specific needs of both the development and residents.

Participants mentioned a need for more staff, particularly staff with specific skill sets, in almost every area of the survey. PSH are staffed 24/7 and given that staff routinely engage with numerous residents, relationships are critical to residents' growth and development. The desired changes reported by staff included developments or programs that promoted independence in the community and reduced the need for emergency services to attend the sites. The need to improve levels of staff capacity was also a theme throughout the survey, and was mentioned numerous times in responses to questions about the type of staff desired (e.g. clinical, counselling, medical and trauma-specific). This again highlights the importance of PSH staff-resident connections and the need to provide appropriate support. Further, PSH have diverse resident populations and individual residents will respond differently to individual staff. Consequently, it is critical for

PSH to employ a mixed team comprised of individuals with different personal experiences and background.

Living environments are important to everyone, including PSH residents. The environments and the spaces and relationships within them are part of the social system that promotes or impedes wellness. Participants indicated that environment is not as much about security as it is about community. They highlighted the importance of this theme in noting that their communities helped connect them to neighbours, staff, programs and services. One respondent indicated that providing shared spaces for residents fosters a sense of community and provides opportunities to learn and grow, while another reported that shared spaces bring people together. While security measures are important and do promote safety, as participants of this study, and Marcheschi et al. (2013) describe, the social environment promotes community wellness and inclusivity, which in turn increase internal safety. Unfortunately, as Whittaker et al. (2016) point out, not all PSH developments provide warmth and community, but rather provide institution like settings that are characterized by oppressive security measures that impede residents' capacity to feel a sense of autonomy and invade privacy, which was not indicated as an issue by any participants of this study.

While staffing and the built environment are important factors for the operators of PSH to consider, as is suggested by the HF philosophy, it is no less important for PSH to have programs and supports available to residents when they are ready. Whether programs are offered by in-house staff or by outside community organizations on-site, they should be inclusive, non-judgmental, accessible and provide safe, welcoming environments (Marcheschi et al., 2013). Not only will this contribute to creating a robust system that addresses residents' complexities and support residents to change and grow, it will also allow residents to provide personal expertise

into programs and services, which creates greater potential for inclusive client-centred programming informed by people who have experienced and overcome similar challenges in life (Larkin et al., 2016). As participants pointed out, it is also important for PSH operators and staff to recognize that not all residents will access programs and supports, and not all will get to a place where they can live independently. This further highlights the importance of creating spaces where residents and operators of PSH develop non-oppressive relationships rooted in equality (Dominelli, 2002).

The findings of this study highlight the need for social workers to become better trained and more educated with respect to addressing the varying challenges and complexities that the clients we serve live with. This includes a variety of participant recommendations, such as: learning how to provide support in a non-oppressive way in order to develop client-centered and involved solutions; increasing understanding and expertise in specialized areas (e.g., mental health, substance use, family systems); developing a greater understanding and practical application of the impact of spaces and environments, and; learning methods to effectively address high risk situations. In addition to hands on work with clients, many social workers will find themselves in areas and situations where they have the ability to direct policies. Results from this study can be used to inform decisions when developing policies that promote inclusive, safe, and appropriate services and environments in PSH to support positive outcomes for residents.

While this study identified a number of factors that contribute towards positive outcomes for residents of PSH developments, it had a number of limitations. One of the primary limitations was it did not look at the specifics of PSH services (i.e., the specific modalities of counselling that were offered to residents to address different needs), or give participants more opportunity to

provide a detailed description of the changes they desired to see in programs, services or environmental considerations. Future studies could provide participants with such opportunities. For example, it would be valuable for studies to examine how PSH can use a harm reduction approach to address addiction among PSH residents, which is critical in light of the current opioid overdoes crisis. Additionally, this study did not identify the professional status or designation of the participant, which would be helpful in future studies in order to utilize the results in specific discipline training and education. Although respondents rounded the figures for the purposes of their responses, another limitation of this study was that the budgetary scale in the survey maintained gaps of $1000 between the levels (for example, $500,000 to $599,000 and $600,000 - $699,000) rather than $500,000 - $599,999.

Another limitation in this study was limited options for participant responses to the question regarding "best times" for services to be offered to residents. Providing more options would enable more comprehensive responses and better consideration of the diverse needs of PSH residents. For example, one resident may have a child that needs child care in order to access services, where other residents may have to access medication management at certain times. A further limitation of the study and area for future research would be to include residents in the sample to obtain more detailed and population specific information regarding service utilization, needs and preferences.

Conclusion

Canada has seen a drastic increase in homelessness since the mid 1980s (Gaetz et al., 2016). No one is immune to economic challenges, family struggles, or personal problems. Given a certain set of circumstances, almost everyone is vulnerable to life struggles and their negative outcomes, including a lack of housing or housing instability. Over time, there have been a

variety of initiatives and philosophies to addressing homelessness. This study detailed the PSH model, which partners with the HF approach to rapidly house people experiencing homelessness and match them with appropriate supports or resources. PSH addresses the needs of people who experience a wide array of complex factors, such as substance use or mental health challenges, poverty, histories of trauma, and criminal behaviors. To that end, PSH provide community and opportunities to access necessary resources. As a result, residents may have a chance to permanently exit homelessness.

To gain a greater understanding of operational and environmental factors that contribute towards positive outcomes for residents of PSH, this study invited operators of PSH in the Fraser Health and Interior Health regions to complete an online survey through the Fluid Survey Platform. The study and survey utilized a mixed methods approach and a consisted of 25 qualitative and quantitative questions. Data was collected and collated using Excel and Fluid Survey tools to capture and present the aforementioned themes, experiences, and expertise. As previously indicated, there were a number of limitations to the methods utilized, which can be addressed in future studies.

PSH operators must consider a variety of factors in order to facilitate safe, inclusive, and home-like settings that give residents the best opportunity for positive outcomes in their lives. Staff quality and training, and a staff presence in PSH developments, are paramount to working with PSH residents. Given the complex challenges that PSH staff face, the developments should have staff with diverse work and training experiences. Additionally, both staff and residents' benefit from an approach to PSH management that is client-centered, compassionate, and supportive.

PSH service provision varies between developments and organizations. Many PSH have on-site services provided by the operator and some give outside organizations space in the developments to provide services. Both the various systems (e.g., mental health, finance, medical, community) and services (directly provided or brought on-site by an outside organization) pertinent to PSH must be available to residents.

Shared spaces and environments can provide an opportunity for residents to thrive. As noted earlier, shared spaces give residents an opportunity to build community and foster relationships. Shared spaces also provide residents with the opportunity to take ownership of the responsibilities involved in the maintenance of those spaces (e.g., keeping shared spaces clean, building outdoor gardens, painting murals), which gives them a sense of purpose, meaning, and value. It is also important to consider safety factors, which benefits both residents and staff. Such factors include security systems, emergency exits, panic buttons, and cameras. If spaces are created effectively, security measures need not be overly invasive and needs for both community and community can be met.

As social workers, it is important to understand and acknowledge the various layers or systems that are involved in operating PSH and working with residents. Social workers deal with many different systems. We often come into contact with clients in various types of housing and may develop relationships with clients who have complex challenges. In order to efficiently and effectively navigate the opportunities and challenges of supporting a PSH organization and dealing with clients, it is paramount to gain an understanding of the different systems and learn how to work within them.

While PSH, and other housing models do not always address with the causal factors of homelessness, getting people off of the streets and into safe and appropriate housing clearly

places them in a better position to lead a healthy and productive life. This in turn supports communities to thrive.

Finally, as a social worker writing this paper reflecting on the aforementioned, it is important that as myself and fellow social workers walk through life and observe or engage the different populations that we do or will serve, we should be vigilant in keeping a humble heart and open-minded attitude − never forgetting to acknowledge that our clients are the best experts on their own lives and that we have much to learn from them. Additionally, when we have the opportunity to be in a position of leadership, we must ensure that those we provide service to have access to the resources, programs and systems they need to pursue growth and change. We must also remain mindful that we have control over vital life circumstances such as housing options and that there is a large power imbalance between us and those we serve. Finally, as social workers, we need to understand that what works for one person may not work for the next person in the case of program development and implementation, environmental opportunities, or relationship styles.

Appendix A

Dear Supportive Housing Operator,

My name is Mike Sikora, and I am a student in the UFV Master of Social Work program. In conjunction with my role as a student, I am also an employee of the City of Chilliwack in the role of "Social Development Coordinator". As part of my coursework, and supported by my role at the City of Chilliwack, I have the opportunity to complete a research study for my major paper. I am conducting a study titled: "Fixed Site Supportive Housing: Understanding Operational and Environmental Factors to Success"

I am contacting you today for the purpose of asking you to take part in my study, which will be in the form of a survey, and should take between 15-20 minutes to complete and submit.

Purpose/Objectives of the Study

This study will explore factors that have contributed to the successful operation of fixed-site supportive housing developments throughout Fraser and Interior Health regions. The premise behind the study is that with increased knowledge and understanding of what has historically worked for other organizations in the operation of fixed-site supportive housing, new organizations, or organizations experiencing challenges operating fixed-site supportive housing developments, would have increased access to information discussing factors that may help their organization be more effective in its operations.

The overall goal of the study is that results obtained could be used to further additional research and/or education that will support best practices in the management and delivery of fixed-site housing development services. Another hope is that by increasing understanding will come evidence-based policy development to aid in operating these developments.

Procedures Involved in Research

Mike Sikora will be the only investigator in the study. Surveys will be sent to participants via an emailed link to a "Fluid" Survey, and results will be returned to Mike Sikora upon completion. Participation in this is completely voluntary and consent will be implied with the completion and submission of the survey. No personal data will be collected for this survey. The only identification of participants will be that they work for an organization that operates fixed-site supportive housing within the Fraser or Interior Health region; the organization will not be named. The survey should take approximately 10-15 minutes to complete, depending on the length of participant answers. All responses will be kept confidential and surveys will be deleted after information extracted and coded.

Thank you for your time and consideration regarding my request to participate in this study. If you have any questions, please contact me by email at Mike.Sikora@student.ufv.ca.

Sincerely,

Mike Sikora, BSW. RSW.
MSW Student, University of the Fraser Valley

Appendix B

Mike Sikora
MSW Student
University of the Fraser Valley
Mike.Sikora@student.ufv.ca

Fixed Site Supportive Housing: Understanding Operational and Environmental Factors to Success

Information Letter

My name is Mike Sikora, and I am a Master of Social Work student at the University of the Fraser Valley. You are invited to take part in a research survey about factors that help organizations operate fixed-site Supportive Housing successfully. This project is part of the research for my MSW degree. Your participation will require approximately 15-20 minutes, although some participants may need more time, depending on the length of their answers. There are no known risks or discomforts associated with this survey.

Obtaining a better understanding of how fixed-site supportive housing operators design and deliver their supportive housing developments to promote successful outcomes for residents, operators, and the community at large could contribute to more effective policy development and program implementation. In addition, understanding fixed-site housing implementation challenges and opportunities could help assist in reducing homelessness and promoting successful independence.

Taking part in this study is completely voluntary. The only identifiers for any participants is that they are part of an operating team for a fixed-site supportive housing development within the Fraser Health or Interior Health region. If you choose not to participate, you do not have to complete or submit a survey. If you choose to withdraw part way through the survey, you may simply close the survey and your answers will not be saved. All incomplete surveys will not be used in the study. Once you submit a completed survey, you cannot withdraw your survey. Only Mike Sikora and the MSW faculty supervisor will have access to your survey responses. The surveys will be deleted after the information is coded and stored on a password protected computer. Any report of this research will not include any participants' personal identifiable information. Results of this study will be published in the University of the Fraser Valley library database under the program "HarvestIR".

If you have questions or want a copy or summary of this study's results as only University of the Fraser Valley students can access the library database, you can contact Mike Sikora at the email address above.

You may also contact MSW faculty supervisor Anita Vaillancourt at Anita.Vaillancourt@ufv.ca. If you have any concerns regarding your rights or welfare as a participant in this research, you may contact the UFV ethics officer at 604-557-0411 or by e-mail at Research.Ethics@ufv.ca.

If you submit this survey, it will be understood that you have consented to participate in this study, titled "Fixed Site Supportive Housing: Understanding Operational and Environmental Factors to Success".
Thank your assistance in furthering the information available on successfully operating fixed-site supportive housing.

Sincerely,

Mike Sikora, BSW, RSW.

Appendix C

Fixed Site Supportive Housing: Understanding Operational and Environmental Factors to Success

Mike Sikora, MSW Student

Thank you for taking the time to complete the following survey. There are no wrong answers, only different ideas. The intent of this survey is to keep the participant's identity and organization confidential; please do not include information that would identify you in your answers. If you submit this survey, it will be understood that you have consented to participate in this study, titled "Fixed Site Supportive Housing: Understanding Operational and Environmental Factors to Success".

Descriptors

Please check only one response below.

1. How long has the organization you are employed by been operating fixed-site supportive housing?

   - ☐ Less than 1 year
   - ☐ 1 – 3 years
   - ☐ 4 – 6 years
   - ☐ 7 – 10 years
   - ☐ 11 or more years

2. How many living units are in your Fixed-Site Supportive Housing development?
   Note: If your organization operates more than one fixed-site supportive housing development, please only answer for the site you currently operate.

   - ☐ 19 or under
   - ☐ 20-24
   - ☐ 25-29
   - ☐ 30-34
   - ☐ 35-39
   - ☐ 40-44
   - ☐ 45-49
   - ☐ 50 or more

3. What type of building is your fixed-site supportive housing development?

- ☐ Renovated motel
- ☐ Modular building
- ☐ New build
- ☐ Other

Staffing

4. What is your annual operating budget?

- ☐ $499,000 or less
- ☐ $500,000 to $599,000
- ☐ $600,00 to $699,000
- ☐ $700,000 to $799,000
- ☐ $800,000 to $899,000
- ☐ $900,000 to $999,000
- ☐ $1 Million or more

5. How many permanent staff (full-time and part time) does your organization employ at your fixed-site supportive housing development?

- ☐ 9 or less
- ☐ 10 – 14
- ☐ 15 – 19
- ☐ 20 – 24
- ☐ 25 or more

Please check all that apply

6. What type of staff does your fixed-site supportive housing development employ on site?

- ☐ Housing/Health care workers (certificate or diploma level)
- ☐ BSW Social Workers
- ☐ MSW Social workers
- ☐ Registered Nurse
- ☐ Registered Psychiatric Nurse
- ☐ Counsellor
- ☐ Doctor

- ☐ Psychiatrist
- ☐ Maintenance
- ☐ Janitorial
- ☐ Clerical Staff
- ☐ Other: (Please type your response in the space below).

_____

_____

7. If you had an unlimited budget and could make any changes to your staffing model at your fixed-site supportive housing, what would these changes include? (Please type your response in the space provided below).

_____

_____

8. Why would you make the changes indicated in your answer to question 7?

_____

_____

9. Based on your experience operating a fixed-site supportive housing development, If you had the opportunity to give a new operator one suggestion regarding staffing, what would it be?

_____

_____

Environmental Design (Factors in the design of the building that promote wellness, safety, inclusion, etc.).

10. Please rank, the utilization of the following, by residents of your fixed-site supportive housing development, from the most to the least.

- ☐ Common computer room
- ☐ Common television room
- ☐ Common cooking/eating area
- ☐ Outdoor gardening areas
- ☐ Outdoor common areas (picnic tables, gazebo, etc.)
- ☐ Physical recreation area (indoor or outdoor)

- ☐ Other: (Please type your response in the space below).

_____

_____

11. Please indicate the impact that the environmental design factors that you identified above have had on your fixed-site supportive housing development. (Please type your response in the space provided below).

_____

_____

12. When considering environmental design factors that promote safety and involvement in programs or services at your fixed-site supportive housing development, is there anything from the original design that did not work and needed to be changed? (Please type your response in the space provided below).

_____

_____

Programming
Please check all that apply

13. What are the main concerns that people who apply to live at your fixed-site supportive housing experience most often?

- ☐ Financial hardship
- ☐ Substance use
- ☐ Family dynamics
- ☐ Mental health
- ☐ Criminal justice system
- ☐ Homelessness
- ☐ Other: (Please type your response in the space below).

_____

_____

14. Please indicate areas that pose the greatest challenges to residents engaging in services when at your fixed-site supportive housing development?

- ☐ Financial hardship
- ☐ Substance use
- ☐ Family dynamics
- ☐ Mental health
- ☐ Criminal justice system
- ☐ Homelessness
- ☐ Other: (Please type your response in the space below)

_____

_____

15. What advantages or disadvantages do you see in the service delivery model that is currently utilized in your fixed-site supportive housing development? (Please type your response in the space below).

_____

_____

16. Please indicate all of the following services that your organization provides directly on-site at the fixed-site supportive housing development?

- ☐ Substance use services
- ☐ Mental health services
- ☐ Medical services
- ☐ Counselling services
- ☐ Financial services
- ☐ Other: (Please type your response in the space below).

_____

_____

- ☐ None: (Please type your response in the space below).

_____

_____

17. If on-site services are not directly provided by your organization, which community based services utilize space in your fixed-site supportive housing development to provide services to the residents?

- ☐ Substance use services
- ☐ Mental health services
- ☐ Medical services
- ☐ Counselling services
- ☐ Financial services
- ☐ Other: (Please type your response in the space below).

_____

_____

- ☐ None: (Please type your response in the space below).

_____

_____

18. When specific services are offered to residents, what are the biggest barriers to accessing the services?

- ☐ Time offered
- ☐ Delivery method
- ☐ Not interested
- ☐ Already accessed similar services elsewhere
- ☐ Other: (Please type your response in the space below).

_____

_____

19. If you had the power to bring any service or program into your fixed-site supportive housing development that is not currently there, what would it be? (Please type your response in the space below).

_____

_____

20. From your experience operating a fixed-site supportive housing development, to foster the greatest involvement from residents, when is the best time of day to offer programming?

- ☐ Early – Mid-morning
- ☐ Late morning
- ☐ Early afternoon
- ☐ Mid afternoon
- ☐ Late afternoon

- ☐ Early evening
- ☐ Evening

21. From your experience operating a fixed-site supportive housing development, what one thing has been most helpful promoting successful resident independence? (Please type your response in the space provided below).

_____

_____

22. What initiatives or steps has your organization taken that have decreased visits from emergency services (Police/ambulance/fire) at your fixed-site supportive housing development? (Please type your response in the space provided below).

_____

_____

23. From your experience operating a fixed-site supportive housing development, what has worked to get residents to engage in services? (Please type your response in the space provided below).

_____

_____

24. How does your organization engage the public to reduce negative perception towards your fixed-site supportive housing development? (Please type your response in the space provided below).

_____

_____

25. From your experience operating a fixed-site supportive housing development, when you have seen residents successfully move from needing to live in supportive housing to being ready to transition to safe, independent living, what has been the biggest contributing *operational* factor that helped those residents succeed (i.e., staff support, substance use counselling, access to health care services, etc.)? (Please type your response in the space provided below).

_____

_____

You have reached the end of the survey. Thank you very much for taking the time to complete this survey. Your time and responses are greatly appreciated.

Appendix D

UNIVERSITY OF THE FRASER VALLEY

Certificate of Human Research Ethics Board Approval

Master's Supervisor	Department	Protocol #
Anita Vaillancourt	Criminology & Criminal Justice	1023C-17
Master's Student		
Michael Sikora		
Title of Project		
Fixed Site Supportive Housing: Understanding Operational and Environmental Factors to Success		
Sponsoring/Funding Agency		
N/A		
Institution(s) where research will be carried out.		
University of the Fraser Valley		
Review Date:	Approval Date:	Approval Term:
10-Oct-17	19-Dec-17	19-Dec-17 - 18-Dec-18

Certification:

The protocol describing the above named project has been reviewed by the UFV Human Research Ethics Board, and the procedures were found to be in compliance with accepted guidelines for ethical research.

Michael Gaetz, Chair, Human Research Ethics Board

NOTE: This Certificate of Approval is valid for the above-noted term provided there are no changes in the procedures or criteria given.

If the project will go beyond the approval term noted above, an extension of approval must be requested.

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