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Staying Home:
Program Assessment of the Multi-sectoral Intensive Supports Pilot Approach to Finding and Securing Housing for Persons Experiencing Chronic Homelessness in Hamilton

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Persons experiencing chronic homelessness (PECH) benefit from intensive and coordinated supports to secure housing (Intensive Supports Pilot Project Overview, 2021). They often experience high levels of mental illness, concurrent disorders, and physical health problems that impact quality of life and life expectancy (Intensive Supports Pilot Project Overview, 2021). While securing housing is an important social determinant of health, those who are chronically homeless and specifically those who experience multiple complex health needs, require ongoing supports to maintain their housing. The focus of this report is on the issue of chronic homelessness in Greater Hamilton as it applies to those facing a high level of health needs, and presents findings from a program assessment that sought to understand a "collaborative organizational cluster" of approaches within the municipality as a means of securing and maintaining housing specifically for individuals that face multiple and serious barriers to maintaining their health and wellbeing. It is notable that this approach focuses on the needs of those who experience chronic homelessness at a highly acute level in addition to complex health needs, and particularly those who had been living in encampments and/or shelters. This represents a smaller proportion of PECH. This program is consistent with the recent shift in policies regarding the need for 'housing first' initiatives that provide barrier free housing and wrap around supports, and is reflective of the Housing First and population specific approach that the City of Hamilton has been providing for over a decade.

An Indigenous-specific clinical guideline developed by Thistle and Smylie (2020) describes Indigenous homelessness as a "breakdown of healthy relationships with self, family, community, land, water, place, animals, culture and language resultant from colonial disruptions" (p. E257). Defining Indigenous homelessness may often contrast with standard definitions of homelessness as the concept is rooted in Western philosophy and can be exemplified by cities such as Hamilton as the city significantly develops and high rates of precarious housing situations experienced by Indigenous Peoples persist. Reaching Home: Canada's Homelessness Strategy Directives (2012) definition of Indigenous homelessness refers "Indigenous Peoples who are in the state of having no home due to colonization, trauma and/or whose social, cultural, economic, and political conditions place them in poverty. Having no home includes: those who alternate between shelter and unsheltered, living on the street, couch surfing, using emergency shelters, living in unaffordable, inadequate, substandard and unsafe accommodations or living without the security of tenure; anyone regardless of age, released from facilities (such as hospitals, mental health and addiction treatment centers, prisons, transition houses), fleeing unsafe homes as a result of abuse in all its definitions, and any youth

transitioning from all forms of care". Indigenous homelessness is distinct and requires Indigenous-specific support that is led by the local Indigenous community.

Based upon the most recent statistics, approximately 15, 230 peoples with Indigenous ancestry live in Hamilton, and 22% identified as homeless in the 2018 Point-in-Time count (City of Hamilton, 2018; Statistics Canada, 2016). A health survey of 540 First Nations people living in Hamilton revealed 13% of respondents reported homelessness, living in transition, or in another type of habitation, and 73.7% live in crowded environments (Smylie et al., 2011). In addition, more than 78.2% of respondents earn an annual income less than $20,000 which represents high rates of poverty and lesser chances of reaching sustainable and safe housing, when compared to 25% of Hamilton's general population (Smylie et al., 2011). Health risk identified in the report noted high rates of diabetes, hepatitis C, and hypertension, in addition to more than 30% of respondents reported fair or poor mental health or live with a mental health disorder (Smylie et al., 2011). These findings represent a snapshot of how Indigenous homelessness is complex, coupled with historical systemic barriers and a growing population of Indigenous Peoples in Hamilton.

Chronic Homelessness in Hamilton

The City of Hamilton (2019) defines PECH as those who "have a total of at least 6 months (180) days of homelessness over the past year or have had recurrent experiences of homelessness over the past 3 years, with a cumulative duration of at least 18 months (546 days)." 2016 census data collected by the City of Hamilton indicates that 820 people will experience chronic homelessness in Hamilton each year (2019). Chronic homelessness has a negative impact on one's overall health status, as can be observed in their increased risk of death (Hwang et al. 2008). For example, a 2001 study by Hwang of men who use shelters in Toronto between the ages of 18-24 experience mortality rates that are 8.3 times higher than that of the age stratified general population.

This may be attributed to their poor health status among other upstream social factors. A study of 687 PECH in Ottawa, Vancouver, and Toronto found that over 85% of participants had at least one chronic health condition and over 50% had been diagnosed with a mental illness (Hwang et al., 2011). Mental illness is common in this population as a study conducted by the Mental Health Commission of Canada (2012) indicated that among 520,700 inadequately housed people with mental illness, 119,800 are homeless. Dual diagnosis of substance use and mental illness is also common. A 2010 study conducted in Toronto found that of 1,191 PECH, 40% reported frequent drug use (Grinman, 2010). Common physical conditions such as lung disease, diabetes, and hepatitis, often go untreated for PECH given experiences of stigmatization and dehumanization that individuals are reported to have encountered in the health system (Buccieri, 2016). Impacts are felt differentially by priority groups as The City of Hamilton's most recent report on PECH shows that Indigenous persons face homelessness at a disproportionately high rate, and youth and women are particularly vulnerable when homeless (2019). A key factor in better supporting PECH with housing is recognition that they face a diverse range of experiences and structural barriers to

their wellbeing. Each group has unique barriers and perspectives that require support systems that are grounded in and sensitive to their own diverse experiences and social circumstances. Findings from this assessment suggest that PECH, hereto referred to as clients with distinct needs separate from the general population of PECH, face more challenges to remaining in permanent housing given health and social barriers and thus require long term intensive supports.

Solutions

Research consistently finds that stable, accessible housing is a paramount social determinant of health (Hainstock & Masuda, 2019). Housing clients first and then providing them with wrap around supports has been proven to be the most effective strategy to maintaining housing long term (Hainstock & Masuda, 2019). However, clients and those who support them must navigate a complex and uncoordinated system of social services to obtain and implement housing first strategies.

As such, a person-centred, upstream, multi- sectoral model to secure and maintain housing holds promise as an effective response to reducing the burden of mental illness and homelessness. Recognizing this need, which has been highlighted given increased visibility during the pandemic, 3 organizations in Hamilton formally came together for the first time to provide collaborative support in December 2020. The Canadian Mental Health Association (CMHA), Hamilton Branch, St. Joseph's Healthcare Hamilton (SJHH), and the City of Hamilton introduced an Intensive Supports Pilot (ISP) program in January 2021. City housing assistance is combined with intensive supports by an interprofessional team of clinical and non-clinical health supports and community case managers to find and maintain supportive housing for clients. It is important to note that these services have always worked together collaboratively in some way given an overlap in systems, however this is the first time they have come together to form a distinct entity and singular collaborative approach.

Methodological Approach

This project uses mixed methods to explore and analyze the development and efficacy of the multi-sector ISP. The focus of this assessment is on the collaborative model of service delivery established to meet the needs of clients in Hamilton. Drawing on elements of a participatory action research design, those involved in the pilot were rather participants in the conceptualization, data collection, and construction of the assessment (Cacari-Stone, Wallerstein, Garcia, & Minkler, 2014). The intent is for participants in the pilot to use the assessment as a means of improving and advancing the program. This participatory approach was deemed most appropriate as it intends to actively bring together participants and researchers - enabling them to use shared resources to take action on a particular social issue (Baum et al., 2006). In addition, this approach fits well with the nature of the program as a multi-sectoral collaboration. The assessment can be seen as another point of collaboration in supporting a program designed to reduce chronic homelessness. Those leading the assessment were integrated into many aspects of The ISP.

Data collection was an iterative process that shaped the outcome and intention of the project. Those leading the assessment began with the goal of understanding what The ISP is, who it is for, how it came to be, and how it is working. They were invited to and participated in directed meetings about the ISP throughout the process of securing housing for clients. The assessment recruited approximately 30 participants using a snowball sampling method and interviewed directors from each organization, program managers, clinical and non-clinical supports, case managers, and clients. The assessment included input from 2 clients whose language has been integrated into the text rather than through direct quotations in order to protect their identities. Interviews took place over "Zoom" and were recorded and transcribed with participant consent. Statements included in this report were crosschecked with participants. Data was analyzed by reviewing transcripts and relaying a narrative that describes how the ISP came to be, what it is, why it is needed, how it is unique, and how it can be sustained.

How did the Intensive Supports Pilot Come to be?

The ISP was formed during the pandemic in recognition of the growing need to find supportive homes for clients in Hamilton. While each organization involved recognizes the need for permanent solutions to chronic homelessness, the increase in clients with a high level of need living in tent communities known as encampments in addition to the availability of COVID- 19 emergency response funding allowed formerly "siloed" organizations to come together and apply creative solutions. Because of the intersection of needs required by clients in encampments, organic relationships were formed allowing for the sharing of resources and expertise. This has led to a unique model of care that is formed directly from client need rather than philosophies and limitations of individual organizational structures.

The Impact of COVID-19 on The Use of Space for Persons Experiencing Homelessness

In addition to the chronic health concerns faced by clients receiving support from this pilot is a need to recognize social and structural barriers that contribute to the issue of homelessness in Hamilton. Indeed, the social determinants of health including such factors as housing and the environment, structural conflict, income and social protection have been cited as more impactful than healthcare or lifestyle choices influencing health, accounting for 30-55% of global health outcomes (World Health Organization, 2021). In addition and in relation, the neighbourhoods and collection of spaces where people live have a major impact on their health and well being (Centers for Disease Control and Prevention, 2018). One consequence of the pandemic has been an uprooting of systemic issues that can exacerbate and highlight existing social barriers to health, and in the following examples those relative to the lived environment. It has been imperative for the health and well-being of Ontarians to "stay at home" throughout the pandemic. The unintended consequences of this directive means that a collection of spaces that come together to create some semblance of *home* were no longer available

to clients in Hamilton. One participant stresses the importance of the library as a resourced community space stating:

> *I think the library being closed was one of the biggest losses for many people. Many individuals that experience homelessness will utilize the library during the day as a warm place to be and access the Internet, you know, especially if you're trying to secure housing or secure employment, you need that access to the Internet and many people can't afford a phone, so it becomes that much more important.*

It has been important to restrict public spaces to safeguard health, yet those considered non-essential are among the spaces that clients are dependent on to meet their basic needs. This loss of social infrastructure- or public third spaces- that are often not only spaces but provide services and support adds to the difficulties faced by people without homes during COVID.

A Loss of Space for Persons Experiencing Chronic Homelessness and an Increased Visibility of Unsheltered Homelessness

Indeed, clients use public spaces for resources, warmth, socialization, and access to facilities such as washrooms. While some private spaces that are considered essential such as grocery stores remain open, the increasing regulation of private space and criminalization of homelessness may render these spaces unusable. Gentrification such as that which is taking place in Hamilton and other cities across Ontario is found to reduce the availability of affordable housing in communities and also restrict public space. Restriction of public space, coupled with other challenges related to mental illness and homelessness, is found to lead to penalization and criminalization of those who use space in a manner that is in conflict with normative behavioural values (Chesnay, Bellot, & Sylvestre, 2013). Criminalization of homelessness can be observed in the recent ticketing of persons experiencing homelessness at rates of $800 and above for congregating in groups of more than 5 during the day in Canadian cities (Gerster & Russel, 2020).

In addition to these precipitating factors were fears surrounding the use of shelters. One participant noted that clients recognized they were at greater risk of both contracting the virus and experiencing serious symptoms which created resistance towards congregate settings. This fear has been proven valid as a recent study conducted on PECH in British Columbia indicates their risk of contracting and dying from the virus are significantly higher than those who are not homeless (Richard, et al., 2021). While the shelter system created viable options for temporary housing such as that offered at the First Ontario Centre, encampments became a preferred option for many. And though City Councillors, businesses, and various groups cited the negative impacts of encampments on the community, they were a safe space for many that met their needs for community and shelter:

> *They create little safe spaces inside of a tent and they allow just one or two [people in] who they consider to be their family… To stay in that tent with them*

> *[...] and it was a good move like if I was living in a shelter, I would have done the same thing.*

Throughout the winter of 2020, the largest encampments were formed in front of the First Ontario Centre and on Ferguson Street across from the Wesley Bay Centre according to participants. Community groups such as Keeping Six in Hamilton advocated for the health and shelter of these individuals, identifying the need for medical support. In particular there was an identified need for support around “mental health, substance use, and infections”. CMHA, with the support of Shelter Health Network who were already engaged in street outreach, shifted their model of care to begin supporting the medical needs of those living in the encampments. One individual describes the change in their street outreach work as being rooted in client need rather than formal organizational shifts:

> *I don't remember how it first started, but I think one day I had just [...] went to the Ferguson encampment and started meeting with the city Street Outreach Workers and [the Shelter Health Network]. And we kind of just organically started working together without any formal partnership… [we saw] the need of all the people and how [few] people were doing [this] type of work… we just saw that we needed to collaborate together based on our strengths and what we weren't able to do [individually].*

It became apparent that there was a need for permanent housing solutions that integrated health supports, and when City units became available along with an opportunity for COVID-19 emergency response funding, community advocacy groups, CMHA and St. Joseph’s came together to strategize targeted solutions.

What has led to the Need for this Pilot in Hamilton?

Participants interviewed in this pilot recognize that, despite their desire to collaborate, there are obstacles that limit their ability to do so. In addition, the intensive supports required to support clients in housing has created strain on the homelessness serving sector and limitations on their ability to serve the most acute clients. Indeed, according to participants in this assessment, clients require at least 3 years of intensive supports to maintain their housing and wellbeing. Clients face unique barriers to housing that can be offset with the right combination of supports. This section will explain the need for both housing and wrap around supports in a person- centred, integrated, multi-sectoral model.

The Disconnect between Health and Housing

While services assisting those experiencing homelessness intersect, according to assessment participants they operate in distinct and siloed manners. This has been related to funding, organizational, and jurisdictional divides that make it difficult for

sectors to coordinate with one another. It has been expressed by a program participant that

> *When serving people with the highest level of acuity, which is a small percentage of PECH, there is a huge gap in our system in terms of our connection to healthcare and the homeless serving sector across the country.*

From this disconnect and limited resources for those with the most need comes a

> *real sense of defeatism in the system […] all we have to offer the most acute people is a bed and an OW cheque. Nobody else has anything to help these folks so there's this attitude that we're just going to walk alongside them because we can't offer anything else to these people.*

This leads to an inability to serve the most vulnerable and acute individuals given a lack of resources and pressure placed on front line workers.

Unique Barriers and Needs of Persons Experiencing Chronic Homelessness

Clients experience challenges with their mental and physical health, as well as social functioning that make it difficult to transition and adapt to living independently (Vaccaro & Craig, 2018). Clients currently participating in the program noted the challenges of navigating across many overlapping barriers to sustaining housing: disability, multiple mental health diagnoses (*bipolar, BPD [borderline personality disorder] ,anxiety, depression) along with FAS [fetal alcohol syndrome], cognitive delays, and ADHD [attention deficit disorder].* Supports that use a person-centred approach to work through these complex barriers have been proven successful (Vaccaro & Craig, 2018; Yeo et al., 2015).

As exemplified in the successful housing program At Home/Chez Sois, 72% of PECH in the Toronto based study site who received intensive supports along with housing allowances maintained housing in the program 2 years from initial placement (Mental Health Commission of Canada, 2014). This large-scale randomized control trial (RCT) of 575 individuals sought to understand the efficacy of a housing first model combined with supports that suited the needs of participants. Applying a housing first model, the RCT supported clients by matching treatment to their needs. Those in the treatment groups received intensive supports inclusive of case management and health supports based on their required level of support. This included substance use and mental health supports. Those in the control group were given access only to those services offered to offset homelessness provided by the City and 36% were able to maintain housing (Mental Health Commission of Canada, 2014).

The program recognized the needs of participants in order to overcome barriers and provide matched services. As relayed by participants in this assessment factors such as poor health, difficulty managing interpersonal relationships, loneliness experienced when transitioning into housing, behavioural outcomes of substance use,

lack of skills and knowledge related to managing a home are among many that make it difficult for clients to maintain their homes.

Experiences of Loneliness in Transition to Housing

A commonly identified theme by assessment participants is the experience of loneliness felt by clients when transitioning into a unit after living a communal life. This phenomenon may be related to the sense of comradery that can be experienced by people while living outdoors in communal spaces with others (Cole, 2018). One participant in this study describes the experience of loneliness for individuals transitioning into housing

> *I think it's that when you remove somebody, particularly from an encampment or from some community even if it's the shelter community… They're suddenly very alone and isolated […]. You know the nights are quiet, the fears come back from past trauma, it seems that often evenings are the hardest for people because everything's closed around them, they can't really go out so they're stuck and alone.*

Indeed, clients from the program related transitioning into housing as being reminiscent of prison in that the four walls of a *bachelor apartment when you have experience of being incarcerated can feel similar especially when you are by yourself.* This experience of loneliness and isolation may have a connection to the tendency for clients to invite friends in when transitioning into housing. Clients spoke of the challenge of losing a routine that featured social networks and the isolation that can result from adjusting to a new home. Being able to bring those networks into their new habitation is appealing but not always without complications because the two worlds do not always align. While clients may long for connection when in housing, the tendency to invite friends into their home can often lead to eviction when friends will not leave and/or cause disturbances within the unit.

Landlord Perspectives

In addition, the outcomes of substance use and responsive behaviours related to mental health concerns may lead to difficulty maintaining housing. These barriers have been identified by participants in the study as leading to interpersonal concerns amongst other tenants, landlords, and the wider community. Eviction was identified to have a devastating impact on the clients that may make it difficult for them to re-engage in or pursue social assistance.

A participant notes the difficulties landlords face and their need to maintain a harmonious community for other tenants. The individual relates that the challenges clients have to following rules related to abstinence and noise control that can contribute to stigma they face in trying to secure housing

> *Often clients] of the highest need have trouble following the rules. Nobody wants to rent to people perceived as problem people when "non problem people" are lined up to get a place.*

As landlords have an obligation to maintain safety for communities, it is important to further investigate their perspectives in an effort to create stronger partnerships.

Level of Acuity

As a result of the difficulty clients face in maintaining housing, those who are most acute are also those who receive the lowest amount of supports according to participants in this assessment. Persons experiencing homelessness in Hamilton are screened using the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) when encountering social services. This survey evaluates an individual's level of risk/acuity and is meant to determine service prioritization based on said risk (OrgCode, 2015). Those scoring above 13 on the VI-SPDAT are considered highly acute. The scores collected are stored in a federal database managed by the City of Hamilton known as The Homeless Individuals and Families Information System (HIFIS). This data informs a By Name Priority List (BNPL) which is used to determine who has the greatest need and in what order to generate referrals to housing services to individuals (City of Hamilton, 2019).

According to participants, the current model in The City of Hamilton homeless serving sector provides Intensive Case Management for individuals who score between 8 and 12 on the VI-SPDAT. An assessment participant shares the difficulty an organization supporting those with higher scores encountered in the past

> *When [an organization first started], they were only working with the individuals that had the highest scores, and I believe they were not having a lot of success because, again, they were housing individuals, but they didn't have any kind of supports after that. [They only had] the case managers and that wasn't enough. So I think they started working [with] the individuals that were [scored between] eight and 12 because, of course, they needed to have some good outcomes.*

As a result, those who score 13 and above "are not connected to any services and there's no way for them to find housing and keep their housing if they are not attached [to a case worker]".

If unsupported, clients may require more use of social services. Research finds that people who are homeless with very high support needs, if in housing with proper support, will not encounter psychiatric services, emergency medical services and the criminal justice system as often as when they were homeless and could stop using them altogether (Pleace, et al., 2013, Culhane, 2008). It is evident that a model that incorporates the needs of those who are experiencing the highest levels of acuity is needed. As mentioned, those scoring above 13 are in need of a higher level of supports

to maintain housing. The outlined barriers among many others may be addressed with additional supports.

How the Intensive Supports Pilot Helps Fill these Gaps

PECH in Hamilton are in need of a program that meets their needs based on their level of acuity. Clients occasionally expressed frustration with “the system” indicating that there are claims for help, but that assistance is too slow or not responsive enough to help. The ISP seeks to fill the aforementioned gaps with an intersectoral collaborative that follows housing first, person first, trauma informed, harm reduction, and equitable approaches to assisting persons scoring high on the VI-SPDAT in securing and maintaining housing with wrap around supports. The pilot employs systems integration by drawing on the strengths and resources of The City, a community health organization, healthcare, and community supports in a non-hierarchical model that values the approaches and skills embodied in each organization. The Pilot also addresses structural barriers to gaining access to housing such as discrimination based on race and gender identity by providing specific access to high priority groups and providing supports that are aligned with their unique needs. To be explored is the model, the intake process participants undergo to become involved in the program, and the benefits of the program.

Housing first is cited in the literature as an effective recovery-oriented approach that focuses on first quickly housing persons and providing them with services to maintain their housing and improve their wellbeing. It typically provides individuals with case workers who can connect them to services and provide support and stability (Buccieri, 2016). Housing first is an integrated care model that combines the knowledge, budgets, and expertise of multiple sectors and has been proven to have a positive effect on overall health and housing stability (Waldbrook, 2015). Integrated care models have the ability to ease accessibility to services such as housing allowances, specialized health referrals, and community supports. However, they have been found to have difficulty particularly in the instance of establishing cross-jurisdictional budgets and strong leadership capacity (Kodner & Spreeuwenberg, 2002). The integrated care model that has been established in the ISP demonstrates the ability for multiple organizations to work together in a coordinated manner that overcomes some criticisms of housing first programs.

What is the Intensive Supports Pilot?

Philosophical Framework

The ISP employs a person centred, trauma informed approach. Healthcare literature suggests shifts towards person centred models of support are more efficacious and preferred by recipients or consumers of care. Person centred care is rooted in the philosophy that care consumers are, of course, people first (Ekman, et al., 2011). Their life situation, inclusive of their social and physical environment, is central to

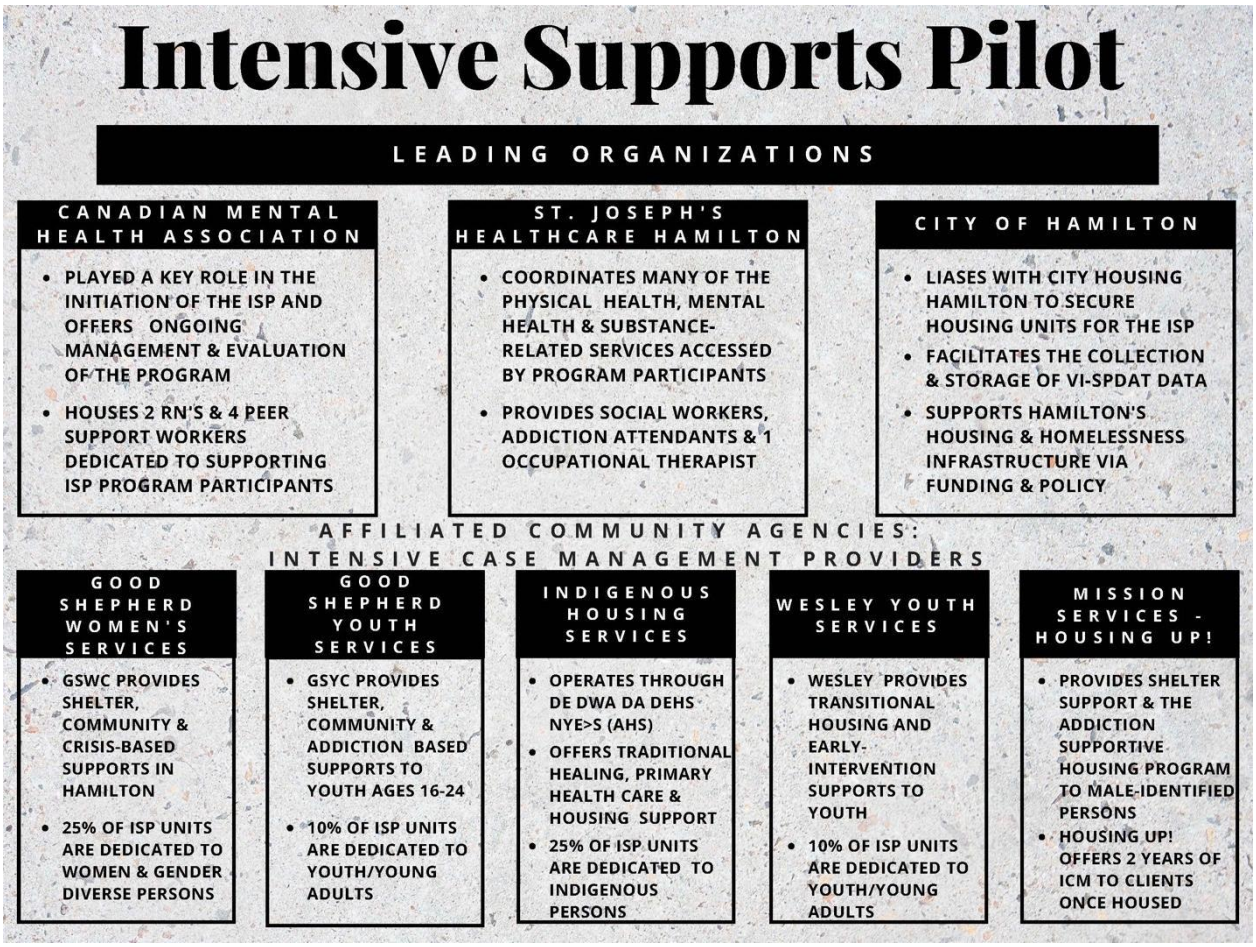
treatment as opposed to the disease(s) they are managing (Berglund et al., 2019). Individuals are recognized for their unique strengths and abilities, their social histories, values, and personalities (Alzheimer Society of Canada, 2013). They are recognized as people who are capable of making the best decisions for their health and are fully integrated into, and mutually respected by, their care team (Alzheimer Society of Canada, 2013). In person centred care, consumers of care have the right to participate in a supportive environment where they are valued and dignified (Surr et al., 2016). They are ultimately viewed first as human beings with feelings, needs, and reason (Ekman et al., 2011). Person centred care is found to enhance care consumer/ provider relationships, improve quality of care, and lead to better health outcomes (Scerri, et al., 2019).

The ISP also incorporates trauma informed care. Trauma informed care recognizes the impacts and prevalence of trauma particularly in the lives of those who experience mental health concerns (Watson et al., 2014). The delivery of said care prioritizes the importance of trusting, respectful, and safe relationships with providers (Bloom et al., 2003). Providers have the ability to respond to disclosures of trauma compassionately and understand its impacts on the individual from a wider context (Harris & Fallott, 2001). It also recognizes the need for participants to be in control of their care to reduce traumatising and coercive practices (Watson et al., 2014).

These approaches complement harm reduction approaches particularly in addictions recovery where the guiding principle is to “meet people where they’re at” (Collins et al., 2016). Thus, participants are not required to be abstinent to receive service, and instead work towards person centred goals, build trust and therapeutic rapport, and improve daily functioning and safety related to using. Participant defined pathways to recovery such as these have been identified in the literature as being preferred and more effective (Collins, et al., 2016). Following this approach, those in the ISP program who wish to be connected to an addictions worker can do so by choice.

The program combines the aforementioned approaches into a philosophical framework which guides supports from The City of Hamilton’s Intensive Case Management Program, the Canadian Mental Health Association, Hamilton Branch and St. Joseph’s Healthcare Hamilton. Intensive Case Managers (ICMs) provide one to one case management support for a period of up to 24 months. They are delivered through 5 community organizations with a specialized lens and model of care reflective of those they serve. The organizations include Wesley Housing Services, Mission Housing Up! (Men’s), Good Shepherd Housing First for Women and Housing First for Youth Programs, and Indigenous Housing Services through De dwa da dehs nye>s Aboriginal Health Centre. A detailed description of organizations offering Intensive Case Management can be viewed in the Appendix. Representatives from St. Joseph’s Healthcare Hamilton and the City of Hamilton provide direct oversight and organization of the support team. St. Joseph’s Healthcare Hamilton supports include an Occupational Therapist, Social Worker, and 2 Addictions Workers. From the CMHA Street Team and supporting The Pilot are 2 Registered Nurses to coordinate care and 4 Peer Support Workers with lived experience of mental illness and/or

problematic substance use. The following infographic provides a visual representation of the supports involved in The ISP and their roles:



The interdisciplinary team is available for clients between the hours of 9am -5pm. After Hours crisis support is available through COAST, though clients have the option to activate their preferred crisis support networks at any time. The interdisciplinary team was designed with the holistic needs of clients in mind and with the goals of partnering to augment their physical, social, emotional, and psychological health. To be addressed next is the process by which clients were recruited and chose to become involved in the program.

Recruitment Process

The ISP began with the intention of meeting the direct current needs of 15 – 20 clients in Hamilton identified to be highly acute and chronic. These individuals are to have a score of 13 and above on the VI-SPDAT or are to be selected by ICMs as appropriate. It employs a health equity perspective that aims to equally represent priority groups. The ISP planned to allocate 25% of resources to individuals who self-identify as women, non-binary, or trans*, with the same percentage of resources

reserved to support individuals who self-identify as Indigenous. Youth, classified as individuals aged 16-14, are also deemed a priority population and were set to receive 10% of ISPs resources. The ISPs commitment to social justice and equitable approaches to supporting PECH is in line with Canada's National Housing strategy. The strategy has also prioritized supporting Indigenous communities and applying a gendered lens to homelessness as the National Housing Strategy has allocated 25% of their funding to support programs specifically for women and girls (Federal Government of Canada, 2017).

The ISP recognizes the unique barriers faced by clients and the need for wrap around community supports as relayed by a participant of this assessment,

> *[…] people don't always do all that well in housing. Homelessness is much more than just [not] having a roof over your head and housing isn't just a roof and walls. It's also the relationships and supports [that] help a person feel safe and secure.*

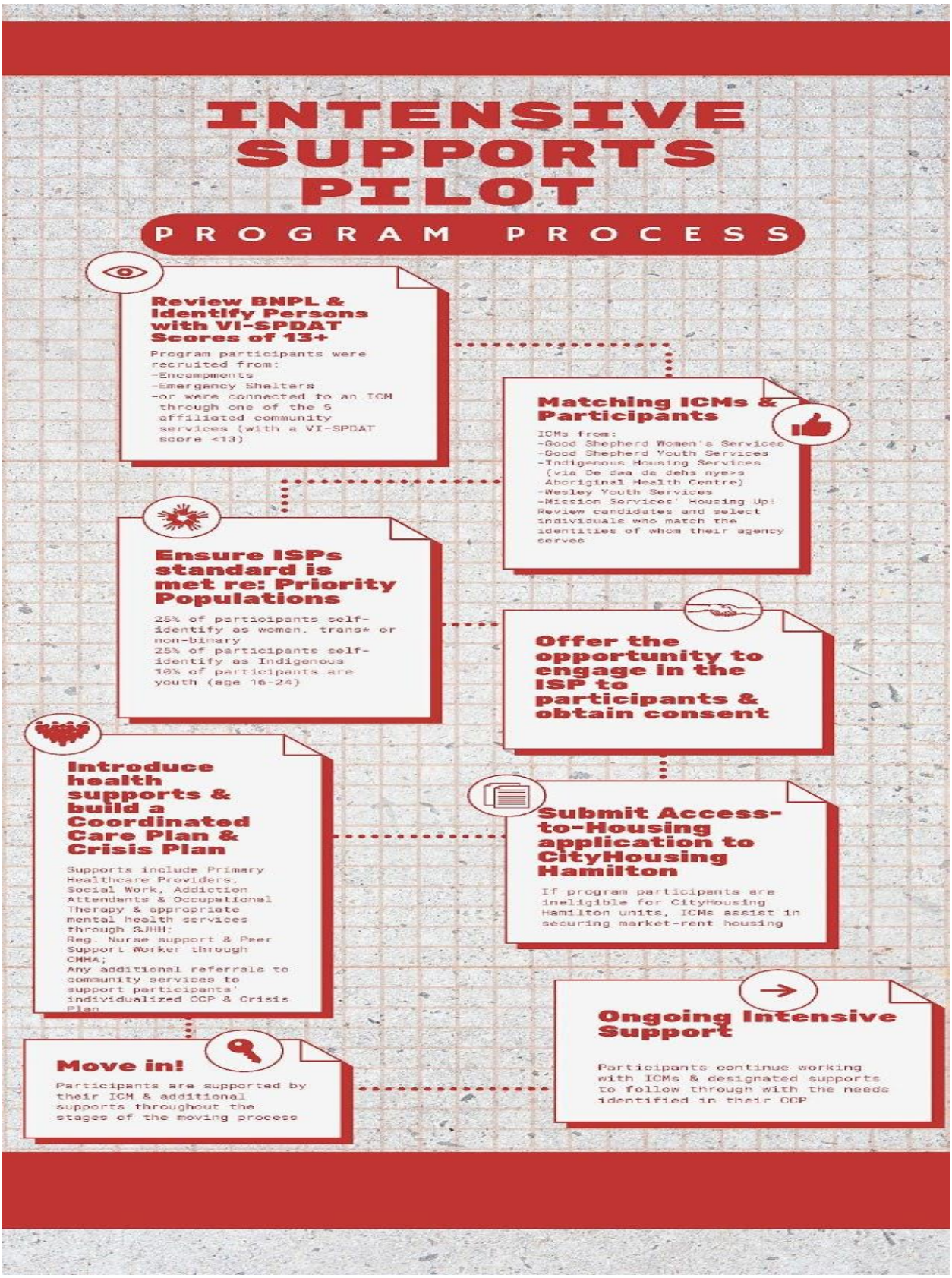
The placement process began by identifying persons on the BNPL with scores above 13. On January 6, 2021, there were approximately 80 individuals in Hamilton who met this criterion. ICMs from each of the 5 different community organizations were asked to select individuals from this list. As each ICM service supports individuals with specific needs, ICMs recruited individuals who match the profiles of those they typically serve. Individuals were mainly recruited from shelters and encampments. In addition, while not part of the inclusion criteria, some were recruited from existing caseloads who had scores below 13 on the VI-SPDAT and were already connected to services given the short recruitment period. Of the 16 participants currently involved, the average length of time reported since being in stable housing was 34 months (City of Hamilton, 2021).

Once the individuals confirmed their desire to be involved in the program, they completed an application sent to Access to Housing, the City's coordinated access program for non-profit housing. Participants had to meet an eligibility criterion which included **some** of the following requirements:

- The participant must have status in Canada (i.e., Canadian citizen, permanent resident, and/or refugee with claim for protection)
- The participant must reside in Hamilton
- The participant must not owe any money to any social housing provider in Ontario (special circumstances will be considered)

Eligible participants were approved for a housing allowance of up to $350 per month to cover housing costs that would not be otherwise covered by the participants' income sources. This housing allowance is attached to the individual and is available for them for 8 years or more as long as they choose to reside in Hamilton. Simultaneously, participants applied to City Housing Hamilton to secure a unit and initiate the lease-signing and move-in process. The majority of clients found suitable units City Housing that supports persons who qualify for rent-geared-to-income housing. As soon as

participants were approved for units, health supports were activated. Participants have the autonomy to decide the type and level of intensity of supports. In addition, participants are connected to primary health care providers through the Shelter Health Network. They are able to be referred for rapid access to various clinics offered by St. Joseph's Healthcare Hamilton such as those related to addictions and mental health. The following infographic provides a visual description of the pathway an individual choosing to be involved in the ISP would take:


INTENSIVE SUPPORTS PILOT
PROGRAM PROCESS
Review BNPL & Identify Persons with VI-SPDAT Scores of 13+
Program participants were recruited from:
-Encampments
-Emergency Shelters
-or were connected to an ICM through one of the 5 affiliated community services (with a VI-SPDAT score <13)
Matching ICMs & Participants
ICMs from:
-Good Shepherd Women's Services
-Good Shepherd Youth Services
-Indigenous Housing Services (via De dwa da dehs nye>s Aboriginal Health Centre)
-Wesley Youth Services
-Mission Services' Housing Up!
Review candidates and select individuals who match the identities of whom their agency serves
Ensure ISPs standard is met re: Priority Populations
25% of participants self-identify as women, trans* or non-binary
25% of participants self-identify as Indigenous
10% of participants are youth (age 16-24)
Offer the opportunity to engage in the ISP to participants & obtain consent
Introduce health supports & build a Coordinated Care Plan & Crisis Plan
Supports include Primary Healthcare Providers, Social Work, Addiction Attendants & Occupational Therapy & appropriate mental health services through SJHH;
Reg. Nurse support & Peer Support Worker through CMHA;
Any additional referrals to community services to support participants' individualized CCP & Crisis Plan
Submit Access-to-Housing application to CityHousing Hamilton
If program participants are ineligible for CityHousing Hamilton units, ICMs assist in securing market-rent housing
Move in!
Participants are supported by their ICM & additional supports throughout the stages of the moving process
Ongoing Intensive Support
Participants continue working with ICMs & designated supports to follow through with the needs identified in their CCP

In the short period since the launch of this pilot, 16 individuals have been approved to be included in the housing, clinical and non-clinical health supports offered. 14 of the participants are currently in City Housing. 2 are waiting for housing with 1 individual looking for a private market unit and another waiting for an opening in an accessible housing unit. The ISP has identified targets though it is notable as framed by a participant

> *That was our initial hope [to house 15-20 people], but I think, from my perspective, very early on, we realized we're still not going to hit those with the highest level of need. It may not be the right intervention for clients in the homeless serving system with the highest level of need as they may require 24/7 place-based supports (permanent supportive housing), which is beyond the scope of intervention in the project. But we also need more than three months to be able to engage with those individuals.*

While it is pre-emptive to evaluate the benefits accrued by clients, it is possible to observe and comment on the creation of an innovative model to servicing clients in Hamilton.

What are the Benefits of The Intensive Supports Pilot?

As noted, the ISP is early in its conceptualization for efficacy to be meaningfully evaluated. Gleaned from the pilot however is a model of service delivery that creates a culture of shared responsibility for the needs of clients in Hamilton. This assessment finds that the model reduces replicability of services, fills care gaps, improves communication among sectors, and allows clients to rapidly access services.

The Model

Aforementioned criticisms of the housing first model imply that it is difficult for social service organizations to come together due to jurisdictional issues, funding barriers, and hierarchical organizational structures. As noted by a participant in The ISP,

> *we often work in silos. And I don't think it's intentional […] we always have the desire to work in collaboration, but I think everyone has their funding, the work they do and […] it's just the way that organizations are structured [as] very separate from each other […] there's not natural touch points where you meet with other services, unless you put yourself out there.*

This lack of collaboration can create gaps in systems that serve the same individuals. Drawing from an upstream, social determinants of health perspective one participant stresses that collaborations are necessary as

> *If people don't have housing… if they don't have income… they're going to end up in the healthcare system, whether you like it or not. So why don't we work together to prevent that from happening.*

Gaps in services can mean that individuals receive a large amount of uncoordinated services that are difficult to track and cause overlap (Richard et al., 2019). When organizations serving similar individuals come together, there may be an opportunity to reflect on ways in which services can be streamlined and resources can be maximized. One participant relays that service providers

> *have a basket of resources that we use each in a certain way and this is the kind of situation [the ISP project] that helps us to reflect on whether or not we need to use some of those resources differently.*

As such, a near unanimously shared reflection from all who participated in the program assessment has been an appreciation for the collaborative model that has come out of the ISP. The model itself has been discussed as an opportunity to not only reach the shared goal of finding and maintaining housing for clients, but to learn about partnering organizations, strategize ways to maximize resources, and see a future where there are minimal gaps in overlapping services to create continuity of care for clients and perhaps beyond. A participant notes the partnerships as being a central outcome of the ISP

> *We're coming together in a partnership that didn't previously exist. It's a new way of working. The partnership itself is critical in terms of learning what each other does, what our respective roles are…building trust to be able to be open to our own limitations. [Learning what] resources to provide but also what our unique assets and strengths are so that we can figure out where are we each limited and then where can we bump up against each other, to try to fill some gaps in a coordinated way, so the ultimate outcome is individuals being housed but also just learning what are we each doing.*

Among participants is a new appreciation for the skills and expertise of different workers, as well as increased knowledge of the groups they service which may translate to benefits at the client level.

From a client perspective, this model may have contributed to the speed at which they were able to access the program. Clients who we spoke with note that the responsiveness of this program - being told they qualify for support and having that support available within weeks - was not only a very welcome change, it was significant in their willingness and ability to take up that support. This coordinated approach and skill sharing may lead to improved connections to necessary services and quick access for clients.

Information Sharing

In addition to an increased appreciation for the unique skills and resources offered by each organization among the partners was an improved means of cross-sectoral communication through a shared Electronic Medical Record system (EMR). The use of EMRs for the collection and storage of medical information allows access to pertinent records on a secure database across and between health-based institutions (Chang & Gupta, 2015). The use of EMRs can increase efficiency and health promotion, as well as avoid duplications in service. Their implementation is connected to better health outcomes, prevention of adverse drug events, and better management of chronic disease (Canada Health Infoway, 2018). However, in Canada institutions and healthcare providers are free to choose which EMR system to use (Goldman, 2019). This can create issues in access and continuity of care, in addition to jurisdictional issues given the provincial delegation of healthcare. While there are benefits to having a single system implemented at the federal level, providers are wary of storing sensitive information given the risk of hacking and security breaches (Huang et al., 2019; Mikka, 2014). At the client level, there are privacy challenges regarding the sharing of health information that may lead to stigmatization according to participants of this assessment.

Given the benefits of a shared EMR, The ISP uses the Open Source Clinical Application and Resources (OSCAR) system developed by McMaster University to share and store participant related information. To improve communication, individuals working for St. Joseph's Healthcare Hamilton and CMHA Hamilton are able to document and view shared information. For example, the coordinated care plan is initiated by the CMHA Registered Nurse (RN) and is a living document within the client's EMR. Both hospital and community health care providers can continue to adjust the care plan in a timely way as the client's needs and goals evolve. This mode of sharing information across sectors is innovative and may lead to better health outcomes and improved collaboration among organizations.

Primary Care Access

Another observed benefit can relate to the ISP's focus on improving access to primary care. Clients are noted to avoid accessing preventative primary care services given reports of dehumanizing and stigmatizing encounters with the health system (Buccieri, 2016). Research finds it is important to create relationships with primary care providers that are based on mutual respect and trust to prevent feelings of shame and embarrassment that may keep clients from accessing health services (Pauly, 2014).

One participant from the ISP outlines that hesitation regarding accessing primary care providers can also be related to fear

> *You [clients] tend not to reach out to primary care and sometimes you're actually afraid because you haven't had any blood work in 20 years and who knows what that's going to look like, if you go there. And what bad news are you going to find*

> *that you're not able to handle right now… because you've got enough bad news in your life. And so you know people tend not to want to reach out to primary care.*

In addition to social factors related to primary care access hesitancy, there is a need for clients to access the same primary health providers to lower the spread of disease that has been found to be correlated with the rapid movement of clients through different agencies (Harris, 2010).

Recognizing this need, the ISP supports clients by connecting them to primary care through the Shelter Health Network. The CMHA RNs work in partnership with the Shelter Health Network Physicians, documenting in the same OSCAR EMR and using the secure internal messaging system to facilitate coordinated, seamless care. The RNs are able to provide timely access to virtual primary care for clients wherever they are. It is advantageous to clients as they do not require a health card to access services, and primary care providers are aware of the unique needs of clients. It does not operate under a Fee for Service model rather through an Alternative Payment Program where physicians can bill hourly regardless of whether the person shows for their appointment. According to a participant in the assessment, this model prevents the tendency Fee for Service models have to encourage the "cherry picking" of patients who are consistent and do not have complex needs. Once connected to primary care providers, follow up can be maintained and clients can be referred to other services to meet their holistic health needs.

Compassionate Providers

The pragmatic ability to connect people to primary care services can be noted as a major benefit of The ISP. It is also important to highlight the formation of relationships between clinical and non-clinical supports and clients that can be said to reduce feelings of stigmatization and build trust. One participant of the assessment reflects on the relationship she's been able to build with a clients who was initially wary and reluctant to engage with providers. The participant cites they have

> *Developed quite a beautiful connection and relationship [with the client who] is really sharing a lot about his past and his history and his childhood. This for him has been very cathartic. He said he's never had a person listen to him as much as I listen […] and I'm also observably seeing his affect lift […] he's amazed by the level of supports offered by this program and he's really just turned a corner in terms of going from apprehensive to entirely invested. He is now connected to the Nurse and is looking forward to connecting with the Peer Support Worker.*

Indeed, the ripple effects of trust established through person centred care are vital to recognize. The compassion for and investment in the people they support was evident in interviews with dedicated and experienced workers.

Peer Support Workers

Other health supports recognized the unique and important role played by Peer Support Workers in establishing rapport with clients. They were identified as having an invaluable skillset and ability to connect with clients. Peer Support Workers are those with lived expertise related to a particular phenomenon, in this case mental illness/homelessness, who can provide support by drawing from their personal experiences (Miller et al., 2020). A recent systematic review on the effectiveness of Peer Support Workers for those experiencing homelessness found an overall reduction in harm related to drug/alcohol use, decreases in number of days spent homeless, improved housing environments, and overall increased satisfaction with services (Miler, et al., 2020). At a social level, participants in this assessment note that Peer Support Workers

> *Can say "I've been there buddy I know what you're going through" […] they've got some credibility they've got authenticity. And they put people at ease because it's like well "you've been there and look at you working... you're an outreach worker you're really healthy you've got your own place or whatever," so it can be very, very inspiring.*

This ability to connect with clients at a relatable level has been cited as beneficial and to go beyond the role as "worker"

> *I think that Peer Support also addresses the loneliness piece, and the relationship needs that people have. We all need to feel connected and accepted and we need to feel a sense of belonging and I think that the Peer Support Workers have a way of doing that that's different than a healthcare provider because they've been there, they've got it, they can relate. They can share their own personal experiences and build a kind of a relationship that is very different than what you might build with a healthcare provider.*

Further, Peer Support Workers have practical experience and a connection to community that can fill gaps in clinical knowledge and practice. One participant of the assessment recalls an instance where the familiarity of community from a Peer Support Worker was beneficial:

> *We were going around trying to find this one client of ours, couldn't find him. We got an address from someone […] And next thing we know we're going to this address and [Peer Support Worker] is going into their house like [the Peer Support Worker] has no problems doing that [and] kind of knows the people in that community.*

It is clear that the role of Peer Support Workers is critical to the ISP given their capacity to build trusting relationships and share an expansive knowledge base rooted in lived expertise.

How can the Intensive Supports Pilot be Sustained?

This report recognizes that The ISP is indeed a pilot that has just begun. The following section seeks to put forward recommendations from participants themselves that may enhance its long-term sustainability. Participants of the assessment are best suited to make recommendations given their proximity to the work. Highlighted was the need to secure ongoing funding, the need for a strong lead, the desire to integrate client voices, and the overarching issue of a limited low barrier housing supply in Hamilton.

Funding

Ongoing funding has been highlighted as a major factor in maintaining the collaboration by participants of the assessment. Funding is needed particularly for clinical and non-clinical health supports, as The City is restricted to contribute only to housing related supports. Budgetary and jurisdictional issues have been cited in the literature as a barrier to ongoing collaboration between sectors in housing first initiatives (Kodner & Spreeuwenberg, 2002). Recommendations for improving funding coordination at the systems level include a full integration of resources where organizational units are pooled and a new organization altogether is created. In this way, funding streams can be centralized preventing fragmentation at the service level (Alina, 2015). Additional funding may also look to implement a 24-hour service model to meet the ongoing needs of clients outside of business hours.

Clear Leadership

The ISP is a collaborative model whereby each organization has equal input and shared leadership. Each organization is recognized as “expert” in their designated area, and no one stakeholder assumes a distinct leadership role. Some participants of this assessment have stated they would prefer to have a clear leader or “project manager” in order to ease communication and reduce confusion. As stated by a participant

> *I don't know if there is a project manager in this pilot project, so I think that would be helpful… just to organize things [because] there were a lot of questions on what direction we needed to go in.*

Having a single leadership entity may be beneficial in establishing a clear vision and mission for the project. A participant highlights the need to

> *have more discussions around the shared vision of each stakeholder involved, […]so we can have our overall shared vision, but I think we can erroneously make assumptions about what that means to each of us, and so I think that could be improved by unpacking that.*

However, while integration at the systems level has been cited to improve communication streams and allow for clear leadership, systems integration only has not

necessarily been linked to improved health outcomes at the client level (Hambrick & Rog, 2000). Rather, localized integration that focuses on sharing of resources and service at the client level is central to improved health and housing maintenance (Alvin et al., 2008). When investigating the structure of daily front line work, it was clear that the manners in which front line workers operate is fully integrated. Front line workers operate as a team and there is no divide between organizations. It was recommended that communication and collaboration could be improved if all clinical and non-clinical supports had a single shared space. Currently, some health supports operate out of CMHA's building and others out of a community housing building. Since service integration that is closest to the client is most effective, perhaps a focus on continuing to improve collaboration at the client facing level will contribute to the long-term sustainability of The ISP.

Integration Across all Collaborators at the Systems Level

While the main organizations involved appear to support a culture that is inclusive and collaborative, participants cited difficulty with social housing programs. City Housing Hamilton is also a stakeholder that acts as a "landlord" and is one of the non-profit building providers that offers social housing units in Hamilton. According to participants, they manage a large portfolio of tenants and are interested in maintaining healthy spaces at the community level. As landlords, they are responsible for creating safe communities for all. This perspective may pose difficulty at the individual client level given that clients in The ISP were required to meet criteria that were considered significant barriers to housing. Due to application requirements,

> *There were definitely people that were turned away… City Housing Hamilton said "no we're definitely not going to host these individuals"… And that was very hard for us to take that information because if City Housing Hamilton isn't going to host them we're not going to be able to find a private market landlord that's going to help these individuals either. So we know that there are still people that are currently in encampments or in tents right now sleeping and we're feeling defeated because there's no way of getting them housed if City Housing Hamilton is not willing to reduce those barriers.*

Indeed, private market landlords are also reluctant to host individuals who are experiencing homelessness and the rising cost of housing in Hamilton has impacted the availability of affordable housing

> *I think Hamilton has seen a huge gentrification and the community has really changed where we once had this very affordable section in the city that has really become a not so affordable section of the city anymore… Because we're seeing people from Toronto and other areas purchasing these houses and turning them into unaffordable rentals. And the result of this gentrification is that individuals who were once able to afford their units are now being evicted due to unaffordability. It's increased the level of individuals experiencing homelessness in our community.*

The stock of affordable housing units is low, and in 2017, the average wait time for a social housing unit in Hamilton was 2.3 years (Canadian Observatory on Homelessness, 2021). While there are other social housing providers in the city, City Housing Hamilton is the largest. Participants stress the need to build relationships with more builders as well as private market landlords to increase the supply of available housing. It would seem that in order to address the systemic issues central to homelessness, there is a need for strong policy initiatives. These might provide incentivization for private market landlords to rent to those on social assistance or address the rising housing prices across the province.

Ethics of Implementing Programs with Short Term Funding

A number of participants highlighted ethical implications of starting a pilot program with short term funding. Difficulty in forming client relationships were presented

> *We want to provide the best care with what we're able to do and yeah it does make it hard to enter into that relationship not really knowing what we can fully offer them […] because we're engaging with these people, and telling them that we're going to support them, but not really knowing if it's going to continue.*

Participants were concerned about the health and wellbeing of their clients if the pilot were to end, though the responsibility of this lies in the hands of funding agencies.

A Bottom-Up Approach

Finally, program conceptualizers reflected on their preference for a bottom-up approach that integrated client voices and participation in planning. Given the limited time the steering committee had to allocate funds and begin The ISP, they were limited in their ability to engage clients in early stage planning. It is notable however that a number of roles have been co-designed by persons with lived expertise such as the Peer Support Worker role within CMHA. Going forward, conceptualizes have expressed a desire to integrate client perspectives and may choose to refer to the Tamarack guide to engaging people with lived experience (Homer, 2019). Following the “nothing about us without us” movement, the Tamarack Institute recognizes the importance of engaging and empowering those who are disenfranchised in the development of strategies aimed at assisting them (Homer, 2019).

Should The ISP continue, a review of its efficacy could take a bottom-up approach guided by clients themselves and perhaps those still looking to secure housing. The literature suggests that systems integration starting at the client facing level is vital, as well as the pooling of resources to form a single entity with a clear mission and vision.

How are the Needs of Priority Groups being Considered and Addressed?

Understanding the unique needs of priority populations, the ISP applied a health equity lens to offer supports to specific groups. To address the high rates of Indigenous homelessness and respond to the growth of encampments that occurred as a result of the COVID-19 pandemic, ISP partners set a target goal to recruit and support Indigenous PECH and allocated 25% of the resources to an Indigenous organization in the community. The first phase of ISP involved De Dwa Da Dehs Nye>s Aboriginal Health Centre as the service designated to recruit Indigenous PECH and provide intensive case management collaboratively with ISP partners. Currently participating in the first phase of the project are three self-identified Indigenous PECH. It is of note Indigenous identifiers in this project include individuals who consent to participate with an Indigenous organization. A key finding related to identity and data collection of Indigenous PECH is integrating Ownership, Control, Access and Possession (OCAP) principles moving forward to protect Indigenous data and promote autonomous decision-making.

An important component of the ISP evaluation assessment included interviews with five key informants in positions at Indigenous organizations in Hamilton who work with Indigenous individuals experiencing homelessness. ISP partners acknowledged the lack of Indigenous engagement in phase one of the project. The research team engaged with three Indigenous organizations who work with Indigenous individuals experiencing homelessness. One of the respondents who participated is directly involved in the first phase of the project, and the four respondents who were not involved in the onset of the project shared their ideas of how ISP may be improved to better meet the needs of Indigenous PECH as this project unfolds.

Below is a brief summary of an evaluation of ISP meeting the needs of Indigenous PECH, including suggestions shared by the Indigenous community to further support the continuity of comprehensive, coordinated care for Indigenous PECH in Hamilton.

Indigenous Partnerships

The main finding is engaging in Indigenous partnerships with stakeholders of homelessness is critical for developing strategies through a coordinated approach of service delivery for Indigenous PECH in Hamilton. It is evident that key steps were missed to involve and engage with the Indigenous community in the onset of this project. Respondents shared their concerns related to recruiting Indigenous PECH for ISP without consulting Indigenous stakeholders to ensure individuals are assessed appropriately and provided opportunities to access Indigenous-led services. Additionally, past efforts were not acknowledged from previous projects and moving forward the Coalition of Hamilton's Indigenous Leadership wishes to be involved at the onset of such proposals to help identify barriers, changes, and provide guidance. Supporting Indigenous leadership is significantly important to effectively identify community led priorities and create dialogue for solutions while also monitoring progress for Indigenous PECH.

Phase one ISP Supports addressing the needs of Indigenous PECH

As noted previously, three individuals are currently participating in the project and receive supports from all ISP partners, including support from COAST. Respondents noted the importance of supporting Indigenous individuals with Indigenous supports, and identified the current supports offered in the ISP project as predominantly led by mainstream agencies and may lead to an inability to meet the needs of Indigenous PECH. Additionally, ISP partners do not have Indigenous led services and health professionals are not required to complete Indigenous specific training. While services offered to PECH are netted within a collaborative and integrative approach, concerns of unmet service needs and barriers to care for Indigenous PECH persist. For example, one respondent noted limitations of services in this project included lack of around the clock support and autonomous decision making.

Indigenous PECH assessment tool

In addition to the limited Indigenous providers involved in this project, respondents discussed limitations regarding ISP's use of the standardized VI-SPDAT assessment tool. The tool primarily consists of Yes/No questions and does not adequately assess the complexity of historical or systemic barriers Indigenous peoples face in the screening questionnaire which may result in this population not receiving the care most appropriate. Upon consulting with Indigenous stakeholders who are situated to assess and serve Indigenous PECH, prioritization for housing placement is assessed on a case-by-case basis. Four key protocols for health and social providers working with Indigenous peoples experiencing homelessness are to situate oneself, keeyoukaywin (visiting), hospitality, and treating people as you would treat your own relative (Thistle & Smylie, 2020, p.E250).

Indigenous organizations capacity to offer innovative services during a global pandemic.

Indigenous led organizations function at maximum capacity prior to the COVID-19 pandemic. Advocates for Indigenous homelessness voiced the importance of engaging and networking with the City of Hamilton to address provincial and federal funding opportunities.

Women and Youth Homelessness

In a 2014 survey of a proportion of the Canadian population of persons experiencing homelessness, of 235,000 people surveyed 27.3% were women and 18.7% were youth (Andermann, at al., 2020). Women and youth are more likely to be vulnerably housed and underrepresented in official homeless counts (Shoemaker et al., 2020). They often experience "hidden homelessness" and can be difficult to reach. Youth who are precariously housed or homeless experience high rates of violence, substance use, and often work in the sex trade to meet their basic needs (Shoemaker, et al., 2020). Women are also vulnerable when homeless and precariously housed, more likely to engage in "survival sex" or become exploited by human trafficking (Andermann et al., 2021). They are more likely to experience homelessness due to domestic violence and limited social supports (Shier et al., 2011).

Establishing priority groups at the outset was a means to ensure that those who were most vulnerable were included. However, given the patterns of “hidden homelessness” experienced by women and youth in particular and as identified by a participant in the ISP, it is possible that the means of recruiting clients could be more equitable. Because many clients were recruited from encampments and emergency shelters, it is possible that women and youth with an equally high level of need were missed. Further collaboration and discussion with community leaders is needed to identify how these individuals could be recruited for The ISP going forward.

In response to the ISP’s commitment to providing an equity-based approach to supporting priority groups, the ISP has met and surpassed 2 of its 3 targets. 31% of participants identify as women, trans*, or non-binary, surpassing the projected goal by 6%. Youth were also identified as a priority group, with 10% of services and supports reserved for this population; currently 19% of ISP participants are youth. The ISP also has dedicated 25% of its services to support individuals who identify as Indigenous; at this stage in the program, 19% of program participants are Indigenous (City of Hamilton, 2021).

The Role of Intensive Case Managers in Meeting the Needs of Priority Populations

In addition to beginning with a framework that sought to include specific individuals identified to be most vulnerable was the inclusion of ICMs from organizations with specific focuses on particular client groups. This expertise is invaluable as it provides a specialized lens and skillset from which to understand and respond to the needs of specific clients. For example, the needs of women were well understood by ICMs working with them. It has been relayed that women face barriers related to safety and intimate partner violence that are important to identify when working with a client. The participant notes the need for a non-stigmatizing approach and experience working with women to meet their needs

> *We have to make sure that women feel safe telling us things. And we try to really normalize. We'll talk about it before it even happens. So that's one of the things, we always ask women if they have exes out there, or about their relationships. And we say, "If there's ever a time that you feel that someone's not safe for you anymore, or there's problems, we want you to feel comfortable talking about it. We deal with it all the time. And we could come up with some strategies for you to deal with those things. But you're the driver. You get to decide.”*

ICMS certainly have a valuable skill set and all have noted their gratitude for the additional supports provided to their clients as they are required to wear multiple “hats” in their role.

> *I'm very excited to hear that there's peer support, that there's addiction workers, that there's mental health workers, that there's an OT, that there's nurses. All of*

those things are things that all of our clients need, for sure. And a lot of the times, I think that our staff, our ICMs, try to be all those things. So this is amazing, to have these opportunities, for sure.

While grateful for the additional supports, ICMs would have preferred to have been involved earlier in the process given the expertise they have relative to their client groups.

Clinical and non-clinical health supports have identified that their approach to working with clients is from a broad framework that puts clients first. It is not, however, necessarily based on their belonging to a particular group. It is possible that more consultation with ICM groups could improve knowledge and expertise specific to the needs of client groups. It is noted that

There's lots of information out there that suggests there's not a huge difference in populations, and that all the needs are all the same. And then there's other ideas that they're very, very different [and specific to the needs of certain client groups].

Perhaps the integration of client-centred perspectives allows space to meet the individual needs of clients. Though it seems that groups working with specific clients would prefer more involvement in service planning as The Pilot continues.

Conclusion and Future Research

The ISP has created an intersectoral collaborative model that other municipalities can integrate into their service of clients. It exemplifies the ability for different sectors to come together and work towards a common goal while creating a culture of shared accountability and mutual respect. Shared among stakeholders is the recognition that

Everybody really deserves a place to call home, whatever that means for them. I think we recognize that people are healthier when they have a home that is safe and secure and that they can afford. And I think we recognize that many of the people who aren't able to sustain housing also have other barriers to housing that we need to consider and we need to address and we need to help to support.

The ISP is early in its implementation and this assessment has sought to describe the pilot and provide feedback on augmentation opportunities based on responses from those most involved in the work. Should The ISP continue, it might be beneficial to improve the model beginning with the perspectives of clients and frontline workers as identified by participants in The ISP. This assessment recognizes that implementation of the pilot occurred in a short time frame and that change is ongoing.

Great consideration has been given to the importance of recognizing how certain populations disproportionately experience homelessness at higher rates. The ISP surpassed its target for the program to ensure a minimum of 10% of program

participants were youth and 25% identified as women, trans*, or non-binary. However, 19% of program participants identify as Indigenous, which falls short of the ISP's target by 6%. ISP partners recognize the need for Indigenous leadership, in addition to further research and community engagement is required to explore what has prevented The ISP from meeting this target, and to develop key recommendations for adjustments to recruitment, program design and service delivery.

It will be interesting to learn more about the long-term benefits of the ISP. There are a number of validated scales that can measure housing stability, housing satisfaction, level of community integration, and health and wellbeing. It will be important to involve clients in future research in order that they may identify program gaps and what is most important to them in a housing environment.

Future research may look at understanding the client perspective as well as their habitation needs. It has been identified that clients often experience loneliness when first gaining access to housing, and further research may look at elements of the lived environment that support community integration for persons who live unconventional lives. Identifying the types of environments that support the lifestyle needs of individuals may be beneficial in conceptualizing those factors that promote long term sustainability in housing. The ability for persons living unconventional lives to adapt to conventional living spaces is a point to consider given the challenges clients face to maintaining housing. There are a number of underlying structural social factors to be explored here. In addition, future research may seek to advocate for policies that look to improve systemic issues such as a lack of affordable housing supply in Hamilton and beyond. It is vital to highlight however that individuals and groups have the ability to apply their stories, perspectives, skills, and compassion to influence systems and be catalysts for upstream change.

Appendix

Key Community Organizations – Intensive Case Management

A vital component of the ISP is the inclusion of an Intensive Case Manager for each participant in the pilot project who provides one-to-one case management support. As part of their role, ISPs ensure that the organization and provision of services is facilitated in a way that responds to the unique needs, experiences and identities of each program participant and ensures that their voice holds power in the development of their Coordinate Care Plan. The ISP has partnered with five community agencies that have dedicated staff to fulfil the Intensive Case Management roles: Good Shepherd Women's Services; Good Shepherd Youth Services; Indigenous Housing Services via De dwa da dehs nye>s Aboriginal Health Centre; Wesley Urban Ministries; and Mission Service's Housing Up! program. Each of these organizations have longstanding histories working frontline with Hamilton residents and understand the unique ways homelessness is experienced differently based on one's age, gender, and cultural identities.

Good Shepherd Women's Services

Good Shepherd Women's Services (GSWS) has been a staple organization in the Hamilton community through their provision of emergency shelter space, transitional living programs, crisis supports, community-based support, and advocacy efforts (Good Shepherd Centres, 2021a). One of the areas that Good Shepherd Women's Services currently offers Intensive Case Management support is through Supporting Our Sisters, a Housing First wrap around program that focuses on providing gendered responses to women experiencing homelessness and assists women in attainting transitional housing (SPRC, 2013b). The ISP has prioritized women and gender diverse persons within the program, reserving 25% of housing units and affiliated supports for this population.

Good Shepherd Youth Services

Good Shepherd Youth Services (GSYS) is dedicated to providing housing and community outreach services to youth in Hamilton. In addition to their emergency shelter, Good Shepherd Youth Services, in collaboration with Alternatives for Youth and SJHH, provides addiction/substance use supports and withdrawal management assessment and monitoring, respectively (Good Shepherd Centres, 2021b). GSYS also provides community outreach services to assist youth in maintaining housing and offers case management and coordination for youth to navigate internal and community-based resources (Good Shepherd Centres, 2021b). Youth are recognized as a priority group within the ISP, with 10% of its resources being allocated to this population. GSYS staff bring in their skill and knowledge of working with youth, along with their network of

youth-serving resources to act as the Intensive Case Managers for youth participants in the ISP (Good Shepherd Centres, 2021b).

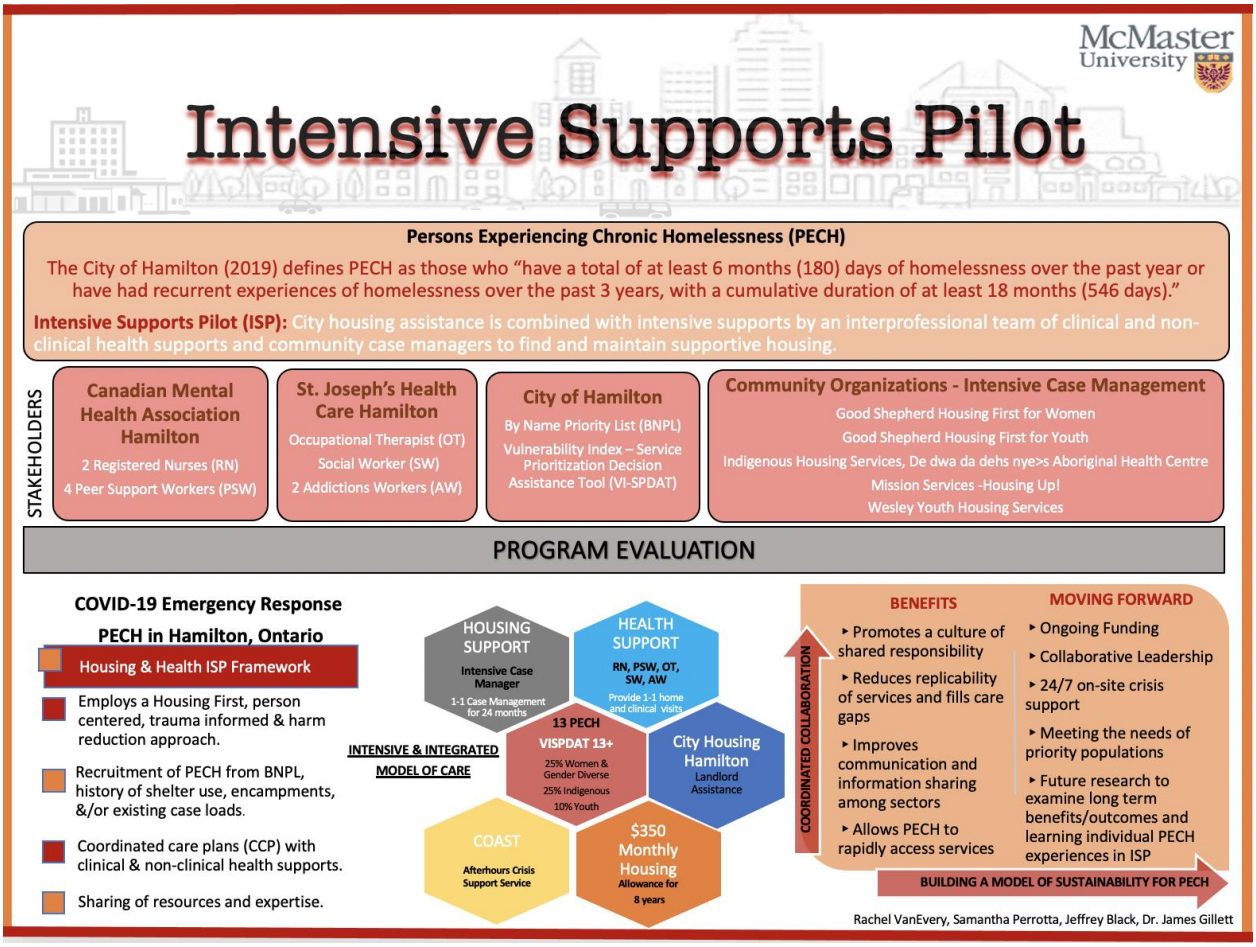
Indigenous Housing Services via De dwa da dehs nye>s Aboriginal Health Centre
De dwa da dehs nye>s Aboriginal Health Centre is dedicated to improving the health and wellbeing of Indigenous individuals, families and communities through a multitude of services, including traditional healing, primary health care and mental health and addictions services (De dwa da dehs nye>s, 2021a). Their Indigenous Housing Services has been providing case management support to clients through a Housing First model; to ensure housing stability and the health and wellness needs of clients, case managers provide support for a two-year period to assist in clients sustaining their housing and wellbeing (De dwa da dehs nye>s, 2021b) . De dwa da dehs nye>s Aboriginal Health Centre's commitment to supporting members of Hamilton's Indigenous community and well-established internal programs and supports play a vital role in supporting Indigenous participants in the ISP. 25% of the Intensive Supports Pilot is reserved to support Indigenous clients, who have been designated as a priority group within the ISP program.

Wesley
Wesley offers a breadth of social services to youth, adults and families in the Hamilton and surrounding areas. They currently play a significant role in Hamilton's housing and homelessness sector through their dedication to youth experiencing or at immanent risk of homelessness. Their residential and early-intervention program has been providing case management support that assists youths' transition to safe and sustainable independent living (Wesley, 2021). Based on the ISP's prioritization of youth within the program and Wesley's expertise in working with young people, it was imperative that they be brought in to assist in providing Intensive Case Management support to youth participating in the Intensive Supports Pilot.

Mission Services – Housing Up!
Through a variety of housing, addiction, food security and wellness focused programs for youth and adults, Mission Services serves over 20,000 individuals per year in Hamilton (Mission Services, 2021a). In addition to providing emergency shelter to male-identifying adults, Mission Services collaborates with CMHA Hamilton to support individuals with histories of addiction and substance use and in need of safe housing through their Addiction Supportive Housing program (Mission Services, 2021b). Through funding received from the City of Hamilton, Mission Services launched Housing Up! in April 2020, which is dedicated to providing long-term case management to males through a Housing First model of care (Mission Services, 2021c). Working with male-identified individuals previously connected to Mission Services and those in community, Mission Services and the Housing Up! program were best positioned to take on the role of Intensive Case Management to male participants in the Intensive Supports Pilot.

Each of the aforementioned community organizations that employ the Intensive Case Managers affiliated with the Intensive Supports Pilot have a number of internal programs and supports which can be accessed by program participants. Additionally,

ICMs are able to facilitate necessary referrals to other community supports to address needs related to physical and mental health, legal support, cultural and social connectivity, and more as part of each participant's Coordinated Care Plan and Crisis Plan.



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