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INDWELL: MAKING SUPPORTIVE HOUSING WORK FOR CANADA'S MOST VULNERABLE

FINAL REPORT

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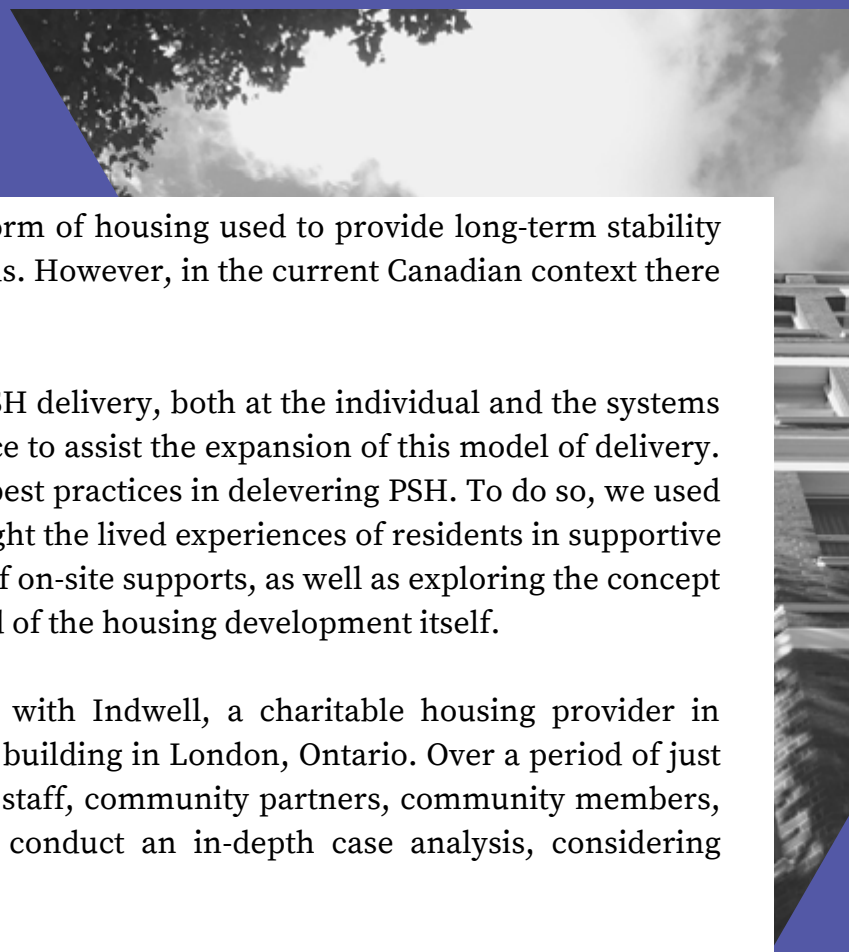
TABLE OF CONTENTS

EXECUTIVE SUMMARY



Permanent supportive housing (PSH) is one form of housing used to provide long-term stability for those facing moderate to high support needs. However, in the current Canadian context there are several challenges to developing new PSH.

In this research we explored the nuances of PSH delivery, both at the individual and the systems level with a goal of providing tools and evidence to assist the expansion of this model of delivery. This includes development of research-based best practices in delevering PSH. To do so, we used both qualitative and quantitative data to highlight the lived experiences of residents in supportive housing, including understanding the impact of on-site supports, as well as exploring the concept of community integration of both residents and of the housing development itself.

This research was conducted in partnership with Indwell, a charitable housing provider in Ontario, and particularly their Woodfield Gate building in London, Ontario. Over a period of just over 2 years we collected data from residents, staff, community partners, community members, and community leaders. This allowed us to conduct an in-depth case analysis, considering Woodfield Gate as a singular case.

In **Phase 1** we focused on what makes PSH work for residents from their perspective. We highlighted the value of readily available supports, the necessity of affordability, and the opportunity to build a community.

In **Phase 2** we focused on the journeys of residents through often life-long housing instability and then into PSH. They spoke about finally being housed, a sense of ownership of their units, and appreciating having the proper supports on-site.

In **Phase 3** we analyzed health and social outcomes and found that residents had reduced behavioural disorders/behavioural health needs and were engaging more in community activities. Qualitatively, we learned that community integration of residents involves keeping goals simple, start with a non-judgmental environment on site, and staff should connect residents with realistic options such as programs offered through other public or charitable organizations.

Overall, we have heard just how fundamental this model is for supporting Canada's most vulnerable persons to find and remain housed. We have heard that as a provider it is a lot of work to find the resources for on-site supports, but these supports are essential to achieve optimal health and housing outcomes. It is our recommendation that both provincial governments and the National Housing Strategy include a more focused funding pathway to expand the PSH model and make it easier for not-for-profit housing providers to also access funding to include on-site supports for residents.

RÉSUMÉ

Les logements permanents avec services de soutien (LPSS) offrent une stabilité à long terme aux personnes ayant des besoins modérés à élevés en matière de soutien. Cependant, dans le contexte canadien actuel, la création de LPSS se bute à plusieurs défis.

Dans cette étude, nous explorons les particularités de la création de LPSS, tant sur le plan individuel que sur le plan des systèmes, dans le but de fournir des outils et des données probantes pour soutenir l'expansion de ce modèle. L'étude comprend l'élaboration de pratiques exemplaires fondées sur la recherche. Nous avons utilisé des données qualitatives et quantitatives pour mettre en évidence les expériences vécues par les résidents des logements avec services de soutien. Nous avons tenté notamment de comprendre l'incidence des services de soutien sur place et examiné le concept d'intégration communautaire des résidents et des ensembles de logements.

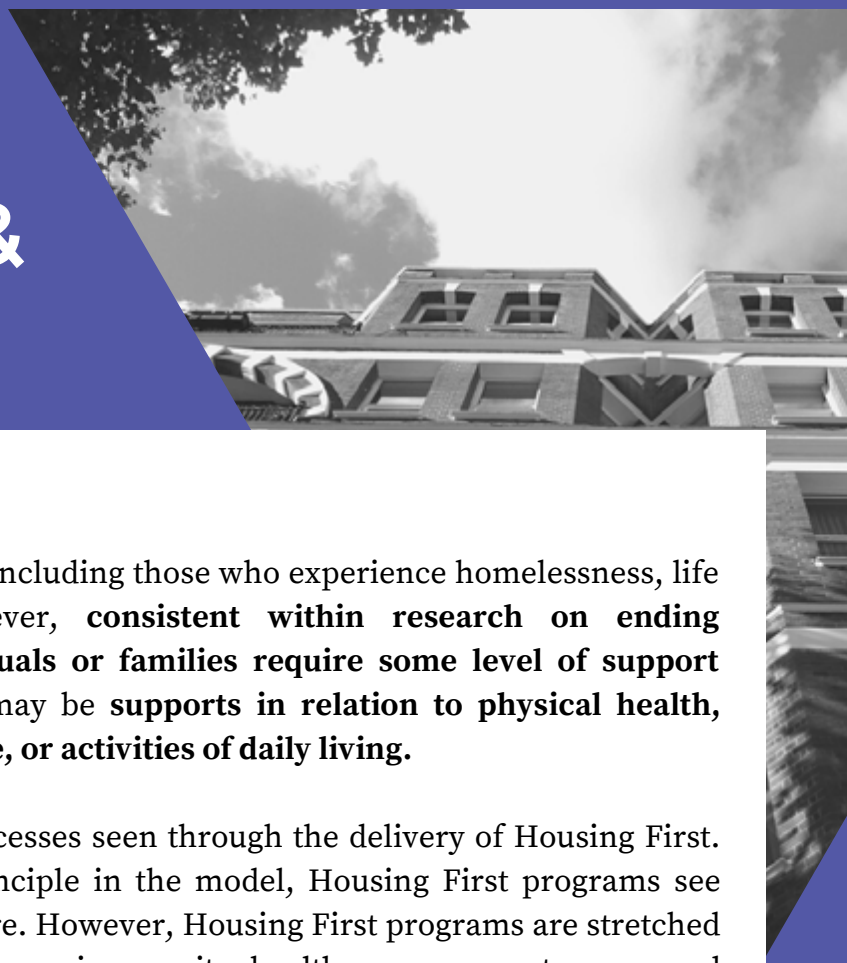
Cette recherche a été menée en partenariat avec Indwell, un fournisseur de logements sans but lucratif de l'Ontario, qui exploite notamment l'immeuble Woodfield Gate à London. Pendant un peu plus de deux ans, nous avons recueilli des données auprès des résidents, du personnel, des partenaires communautaires, des membres de la collectivité et des leaders communautaires. Nous avons pu effectuer une analyse de cas approfondie, en considérant Woodfield Gate comme un cas particulier.

À la phase 1, nous nous sommes concentrés sur ce qui fait que les LPSS sont une solution viable du point de vue des résidents. Nous avons souligné la valeur des services de soutien facilement accessibles, la nécessité de l'abordabilité et la possibilité de bâtir une collectivité.

À la phase 2, nous nous sommes concentrés sur le parcours des résidents, qui ont souvent vécu de l'instabilité en matière de logement avant d'habiter dans des LPSS. Ils ont parlé du fait d'être enfin logés, du sentiment de possession de leur logement et de la reconnaissance de disposer de services de soutien adéquats sur place.

À la phase 3, nous avons analysé les résultats sociaux et liés à la santé. Nous avons constaté que les résidents présentaient des besoins réduits sur le plan des troubles comportementaux et de la santé comportementale, et qu'ils participaient davantage aux activités communautaires. Sur le plan qualitatif, nous avons appris que l'intégration communautaire des résidents implique de se limiter à des objectifs simples. Nous devons commencer par créer un environnement sans jugement. Le personnel doit ensuite offrir aux résidents des options réalistes, comme des programmes offerts par d'autres organismes publics ou de bienfaisance.

Dans l'ensemble, nous avons vu à quel point ce modèle est fondamental et aide les personnes les plus vulnérables au Canada à trouver un logement et à le conserver. Les fournisseurs ont de leur côté beaucoup de travail à faire pour trouver des ressources de soutien sur place. Ces mesures de soutien sont toutefois essentielles pour atteindre des résultats optimaux en matière de santé et de logement. Nous recommandons que les gouvernements provinciaux et la Stratégie nationale sur le logement permettent la mise en place d'une trajectoire de financement plus ciblée pour élargir le modèle des LPSS. Ils devraient également faciliter l'accès des fournisseurs de logements sans but lucratif au financement afin d'inclure des services de soutien sur place pour les résidents.



BACKGROUND & SIGNFICANCE

Background

For those who struggle with housing stability, including those who experience homelessness, life histories are complex and unique. However, **consistent within research on ending homelessness is the fact that many individuals or families require some level of support services to achieve housing stability.** This may be **supports in relation to physical health, mental health, substance use, trauma, culture, or activities of daily living.**

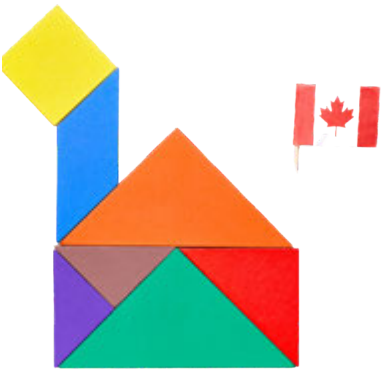
This need for support explains in part the successes seen through the delivery of Housing First. With individualized supports being a key principle in the model, Housing First programs see higher levels of housing stability than usual care. However, Housing First programs are stretched for resources, and in particular those who require on-site health care support may need additional services beyond what a Housing First program offers. Secondly, **community integration is a principle within Housing First that has received the least consideration**. With Housing First program metrics primarily focused on getting people housed or re-housed, housing stability workers are stretched beyond the ability to do significant community integration work other than usual practices of referrals to other community resources.

Therefore, **two key gaps exist in our knowledge of housing stability: How on-site health services impact housing stability for persons recently re-housed; and what community integration really looks like in the lives of vulnerable persons living in supportive housing.**

Overall, this study helps us understand how to create supportive housing to meet the needs of Canada's most vulnerable people, particularly those experiencing chronic homelessness and health or mental health challenges. **This knowledge can assist current or potential supportive housing providers in overcoming the frequent gap of how to include supports in affordable housing developments.** Additionally, the knowledge speaks to how housing providers can seamlessly integrate into local housing and health services. In addition to this systems perspective, the project creates knowledge around resident-level outcomes, particularly in regard to community integration. Housing providers can gain an understanding of best practices to ensure that vulnerable residents in supportive housing environments find a sense of belonging in their building and in their neighbourhood. This interim report focuses on the first phase of the study that highlights how residents are experiencing supportive housing.

Significance

Homelessness is a complex challenge with factors at macro, meso, and micro levels. One notable historical structural change was the cessation of new social housing builds in the 1980s. This led to a measurable increase through the 1990s in both street homelessness and emergency shelters that accelerated through the 1990s and continues today with some limited reprieve from Housing First and from new affordable housing. However, this reprieve has been short-lived with many communities seeing a returning to the increase in homelessness, such as rough sleeping, as affordable market stock has been exhausted by Housing First programs and support services are vastly over-subscribed. In the context of the increased financialization of both land and housing stock, rapidly escalating rents put both market housing and government funded affordable housing out of reach for many exiting homelessness. For those who can make rent work, such as those on Ontario Disability Support Program (ODSP) accessing affordable housing, the other significant limitation is the availability of supports to sustain positive housing tenures.



London, Ontario, like other communities across Canada, is **experiencing a significant crisis through lack of permanent supportive housing options.** The impact of this shortage disproportionately **affects some of our most vulnerable citizens by prolonging shelter use, loss of personal functioning through unnecessary, prolonged institutionalization, and exacerbating street homelessness.** Furthermore, lack of system flow of individuals moving from shelters and institutions into housing creates an unacceptable backlog in our health care and emergency shelter systems. This further exacerbates homelessness by placing vulnerable people in situations where untreated mental health and addiction threatens housing stability.

In other words, **lack of permanent supportive housing resources, and an absence of a plan to implement and replicate these resources, is ultimately creating an exacerbation of chronic homelessness.** As Housing First continues to be implemented, the lack of available housing stock combined with a lack of permanent housing supports is placing limits on who can access housing and for how long. This situation **particularly affects individuals with the most severe impairments, people who need immediate access to mental health and addiction supports.**

This research study provides an opportunity to **tell the story of how integrated health and housing systems can end individual experiences of homelessness** and create system impact that further advances the goal of reducing chronic homelessness.

RESEARCH PROBLEM & QUESTIONS

Research Problem

Supportive and affordable housing providers stand out as an anomaly in a system that prioritizes 'shallow' affordability (such as 80% of average market rent) and capital funding more than operating dollars. In order to **increase supportive housing provision for Canada's most vulnerable** we need a better understanding of how it works. In particular, little is known about the experiences of people with high needs, including health support needs, moving into permanent supportive housing. This report sheds light on such experiences and also addresses the potential impact of the COVID-19 pandemic on these experiences.

Research Questions

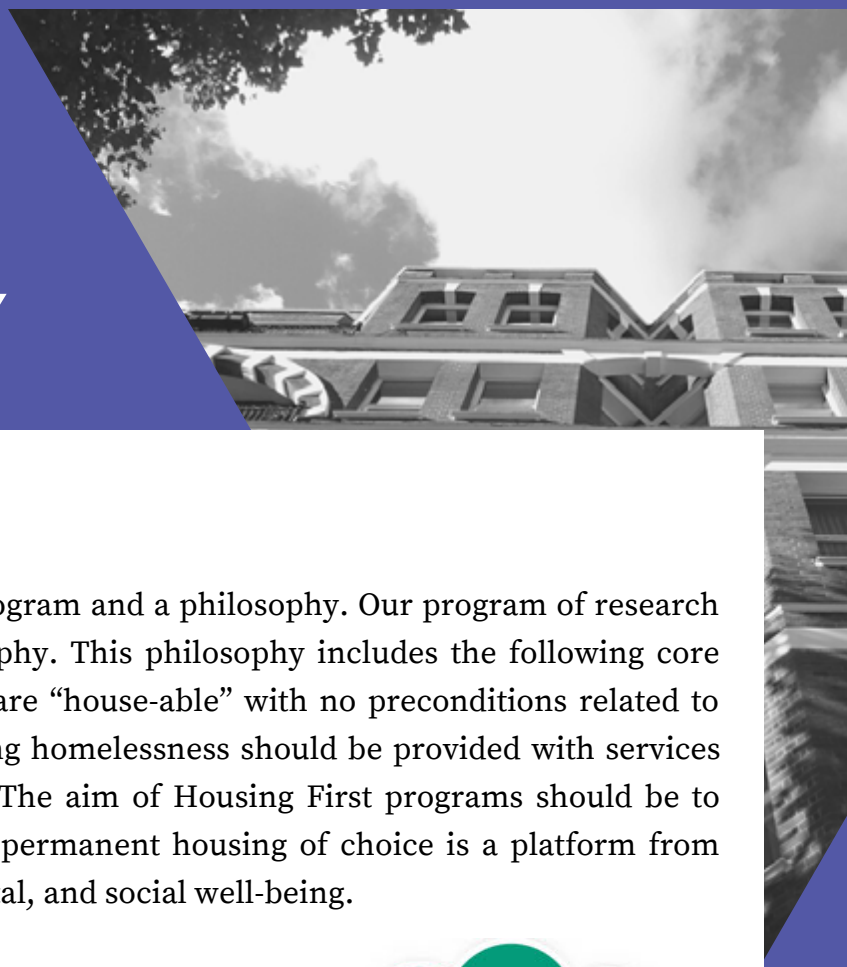
How can we create supportive housing to meet the needs of Canada's most vulnerable people, particularly those experiencing chronic homelessness and health or mental health challenges?

In particular, from the perspective of residents, what makes supportive housing work or not work for them?

What are the particular impacts of COVID-19 related to living in supportive housing?

What is the impact of access to on-site supports in terms of housing stability and community integration for residents?

THEORETICAL PERSPECTIVE & METHODOLOGY



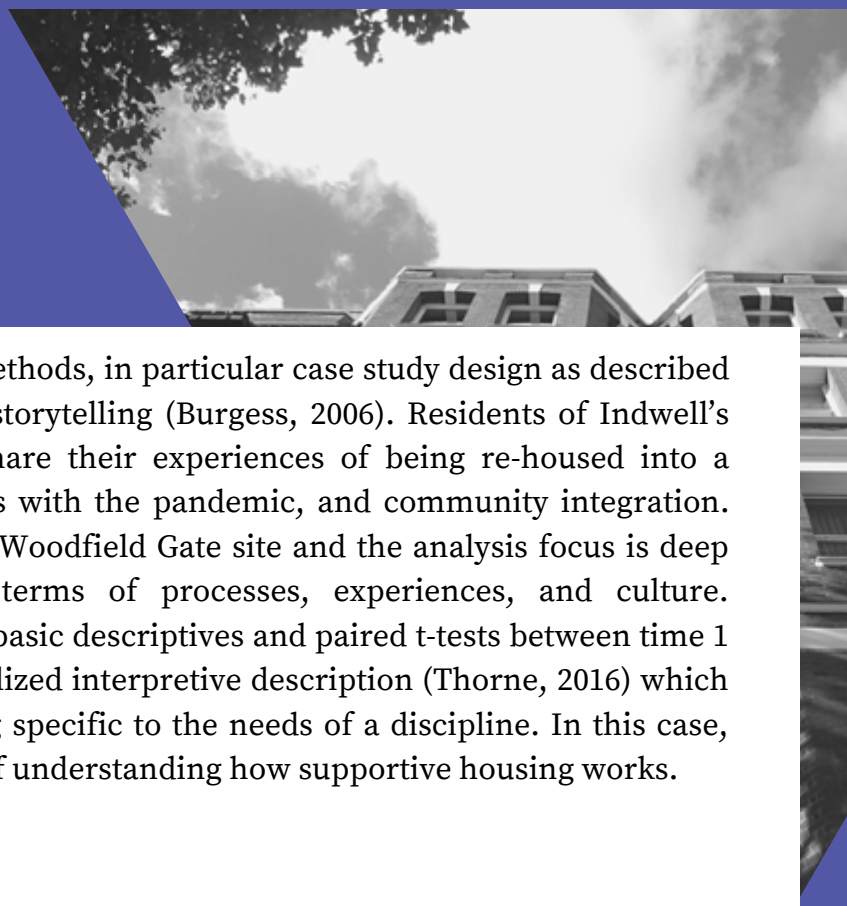
Theoretical Perspective

Housing First has been described as both a program and a philosophy. Our program of research is underpinned by Housing First as a philosophy. This philosophy includes the following core elements (Goering et al., 2011): 1) All people are "house-able" with no preconditions related to wellness to be successful; 2) Individuals leaving homelessness should be provided with services that are tailored to their individual needs; 3) The aim of Housing First programs should be to target community integration; and 4) Stable, permanent housing of choice is a platform from which people can enhance their physical, mental, and social well-being.

Image obtained from: Goering et al., 2014

Methodology

This project follows a community-based participatory action research (CBPAR) methodology (Minkler & Wallerstein, 2009). Western researchers, Indwell staff, and interested residents are working collaboratively through the project. During project inception, pandemic restrictions limited participant engagement. With the easing of pandemic restrictions, residents were engaged more in crafting project deliverables (e.g., video narratives). In this way, while exploring community integration, the project itself fosters integration and capacity building.



METHODS

This study uses quantitative and qualitative methods, in particular case study design as described by Merriam (2009) and supported by digital storytelling (Burgess, 2006). Residents of Indwell's Woodfield Gate site have been invited to share their experiences of being re-housed into a supportive housing environment, experiences with the pandemic, and community integration. The 'case' in this study is a single case of the Woodfield Gate site and the analysis focus is deep immersion in understanding this site in terms of processes, experiences, and culture. Quantitative survey data were analyzed using basic descriptives and paired t-tests between time 1 and time 2. To analyze qualitative data, we utilized interpretive description (Thorne, 2016) which is a method designed to create understanding specific to the needs of a discipline. In this case, the disciplinary need being addressed is that of understanding how supportive housing works.

Recruitment and Setting

Participant recruitment began during project inception with a community meeting at the site, in the common courtyard, where details on the project were shared along with food and a discussion. This allowed researchers to connect with residents and included a sign-up list for individuals interested in phase 1 interviews. Recruitment was open to all adult residents of Woodfield Gate. Compensation was provided to reduce the likelihood that only those with postivie things to say or those with current complaints would participate. During each subsequent phase of the research, research assistants did on-site recruitment with residents and a sign-up sheet was available in the on-site staff office. Indwell staff and leaders, as well as community members and partners were recruited via e-mail.

The Woodfield Gate site provides two levels of support, standard support and additional (enhanced) supports. Support services are tailored toward individual needs, identified through an intake assessment process. Enhanced support services range from medication distribution, a daily hot meal, to addiction and recovery support. Services are administered by an interdisciplinary staffing compliment, available on-site 7 days a week. Programs and services are intended to foster a sense of community where everyone can strive to achieve health, wellness and belonging.

Image obtained from: Indwell

Data Collection

Over the duration of this project data collection took place from September 2020- November 2022 in three phases outlined below.

Phase 1: What Makes Supportive Housing Work

Data collection in phase 1 of the research (September 2020- March 2021) involved in-depth interviews with residents (n= 20), Indwell leaders (n= 4), and Woodfield Gate staff (n= 4). The interview guide for Woodfield Gate resident participants is provided in Appendix A. Two members of the research team (V.E. & M.C.) shared interviewing duties for residents and interviews were conducted in a common room that allowed sufficient physical distancing. Leader and staff interviews were completed virtually with two members of the research team (A.V. & Y.A.). All interviews were audio-recorded and Woodfield Gate resident participants were provided $20 compensation for their time.

Phase 2: Digital Narratives

The second phase of data collection (August- September 2021) involved qualitative interviews in the form of short (approx. 5 minute) video narratives with seven residents (n= 5; 2 withdrew). An interview guide is provided in Appendix B. Graduate students were trained in video narrative interviewing and shared interviewing duties (Y.A., S.H., A.K., P.C., & E.C.). A trauma-informed research approach (Jefferson, et al 2019) was utilized in narrative developing, centring control with participants around which parts of their stories they choose to share, as well as what parts make it into the final form of the narrative. Interviews were video recorded and participants were provided with $20/ hour compensation for their time. During phase 2 of the research, students also completed the Global Appraisal of Individual Needs-Short Screener (GAIN-SS) (time 1: September 2021; n= 51) survey with Woodfield Gate residents. Surveys were completed at the Woodfield Gate site in a confidential setting and participants were compensated $10 for survey completion.

Phase 3: Effectively Integrating Affordable Housing into Neighbourhoods

The third phase of data collection (June- November 2022) involved qualitative interviews with Woodfield Gate staff (n= 7), a housing administrator (n= 1), community service partners (n= 6), and community members who live/work near Woodfield Gate (n= 3). An example of an interview guide (i.e., community partners & housing administrator(s)) is provided in Appendix C. Interviews were completed with two members of the research team (A.V. & A.K.), either through a virtual platform (e.g., Zoom), or in a community space that allowed for confidentiality. Interviews were audio-recorded and community participants were offered $20 compensation for their time.

The third phase of data collection also included completion of the Community Integration Scale (CIS) (time 1: June 2022; n= 51); GAIN-SS (time 2: November 2022; n= 49) and CIS (time 2: November 2022; n= 49) with Woodfield Gate residents. Surveys were completed at the Woodfield Gate site in a confidential setting with a member of the research team (A.K.). Participants were compensated $10 for each survey completed.

Data Analysis

Phase 1: What Makes Supportive Housing Work

Qualitative analysis of interviews followed Thorne's interpretive description (2016) whereby our pre-identified disciplinary focus on making supportive housing work for Canada's most vulnerable guided the analysis. The research questions were practical questions and therefore rather than open coding, data was coded to segments that specifically provided answers to these questions. Preliminary coding was shared by two members of the research team (Y.A. & A.V.). From these codes, general themes were proposed by the study lead (A.O.) that addressed how supportive housing is or is not working for residents. In addition to what makes supportive housing work, data was also noted around where participants are struggling and any particular impacts of the COVID-19 pandemic. These themes were assessed and revised by the full research team. Accompanying the Woodfield Gate resident analysis, Thorne's interpretive description (2016) was utilized to analyze qualitative data from Indwell leaders and Woodfield Gate staff (A.V. & A.O.) and themes were identified to guide key best practices for building supportive housing in Canada.

Phase 2: Digital Narratives

Digital storytelling (Burgess, 2006) in the form of video narratives supported interested residents in telling their stories as cases, and followed a qualitative case study design (Merriam, 2009). Stories had three main narrative moments: prior to being re-housed at Woodfield Gate, the transition period of moving in, and stability experiences in Woodfield Gate. Members of the research team (Y.A., S.H., A.K., P.C., & E.C.) utilized a storyboard technique to outline video content based on the three narrative moments, and a hired student (S.B.) curated the final videos. All videos underwent member checking with the participants and two students (S.B. & S.H.), at which time one participant was unreachable and one participant withdrew their video narrative from the study.

Phase 3: Effectively Integrating Affordable Housing into Neighbourhoods

Qualitative analysis of interviews followed Thorne's interpretive description (2016) whereby our pre-identified focus on community integration guided the analysis. The research questions were practical questions and therefore rather than open coding, data was reviewed and key quotes extracted to provide answers to these questions. The data review was shared by two members of the research team (A.K. & A.O.). General themes regarding community integration were identified and included as key aspects of what makes supportive housing work in Canada.

Quantitative survey data were analysed using basic descriptives and paired t-tests between time 1 and time 2 data collection.

Ethical Considerations

Ethics approval was granted through Western University's Research Ethics Board (protocol #116262). Informed consent was obtained from all participants. All participants have been assured anonymity and pseudonyms are used for participant quotes with the exception of video narratives in which participants had the option to utilize their real name or a pseudonym.

Participants

Phase 1:

It is noted that many of the Woodfield Gate residents have long histories of housing precarity including homelessness and hospitalization, many are very familiar with just how hard it is to find anything affordable (let alone with supports). Participants have complex histories of trauma and very much meet the Canada Mortgage and Housing Corporation (CMHC) criteria of "Canada's most vulnerable" (Government of Canada, 2017). While their personal perspectives on their mental health and substance use challenges vary, it has been our observation that participants range from moderate to high-support needs with a significant number at the higher support end meaning they have barriers to independence without supports.

Woodfield Gate residents were asked several demographic questions based on personal characteristics, experiences of homelessness, income source, and health (Appendix D). Of the 20 participants, seven identified as female, nine as male, one as transgender, and three preferred not to answer. There was a relatively equal complement of those who are young adults (26-40 years) and middle aged (41-64 years), with only one participant over the age of 65 years, and two participants choosing not to answer. The vast majority of participants preferred not to share their primary racial or ethnic group, but of those who did, the majority were Caucasian. Six participants choose not to disclose the number of times they experienced homelessness, five participants reported none, and the majority of other's had experienced homelessness between 1-3 times. The majority of participants had lived in London for greater than 10 years and were supported financially by Ontario Disability Support Program (ODSP), four with employment supplements. A handful of participants chose not to share about their health, but of those who did, many identified as having mental health challenges, fewer with physical health concerns, and fewer yet with substance use issues.

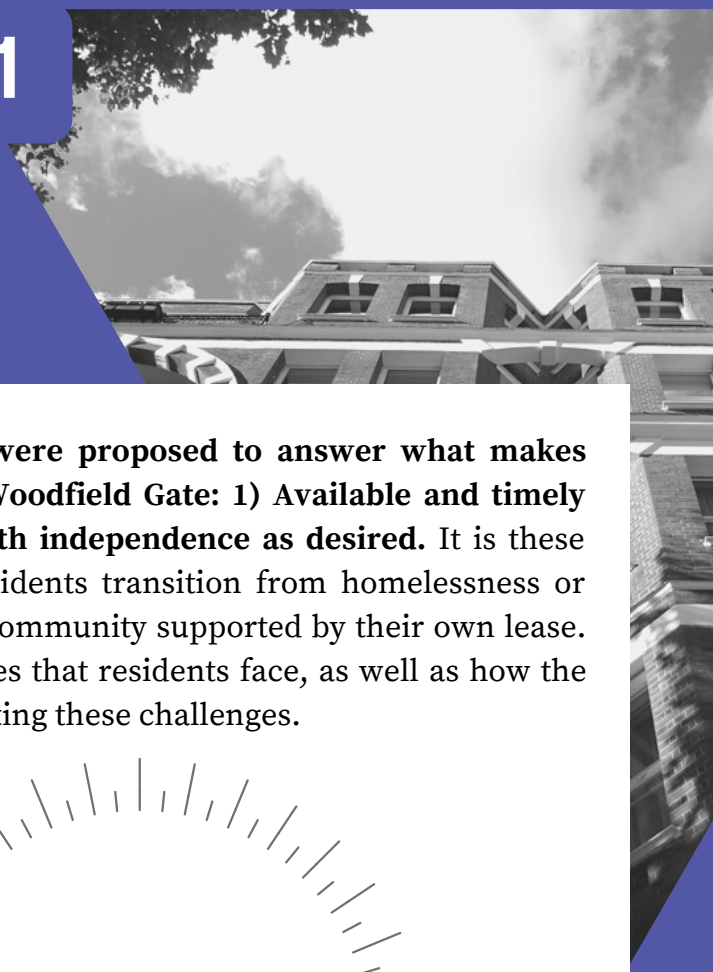
Indwell leaders and Woodfield Gate staff were also asked a brief set of demographic questions (Appendix E). Of the eight participants, three identified as male, and five identified as female. All staff participants identified as white (Caucasian), apart from one who did not respond. The majority of participants (n= 6) were within 41-64 years of age, and two were within 26-40 years of age. Two participants had less than five years of experience working in supportive housing, three had 5-10 years, two had 10-20 years, and one had greater than 20 years.

Phase 2: Through their stories, it was notable that participants in the video narratives tended to be those who were relatively long-term residents of Indwell's Woodfield Gate and those who are relatively stably housed therein. That said, some participants shared stories of conflicts with staff and/or other residents. Participants shared stories that paralleled the challenges heard in phase 1 of this project and congruent with other research on housing loss, including histories of trauma, job loss, relationship breakdown, mental illness, and substance use. One participant was a person of colour. One of the five participants was male. Two of the participants identified as lesbian.

Phase 3: A total of 17 participants made up of Woodfield Gate staff, community members, community partners, and a housing administrator were interviewed during Phase 3 data collection (Appendix F). Thirteen participants identified as female, three identified as male, and one identified as other. The majority of participants (n= 9) were between the ages of 41-64 years old, while five were between the age of 26-40 years and three were between 18-25 years old. One participant identified as Latin American, one participant identified as African decent and all other participants (n= 15) identified as white (Caucasian). Of the Woodfield Gate staff (n= 7), five had less than five years of supportive housing work experience, and two had between five and ten years.

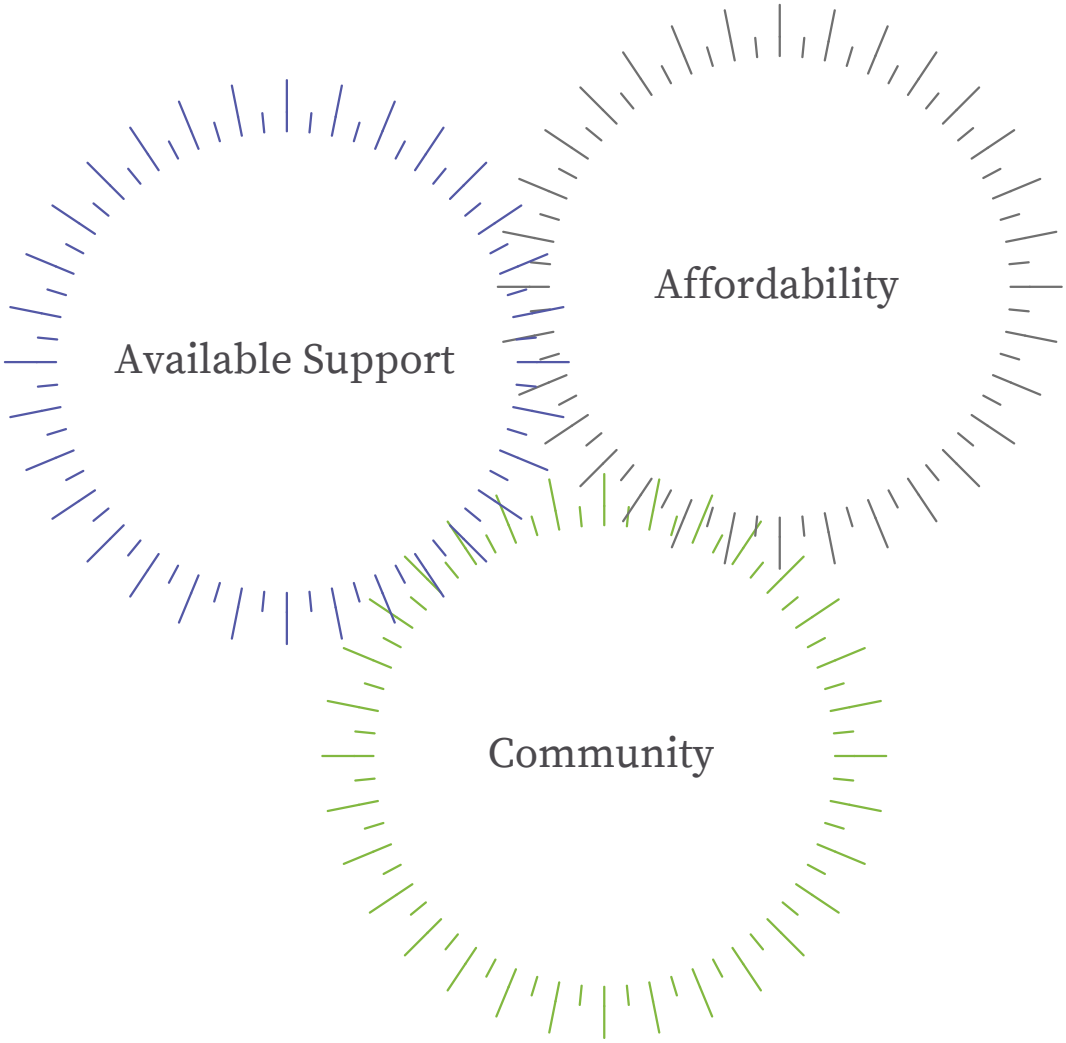
Community partners, community members, and a housing administrator were asked about any past of current experiences of poverty. Three participants reported that they have had a lifetime experience of poverty, and seven reported that they have not. This same participant group was asked whether or not they had donated time or money to housing or mental health services, in which all participants reported having done so.

FINDINGS: PHASE 1



WHAT MAKES SUPPORTIVE HOUSING WORK

Through the analysis, **three interconnected themes were proposed to answer what makes supportive housing work for residents at Indwell's Woodfield Gate: 1) Available and timely supports; 2) Affordability; and 3) Community, but with independence as desired.** It is these three interconnected components that are helping residents transition from homelessness or long-term mental health inpatient care to living in the community supported by their own lease. At the same time, we have noted a number of challenges that residents face, as well as how the pandemic serves as a sort of "pressure cooker" accentuating these challenges.



Available and Timely Supports

For residents/participants living with mental health and addiction challenges, rapid access to supports as illness progresses or crisis occurs is a very well-established best practice. Early intervention decreases the level of crisis, prevents hospitalization, and supports individuals to maintain their recovery plan. The timeliness of support is more challenging if supports are off-site, non-existent, or only available through hospital emergency services. **Supportive housing with on-site support therefore provides better options to sustain resident well-being in a timely manner.** Participants spoke to the therapeutic nature of staff being available for constant supportive interactions:

> "Even just one staff that's dedicated to being able to do conversations with people all day, every day, for issues like being able to talk to somebody. Just chatting with them, discussing issues, discussing health benefits and stuff like that. Having that type of interaction with somebody, it's really helpful, because when you're not able to get that interaction with somebody, being able to sit there and chat with somebody, can really put a strain on your life. It can make you fall into a deeper hole." – Gary

Indwell staff are often able to respond in a timely and effective manner to meet needs as they arise and prioritize responding to crises. With professional mental health support, they are able to triage more urgent health needs and distinguish between supportive care. A participant spoke to crisis response:

> "My assistance from everything else is pretty much there all the time. Whenever I need the staff I run downstairs, "This one". Like someone was on the floor one day, I'm like I didn't know if it was a dead person, it's like there was an old person on the second floor so I'm going to call…and they came and got him right away, but he was – an ambulance came and, yeah, he was fine. They're there pretty quick." – Tim

Due to some participants having lived long-term in mental health inpatient care, there was a degree of institutionalization noted in terms of several participants having expectations of staff to be available at all hours for basic conversational support. While it was noted that staff did not always address these lower priority needs, they still attended to them as they were able:

> "I'm glad that there are people around here that I can just phone or talk to, or like, order – that help me with basically anything I need or assist me the best they can to help me. So it's better than where I was when I was in an apartment and if there was an issue or something that I needed help with, you know, I was on my own and I had to ask my family, oh, what do you think, or what is this, or whatever. And you know, if they didn't know, then I was literally on my own." –Karen

Affordability

As noted in the description of participants, most had lived for many years in poverty and are very familiar with the financial challenges of making rent work on low incomes including Ontario Works (OW) or ODSP. Giving the high support needs, limited incomes, and poor rental histories of many participants, having units that include support at a rate within reach on ODSP is vital to making this housing work as an exit from homelessness or from hospital. Many participants had histories of repeated housing loss prior to intake at Indwell due to difficult relationships with landlords or other residents, insufficient support including mental health crises, being victims of violence or other predatory behaviours, and limited capacity to fulfill tenant responsibilities.

Given the desperate state of housing costs, the rental rate alone was an appeal to most residents regardless of the support/community aspects as options for affordable housing are so truly limited. For residents who self-referred, this aspect was what stood out the most and attracted them to Woodfield Gate in the first place. Whether supports were required or not, so few other housing options in London are available at social assistance rates:

> "Well [I was] looking for accommodations connected to my disability, so I came up with a list of accommodations that support me in housing and financial support is one of the pillars. So I'm on ODSP and my ODSP there's only so much for housing and Indwell accommodates that and provides housing for the amount that I get off ODSP…. Then I think they match the rest of the amount for the apartment, so there's a donation or a charitable donation given to the cost of the apartment. So I'm able to afford it, so affordable is primary." –Jane

Notably, **affordability does not come at the cost of quality** as happens with other room rentals in the city. It is a new building with a quality of design and finishes equivalent to private sector rentals:

> "The day I first moved in here, big apartment, it was my dream home because I never had an apartment like the one I got right now in my entire life. That's the best one I had so far. And Indwell is very – it's a beautiful building and a wonderful building, it's a nice layout." –Laura

Community- but with Independence

The third interconnected factor making supportive housing work for participants is the **intentional creation of community within their residence.** As noted above, some of this involves staff who are able to provide relational support when other more urgent needs aren't occupying their time:

> "They've got the staff here and the support of them. So if ever I needed to talk to anyone, I can just talk to them and that kind of works out." –Tracy

Beyond that, however, Indwell as an organization and within its core mission prioritizes creating community which includes helping residents get connected to each other and out of their apartments. While much of these efforts have been stymied in the context of the COVID-19 pandemic, residents who have been there since before the pandemic are indeed finding quality friendships with neighbours:

> "And just having like … just having friends in the building that we could kind of still self-isolate with or isolate with, not in a perfect way, but in a, we still need, like I need to be around people for mental health. So, I don't think I, unless I had Indwell and I had like community online, I don't think I made, would've made it through the pandemic without like a hospitalisation." –Malibu

Many of the participants faced barriers to accessing technology, whether due to cost or internet literacy, which created a challenge as most of the world shifted online during the global pandemic. However, where residents have barriers to finding belonging through technology, they are able to find it here in person:

> "So the supports from the tenants were amazing. And then like they're still amazing, I still have friends here who are my highest cheerleaders--Carole, Jorge, just to name a few, that are all my cheerleaders." –Cassie

At the same time that community is an option for residents, they still have the privacy of their own space, their own key, and choices about participating in community events. Therefore, these **social supports do not come at the cost of independence** that was so vital to participants, most of whom are exiting congregate living environments. There's autonomy and control in deciding when to connect and when to seek privacy. Community is there but it's not forced as it might be in group home environments or even transitional units that are very regularly inspected. Overall, this community aspect is healing:

> "Living at Indwell is teaching me to do things and is teaching me and taught me how to get along with better people, be better people and trust people and let people do and say what they want." –Goj

Where they Struggle

While the mix of timely support, affordability, and community was creating positive housing outcomes for participants and other residents, the environment was not without its challenges.

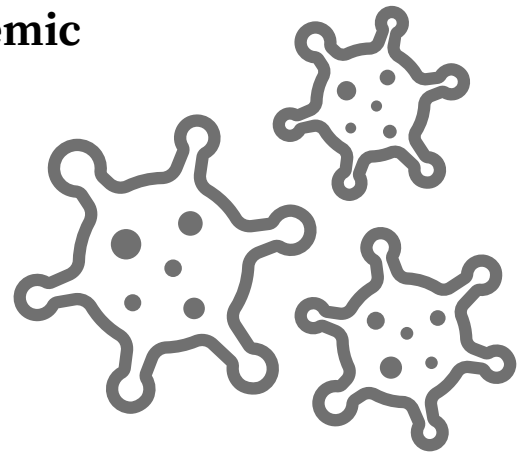
Residents shared the following three concerns:

1. **Mixed acuity creates tensions about 'who the space is for'** and the frequency of resident conflicts is a concern. Residents with less urgent mental health challenges expressed frustrations with those whose crises included disturbing the more general order of the building. Some noted that they hadn't expected so many people with high needs living in one building. At the same time, those with higher support needs at times felt discriminated against and that complaints were being leveled against them unfairly. All participants tended to see staff as responsible for solving conflicts whereas staff tried to support residents to learn their own conflict resolution skills.

2. **Staff availability for lesser urgent issues can be limited** and is a challenge for those who seek social support more from staff than from neighbours. The building does not offer 24/7 support with the same staff compliment that residents might be used to in emergency shelters or long-term mental health inpatient care. Due to experiences of institutionalization, some participants had very high expectations of staff providing constant social support and being a phone call away at all hours of the day (and night). Again, staff were trying to support residents to find more independent ways to address their concerns, but there were also examples provided by participants of potentially missed de-escalation that might be done with more staff resources.

3. While units are affordable compared to the private market, rent still consumes more than 50% of income for those paying for support services if they are a single adult on ODSP. Those paying the base rent rate of $500 are still in core housing need (shelter > 30% of income) on an ODSP income of $1,200. Participants noted the tension that they were both thankful to finally afford something while at the same time dismayed that rent consumed most of their monthly income and left them still living in fairly deep poverty. Rents are also out of reach of those on a single OW income, therefore limiting options for some who were seeking to exit from shelter or absolute homelessness. This is in the context of an organization that was accessing every resource available to **develop supportive housing as deeply affordable as financially feasible.**

Impact of the Pandemic



Participants spoke readily to the impact of the pandemic on their lives more generally and how this related to their experiences of living in supportive housing. Essentially, the pandemic has been serving as a sort of "pressure cooker", accentuating each of the challenges faced by residents of Woodfield Gate.

The three most noted challenges are:

1. For a population already at risk of isolation **the pandemic has deepened social exclusion by limiting options for structured on-site community building.** An organization dedicated to bringing residents together and building natural supports found itself encouraging residents to appropriately physically distance and isolate when required.

2. Much of the service world going online has **intensified barriers to online access** faced by many residents. For those with lower technology access than the general public, while also facing higher social services support needs, this meant risks to meeting basic necessities around food and health care. Staff found themselves much more frequently needed to assist people in connecting with other services and supporting basic technology access and use.

3. **Resident conflicts have intensified around particular aspects of pandemic guidelines in shared living environments.** Where resident conflicts were already a noted concern of residents, having to share common spaces in the context of the pandemic rules and many individuals with limited self-care capacity created an environment ripe for struggle. While interpersonal contact has reduced, resident conflicts remain a concern with many related to proper pandemic protocols.

Recommendations for how to Build Supportive Housing in Canada

1. Employ a values based approach
2. Have engaged, knowledgable, dedicated, hopeful and flexible leadership
3. Guidance of lived experts
4. Navigate complex funding
5. Focus on housing affordability
6. Involve community participation in project development
7. Support tenancy
8. Create healthy living environments
9. Provide sustainable and professional services
10. Consistent innovation
11. Supporting & Prioritizing Community Integration

These recommendations were developed into a best practices guideline:

Best Practice Guideline: How to Build Supportive Housing in Canada

The guideline is available at:
https://assets.cmhc-schl.gc.ca/sf/project/archive/publications/nhs/research_and_planning_fund_program/intructional-guide-2-003.pdf

This best practice guideline is intended to help all individuals and organizations who are involved in supportive housing and related systems/services to develop effective, permanent supportive housing. Based on a research study aiming to understand how to create supportive housing to meet the needs of Canada's most vulnerable people, this best practice guideline provides depth and detail from a single case study analysis of a successful permanent housing site in London, Ontario, Canada.

Best Practice Overview

Housing is a human right, social determinant of health, and anchor for personal stability (Suttor, 2015). For some of Canada's most vulnerable, housing stability is not achieved without on-site support. Utilizing best practices to create permanent, supportive housing helps to address the call for unique and comprehensive approaches to ending homelessness.

What:

Overcoming barriers:

- Navigate complex funding
- Create affordable housing
- Consistent innovation

Who:

Right people and the right partners:

- Dedicated direct support staff & leadership
- Lived experts
- Community involvement
- Values based approach

Why:

Ending homelessness for Canada's most vulnerable:

- Support tenancy
- Healthy living environments
- Community integration
- Professional, on-site services

"We end homelessness, one person at a time."

-Thomas, Indwell leader

FINDINGS: PHASE 2

DIGITAL NARRATIVES

The stories of residents at Woodfield Gate added context for us to understand the lived experiences of leaving homelessness or institutionalization and finding a permanent home.

The full report with links to the narratives is available at:

https://assets.cmhc-schl.gc.ca/sf/project/archive/publications/nhs/research_and_planning_fund_program/indwell-video-narratives---nhs-research---nov-17-2021.pdf

In brief, here are the stories they shared with us:

Paul

Paul shared with us a long history of alcoholism and housing instability. This included couch surfing with family members and regular use of emergency shelters. Paul's history was a difficult one with conflicts, frustrations, and many failed attempts to maintain his goal of sobriety. Coming into supportive housing has been a highlight for him. He views Indwell as finally having a place to live permanently and a place where staff will also understand and assist him related to his alcohol use. For Paul, he is optimistic that supportive housing is the end to his chronic and episodic experiences of homelessness.

Sharon

Sharon lived with her mother and has had some challenges with looking after herself. When her mother aged into a home, her sister helped her into hospital out of concern. From there, she had nowhere to move to in order to be discharged from the hospital. Through the hospital, she was able to find Indwell as a permanent supportive housing option. Sharon has made friends at Indwell and considers it home.

Digital Narratives

Brenda

Brenda grew up in Canada's east coast and lived a precarious life of low-income labour and affordable housing environments. She came to London to marry a woman she met online and lives with her now at Indwell. Brenda values her independence and wants to find stable employment in London. She uses the mental health support services and values how this helps her. However, she is also honest about her struggles in terms of living in a shared environment and some conflicts with other residents. Her goal is to move to Indwell's other site currently in progress because it will have a cafe and she wants to work there.

Cathy

Cathy grew up in the foster system in lived in a group home followed by a rooming home. After some difficulties with housing she wound up in emergency shelter. She was able to stay with a friend after that before being accepted into Indwell. Indwell has been important do her because of her physical disabilities, including current use of a power chair. It was a staff member who noticed her worsening condition and connected her with surgical care that she believes saved her life. Cathy engages in as many social activities on site as she can. This has given her social supports that she hasn't felt she has had before.

Laurie-Ann

Laurie-Ann has had a long history of living in a variety of challenging housing environments including social housing. She uses a power chair and is on a low, fixed income. Because of this, Indwell provided her a great option both in terms of accessibility and affordability. She sees the poverty around her and tries to help out as much as she can, and wishes there were more affordable, supportive options available for everyone. Sharing the apartment with her partner, she is hoping to get into a newer Indwell building that offers her a bit more space and accessibility.

Digital Narratives - Discussion

Three key themes are present in the stories of residents:

FINALLY **OWNERSHIP** **RIGHT SUPPORTS**

Finally

All residents had complex housing histories that included various forms of instability from being under-housed, to being homeless, to living in precarity. Most had also lived in the majority of other forms of housing or accommodation available such as social housing, shelter, transitional housing, and various forms of institutionalization such as hospitalization or incarceration. Many of these forms of accommodation are notably temporary so while they might provide some level of affordability (e.g. social housing) or support (e.g. hospitalization), they are not perceived by residents as the desired form of housing.

In this way, finding permanent supportive housing was perceived by most residents as the end of an excruciating journey of housing instability. There was a noted tone on the stories of residents that this place was the pinnacle of housing achievement for themselves. Several explicitly stated that they anticipated remaining in their current unit for life.

Ownership

While participants appreciated several aspects of their permanent supportive units, such as quality materials, good staff, and an accessible location, a transformative component was being the leaseholder on the unit. Residents felt a sense of ownership of their space, which was new to several participants and for others had not been experienced for many years. As opposed to other forms of emergency or transitional accommodations, as the leaseholder residents had the right to make the space their own. As noted above, with many anticipating remaining in these units for life, they were actualizing this sense of ownership in many ways to enhance their sense of comfort and belonging. While not ownership in the traditional sense of a purchased condo unit, the differential in moving from institutionalization to having one's own lease was fundamental and noted by all participants in some form.

The Right Supports

This finding is noted in all aspects of our study but was repeated here as well. Participants in the video storytelling noted how having supports, even as simple as access to daily food, were fundamental to sustaining their housing over the long-term, and hopefully indefinitely.

FINDINGS: PHASE 3

EFFECTIVELY INTEGRATING AFFORDABLE HOUSING INTO NEIGHBOURHOODS

The third phase of the study included analysis of the quantitative data measuring health and wellbeing outcomes over time. This data is presented first, prior exploring the qualitative findings regarding effectively integrating affordable housing, and residents of affordable housing, into neighbourhoods.

Two tools were used and data was collected over two time periods with (n= 49) forty-nine residents completing the GAIN-SS and (n= 51) fifty-one residents completing the CIS. For the GAIN-SS, Time 1 data were collected in August of 2021 and Time 2 data were collected in November of 2022, meaning a period of 15 months between data points. For the CIS, Time 1 data were collected in June of 2022 and Time 2 in November of 2022, for a 5 month data period. It was nearly a fully matched sample with only 5 new participants completing in Time 2.

GAIN-SS

The first tool is the Global Appraisal of Individual Needs - Short Screener (GAIN-SS) which is a 24-item tool to assess for the presence of behavioural disorders across 4 domains. These are: 1) Internalizing disorders - somatic complaints, depression, etc. 2) Externalizing disorders - impulsivity, conduct problems, etc. 3) Substance disorder 4) Crime/violence. Each is measured on how recently symptoms have occurred, and then symptoms as recent as within the past year are tallied to give a score of low (0), moderate (1-2), or high (3+). This tool is helpful both for identifying those who may need support as well as observing changes in symptomology over time. These are the results on the GAIN-SS:

GAIN-SS	Internalizing Disorder	Externalizing Disorder	Substance Disorder	Crime/Violence
Time 1	High - 36 Moderate - 8 Low - 5	High - 22 Moderate - 13 Low - 14	High - 17 Moderate - 14 Low - 18	High - 2 Moderate - 13 Low - 34
Time 2	High - 27 Moderate - 17 Low - 5	High - 9 Moderate - 26 Low - 14	High - 7 Moderate - 22 Low - 20	High - 0 Moderate - 5 Low 44

Phase 3 - GAIN-SS

Improvements on all 4 domains of the GAIN-SS are significant and striking.

For internalizing disorders, 9 participants dropped from high to moderate.

For externalizing disorders, 13 participants dropped from high to moderate.

For Substance use, 10 participants dropped from high to moderate and 2 from moderate to low.

For crime, 2 participants dropped from high to moderate and 10 from moderate to low.

These outcomes exceeded our expectations for improvements on behavioural disorders and symptomology given that most participants had experienced housing precarity for many years, up to decades and their whole lives. These individuals came to Indwell - Woodfield Gate due to high support needs which included major mental illnesses and substance use disorders. While other Housing First studies to-date show no increases in symptoms and reduction in service utilization, in this case we have clear reduction in symptoms across all domains.

Therefore, we are confident in making the following claim:

PERMANENT SUPPORTIVE HOUSING IS AN EFFECTIVE INTERVENTION FOR REDUCING BEHAVIOURAL DISORDERS AND MEETING BEHAVIOURAL HEALTH NEEDS

Phase 3 - CIS

Community Integration Scale

The second tool used was the Community Integration Scale for Adults with Psychiatric Disorders (CIS) (Cabral et al, 2014), in particular the 11 items of the Physical and Psychological Integration domains. This tool assesses dimensions of community integration for persons living with psychiatric disorders for the purpose of supporting individuals to live within a recovery-focused model of care. The Physical Integration component uses a 7-item binary scale to identify external places/activities an individual has attended within the past month. The Psychological Integration component uses a 4-item, 5-point likert scale to assess a sense of belonging.

For Physical Integration, we saw participants engaging in significantly more activities in the previous month in Time 2, including an overall average increase from 2.1 to 2.5. We note that this is in the context of Time 1 being summer and Time 2 being winter, likely suppressing Time 2 outcomes to an extent. The columns represent how many out of 51 participants did each activity once or more in the past month. Using a paired t-test, this increase in physical integration was statistically significant ($t(6)=4.04$, SED=0.57, $p = 0.0068$).

CIS - Physical Integration	Time 1	Time 2
Attended a movie or concert	4	6
Participated in sports/recreation	18	18
Met people at a restaurant/coffee shop	25	29
Participated in a community event	16	18
Went to a place of worship	16	19
Participated in a volunteer activity	12	13
Went to a library	17	21
Average different activities attended by all participants	2.1	2.5

Phase 3 - CIS

For Psychological Integration, mean scores for Time 1 were 15.78 and mean scores for Time 2 were 15.06. Using a paired t-test, this drop in psychological integration was not statistically significant ($t(48)=1.44$, SED=0.51, $p=0.16$). Therefore, we note no statistically significant change in Psychological Integration over the 5-month period.

Limitations

As noted above, for both tools Time 1 occurred in the summer whereas Time 2 occurred in the late fall. It is possible that seasonal effective impacts might have suppressed CIS-Psychological Integration scores on top of Physical Integration scores. However, there was still a noted increase in Physical Integration. It is also possible that there is a lagged effect between increased Physical Integration and increased Psychological Integration. That is, it might take time between increasing one's activities and positive psychological effects. This could be tested through adding subsequent time periods over several years. The short 5-month window between Time 1 and Time 2 for the CIS was also a limitation.

Overall, from the CIS we can conclude:

PERMANENT SUPPORTIVE HOUSING IS AN EFFECTIVE INTERVENTION FOR ENGAGING RESIDENTS IN MORE COMMUNITY ACTIVITIES

Phase 3 - Qualitative

Community integration remains the "final frontier" of Housing First, that is the foundational principle which is least explored to-date. While housing stability is the priority measurement outcome for Housing First success, and resources are prioritized to housing finding first and housing stability second, few surfaces have the staffing power required to work with people consistently to help them finding integration and belonging within their buildings and their neighbourhoods.

Permanent supportive housing provides a unique platform for building integration in that staff are located on-site, in the building where participants live, and can therefore hypothetically provide more long-term focused support around belonging, including expanding community participation, building social relationships, and just generally encouraging residents to get out of their units and into the community. As noted in the data above, Indwell's Woodfield Gate site has been successful in increasing engagement in community activities.

Qualitative interviews with staff, leaders, and community members allowed us to explore in further details what exactly community integration looks like in practice. Our findings are divided between integration at the personal level, helping residents build belonging, and integration at the systems level, helping PSH developments fit within communities.

Resident Integration

From the interviews, three themes were identified that speak to how to support resident community integration particularly geared towards those with complex support needs and significant health challenges:

KEEP IT SIMPLE

START WITH A NON-JUDGMENTAL ENVIRONMENT

OPEN DOORS TO REALISTIC OPTIONS

Phase 3 - Qualitative

KEEP IT SIMPLE

The first theme is about managing expectations for integration. Participants spoke to the fact that goals for integration need to be individualized to resident needs and interests, and in the context of those with highest support needs this often means tempering expectations of what integration might look like. Expecting residents to go out on their own in the community, meet neighbours in a positive manner, or attend random community events/clubs is often not realistic. This is in the context of individuals who may have long histories of institutionalization or may be living with ongoing mental health and addiction challenges. As one staff member stated:

"I definitely thing there are other barriers, because the acceptability, it could be like a poor mental health day where socializing and building that community is kinda harder for them."

Managing expectations can mean not projecting staff perspectives on what it means to find belonging but rather situating the focus within the resident's own abilities:

"I think we can have a very idealistic view of belonging. And so I want to be realistic in my answer, because I think belonging looks different for each tenant. Like some tenants, if you ask them like do you feel like you're a part of this community, they'll talk about people know my name, people say hi to me. And that's kind of where it ends. But they are like satisfied with that. And that's what belonging looks like to them... Others will talk about the social aspects of being engaged in a program, having relationship with other tenants, having relationship with staff. So belonging and being integrated in your community."

START WITH A NON-JUDGMENTAL ENVIRONMENT

The second theme speaks to how creating an environment where everyone can feel welcome creates a psychologically safe platform from which residents can seek to broaden their belonging. As one staff member stated:

"It's being encouraged and challenged. I think it also is related to feeling safe and accepted. So that nonjudgmental approach, but also having a strong sense of I'm safe and secure, physically, in this space and emotionally in this space."

Another staff member defined how they facilitate an accepting environment:

Phase 3 - Qualitative

"It's more like acceptance for who you are and that we may have, people may have like different stories but we're all here in the same place with a similar goal of like, trying to just like make it through life, trying to do well for ourselves and just accepting people for who they are and what makes them unique, what makes them different, but also understanding how it comes around in a circle and how we're all connected still through the differences."

As one system administrator noted, you need internal community first if you are then going to seek out external community:

"Creating community, creating that building sense of ownership, creating that and then overtime once those buildings have been established and anchored in community they do a good job at reconnecting to, you know community programs."

"I think it you know it's a sense of safety. It's a sense of trust… allow people to anchor into space to then be able to feel like they can let their guard down to start to build those personal relationships with people in your building."

OPEN DOORS TO REALISTIC OPTIONS

The third theme is very much related to the first in terms of being realistic regarding expectations of integration. It builds on this by providing clarity on the role of staff in supporting integration. Essentially, the focus is on considering thoughtfully what community activities are relevant, affordable, and desirable, particularly for PSH tenants. They note that recommending very expensive recreational options would be meaningless, for example. It is staff who can help make the connections:

"The staff are like very eager to make connections, to provide different kinds of programming for the residents, really trying to make more relationships for them,"

but the connections need to be matched to the resources and abilities of the residents. For the most part, this includes connecting residents to community programs offered by other social service organizations or by public services such as municipal programs (ex. libraries, rec centres). One staff member highlighted that this is a simple as bringing residents to the meal program in the neighbourhood:

"The way they do is by attending programming that we run as well as active in-community resources in the area, like going across the street to the Ark-Aid mission and just getting some friends and eating some food together over there and also just participating in events around the parks."

Phase 3 - Qualitative

System Integration

From the interviews, three themes were identified that speak to how PSH organizations can help integrate their services into communities:

MEET THE COMMUNITY ONE-ON-ONE | **BRING THE COMMUNITY IN** | **TELL A CLEAR STORY**

MEET THE COMMUNITY ONE-ON-ONE

One of the most significant barriers to integrating PSH buildings into communities is resistance from neighbours regarding any form of not-for-profit housing. Termed NIMBYism (not in my backyard), this resistance is very well known within the sector. Regardless of the form of housing proposed (affordable, social, PSH, group homes, etc.), not-for-profit housing is notoriously poorly received. This takes several forms such as community demonstrations, negative feedback and public hearings, or negative messages provided to councils considering zoning approvals.

Having developed PSH across southern Ontario, Indwell has growing experience in how to work with communities to minimize resistance and build partnerships. The most important theme arising from our interviews was the idea of meeting community members one-on-one. The core point was that in large public forums there is little ability to manage the direction of a dialogue whereas there is respect, clarity, and calm that comes from talking with neighbours or others who might be worried about the PSH being proposed or being implemented.

To support this process they have a staff 'community engagement coordinator' who meets directly with many, many people in advance of and during development of a new project, such as neighbours, community associations, politicians, and donors. A community partner noted that they had received a pesonalized email regarding a new development:

"They sent me an e-mail, right? Yeah, they sent out, probably an e-mail to all community players and we were part of that, so we received that e-mail."

Phase 3 - Qualitative

The engagement coordinator noted:

"The very near neighborhood doing a lot of community building and getting that very micro, local support for projects, or non-support, engaging in those conversations about why they should support us. You know, it's such a broad community is such a range of stakeholders. And we all kind of have a different hat, but it's really important."

This includes boldly and explicitly connecting with known opponents of the work as soon as possible:

"…be able to flesh out whether there's going to be some strong voices of opposition and then if there are we follow up with those voices, individually, or in a smaller group. And then, depending on how much involvement we receive from the community, as many times when we feel it's necessary."

Asked about the development of a recent project, they noted:

"I met with the [concert hall]. Oh, gosh, I met with a community health center. [Emergency shelter]. Like I said, the Business Improvement Association and some individual board members as well. We met with churches; we often are invited to speak at churches. And then we held a formal sort of meeting at the [concert hall], where we, presented what we were doing, we have, it was a nice event. We welcomed people in we had information tables, had some very pointed questions, some people with real reservations about what we were doing. And sought feedback in a formal way."

After a development opens, this one-on-one approach continues:

"We also just knocked on doors and introduce ourselves left business cards and other materials. So, that people understood that we're accessible, we're here. And if there's a problem, tell us right, we want to hear about it. Don't just go somewhere else with it, tell us and we'll deal with it."

"YOU NEED ONE-ON-ONE MEETINGS WITH THE PEOPLE WHO ARE MOST CONCERNED, IT'S THE MOST EFFECTIVE WAY AND WORKING THROUGH THOSE CONCERNS."

Phase 3 - Qualitative

BRING THE COMMUNITY IN

While talking one-on-one with stakeholders and community members is an important step both in developing new PSH and having it operate effectively, integrating the service into communities is also enhanced by bringing community members into the building, sometimes virtually other times literally. As one community member noted:

“I think it’s important that they you know are integrated with the rest of our community.”

This can include tours of buildings, as a staff member noted:

"I do a ton of tours of Woodfield Gate; I bring people through two or three times a month. And small groups.”

Or, it can be done through intentional design of a building such as inclusion of one or more community rooms in the building that provide services both for residents as well as for members in the wider community. Use of ground-floor commercial spaces can also be intentional in integrating the kind of community-focused businesses that bring neighbours and others into the building. Reflecting on a newly opening PSH building also in London, a staff member noted the importance of the cafe and bike co-op coming into the space:

“Opening a cafe at, [social enterprise cafe] is opening a new cafe there. And that was something we heard from the neighborhood that they want more breakfast and lunch options and a coffee shop. And the [bike shop and co-op], which already has a big presence in the neighborhood, but had to move. They were really excited to be able to have a storefront instead of just being in this dingy basement where they were.”

Building in this area was seen by a staff member as a future focus to continue integrating the building into the community:

"I would love if we can have like a community event where it happens at the building, like all the neighbouring businesses and neighbouring, like house occupants like we all gather and they get to know who these individuals are and be like, they aren’t just, their mental illness or its just…it’s like, its actually people”.

Phase 3 - Qualitative

TELL A CLEAR STORY

In a way, community integration is also a marketing issue. It's about how the story of a building is told, its purpose, its impacts, and its fit in the community. Public narratives regarding supportive housing can easily become negative and a media story or two about loitering or about a crime within a building can significantly impact community perceptions of a building and a provider.

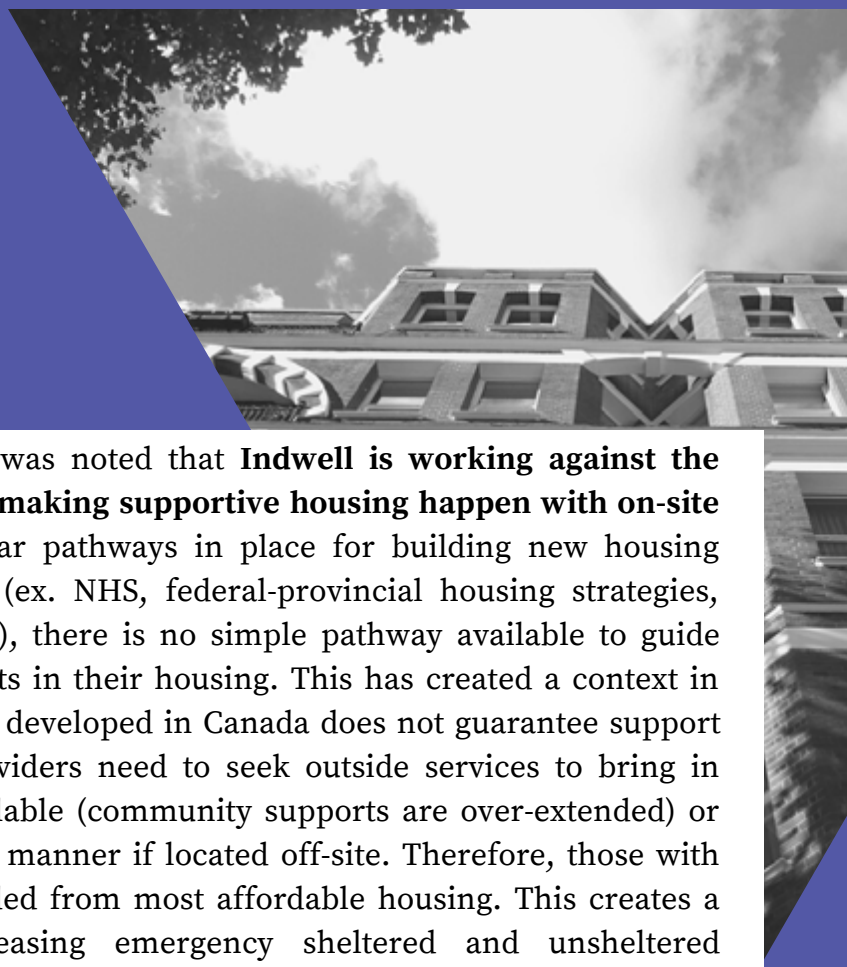
Therefore, participants recommended PSH providers be proactive in telling the story of the work and the importance for all people in that community. This includes at the development stage where consultations are a first point to tell this story. The engagement coordinator noted that in doing community consultation it's not about just an open forum for anyone to share preconceptions or prejudices, but rather a structured dialogue with clear purpose and designs already in place:

“We go to the community with most of our plan in place. So, we're not blue sky thinking with the community, we say, this is what we're going to do, and we're very transparent in terms of what our intentions are. And you know, where we're asking for either design change or minor variance and want to really engage the public in a meeting that's kind of on our terms.”

This allows the organization to manage the story. Awareness raising then becomes a never-ending part of the work of the housing provider, constantly informing community members of what the housing is providing in terms of rehousing those with highest support needs:

"I just know that when people have more knowledge and they can also have with of course with the consent of the people living there, the people who have had a good experience living there, they can use like real lived experience people being part of the campaign of the awareness telling people how this has helped them and and and how now they are doing better, and they're not necessarily messing up the community they are becoming part of a community.”

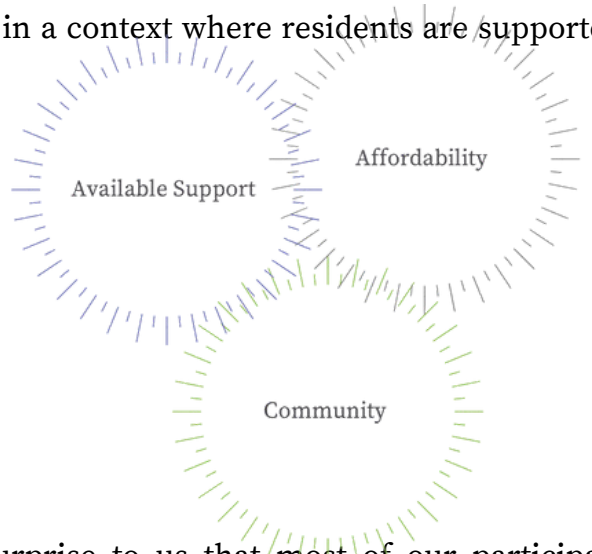
By focusing on the real stories of people living in the PSH it humanizes the space for the community so that buildings don't become stigmatized by, for example, just their address. The more the broader community can feel a connection to the residents, the more likely they will find ways to support integration of the services. Additionally, community members are more likely to feel positively about building if they know that on-site supports are provided for tenants.



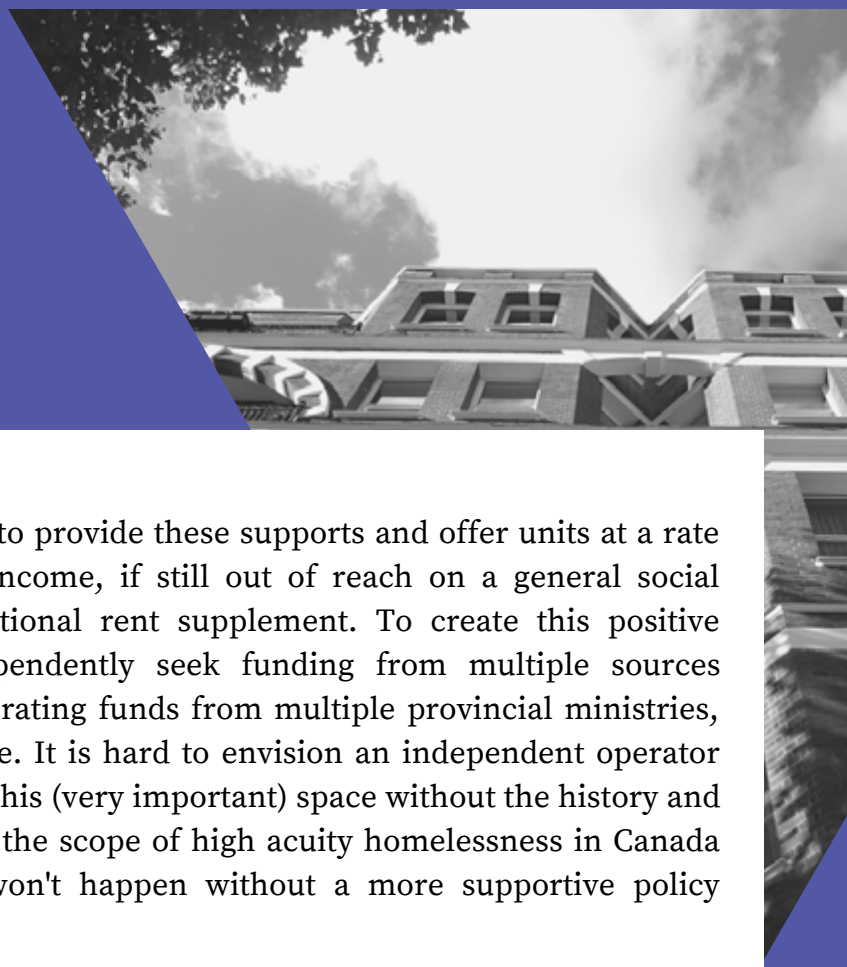
DISCUSSION

Throughout the process of this research it was noted that **Indwell is working against the structural limitations currently in place and making supportive housing happen with on-site supports.** That is, while there are fairly clear pathways in place for building new housing structures as a non-profit housing provider (ex. NHS, federal-provincial housing strategies, municipal/regional development corporations), there is no simple pathway available to guide providers who want to include on-site supports in their housing. This has created a context in which the majority of new affordable housing developed in Canada does not guarantee support for those who are most vulnerable, and providers need to seek outside services to bring in supports. These supports are not readily available (community supports are over-extended) or when available cannot respond in as timely a manner if located off-site. Therefore, those with highest support needs are systemically excluded from most affordable housing. This creates a downstream effect wherein we see increasing emergency sheltered and unsheltered homelessness in communities across Canada constituted significantly of those who require some degree of support to remain stably housed.

The difference observed in this research at Woodfield Gate was readily available supports, offered at an affordable rate, and in a context where residents are supported in achieving better community integration:



In this context it was of little surprise to us that most of our participants had experienced extensive histories of homelessness, including periods of institutionalization. Moving into Indwell included a significant sense of relief to be finally housed in something wherein they were the leaseholder, there were supports if they needed them, and they could envision a lifetime of affordability. In the context of a private sector where rents escalated rapidly over the past 6 years in London, this was a significant relief.

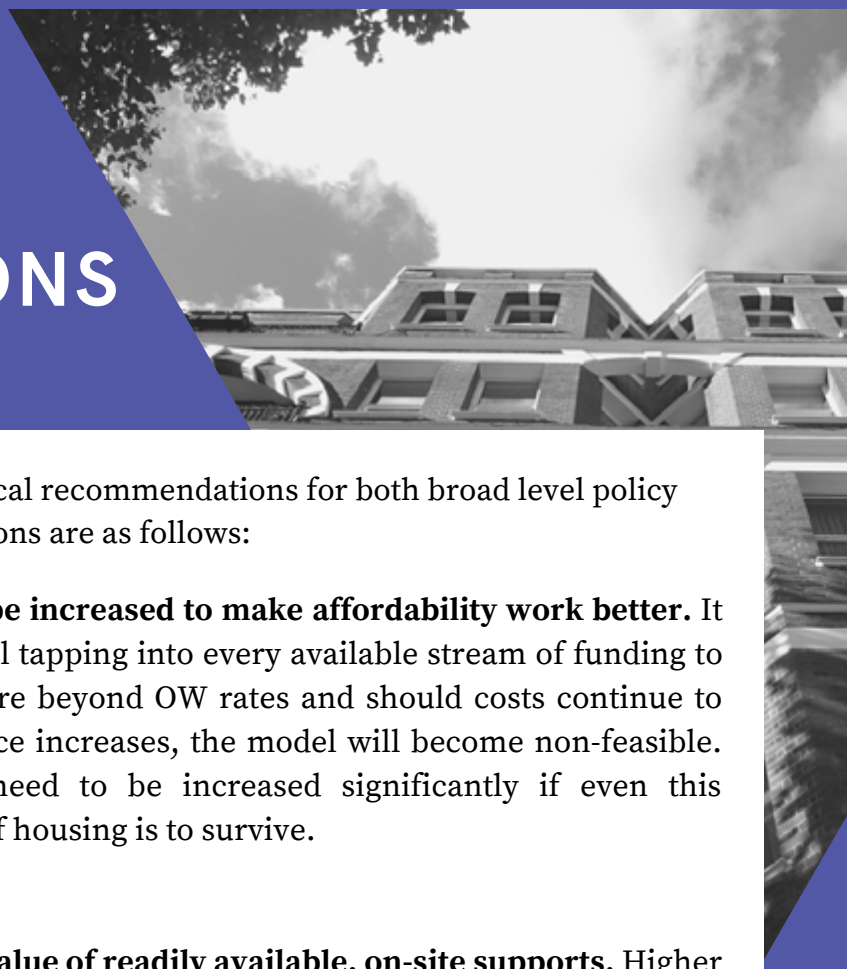


DISCUSSION 2

However, it was not a simple task for Indwell to provide these supports and offer units at a rate that was at least affordable on a disability income, if still out of reach on a general social assistance income (unless receiving an additional rent supplement. To create this positive housing outcome requires Indwell to independently seek funding from multiple sources including: rents, capital grants and loans, operating funds from multiple provincial ministries, independent fundraising, and social enterprise. It is hard to envision an independent operator with a single property being able to enter into this (very important) space without the history and resources of scale achieved by Indwell. Given the scope of high acuity homelessness in Canada this model needs to scale up, however it won't happen without a more supportive policy environment to do so.

A key part of the work of Indwell is community integration. This may be seen as the "final frontier" of providing rehousing through a Housing First philosophy as it is often an after-thought or missed in models that are under-resourced and where rehousing and housing stability are the key metrics, sometimes leaving a long-term and very nuanced service like community integration left out of the equation. At Woodfield Gate, through this research we were able to observe residents becoming more involved in their local communities, getting out of the building to various events, but built on a foundation of first making the building itself a welcoming environment and encouraging socialization through, for example, activities in the community room. This integration was happening through realistic goals of simple things like helping people start to access a library, or to get out to a free community meal through another organization.

A final barrier that PSH providers can face is integration of the building itself within the community. Affordable housing can easily become stigmatized buildings, with stigmatization as well of those who go in and out of these buildings. Through a depth of experience, Indwell staff were clearly thoughtful from the outset of conceptualizing a new space as to how to tell the story of the work in a positive way, and extensive personal and small group engagement required to get (and keep) communities on board with the work. This is a significant amount of labour that again it is difficult to envision a new or smaller organization taking up, without the resources of a communications team and community engagement specialist. This brings to light the more hidden labour involved in making PSH a reality in Canada. Again, policy and funding needs to support this model if we are going to see it scaled up and scaled out.



RECOMMENDATIONS

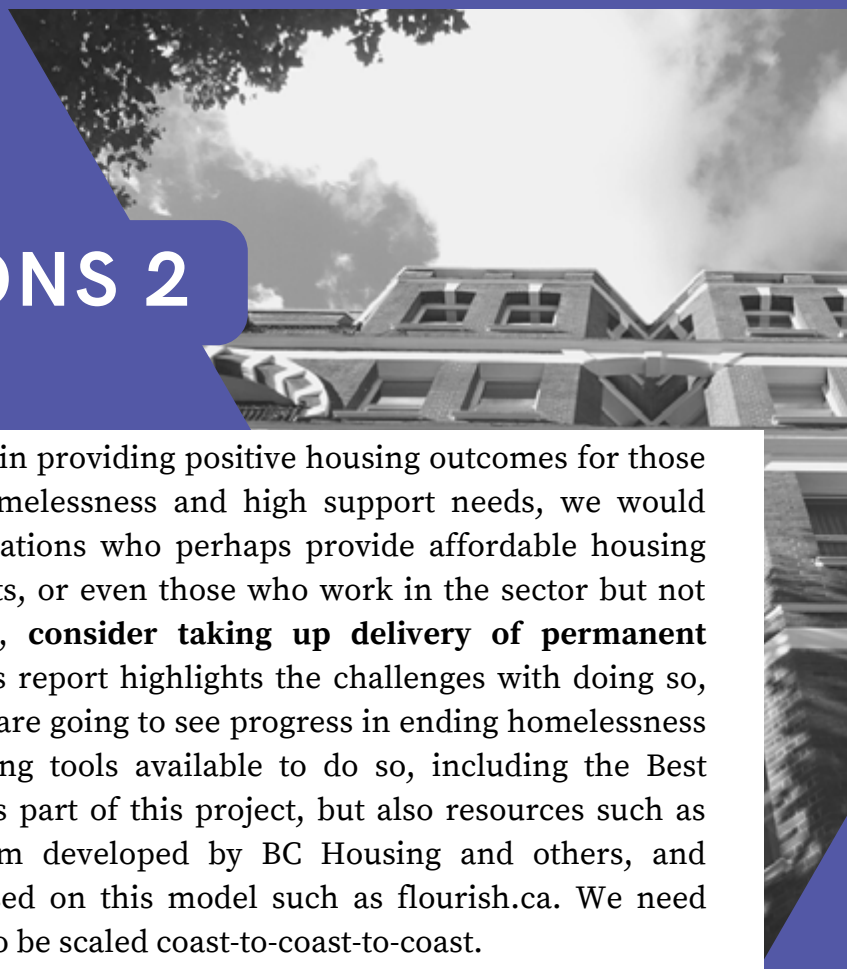
From this research we see a number of practical recommendations for both broad level policy and local service delivery, our recommendations are as follows:

1. **Social assistance rates must be increased to make affordability work better.** It is noted that in spite of Indwell tapping into every available stream of funding to optimize affordability, rents are beyond OW rates and should costs continue to vastly out-pace social assistance increases, the model will become non-feasible. Therefore, assistance rates need to be increased significantly if even this government-supported form of housing is to survive.

2. We can't over-emphasize the **value of readily available, on-site supports.** Higher and more consistent provincial funding to integrate supports into more existing community/social housing and affordable housing sites would expedite the process of expanding supportive housing. This includes actualizing promised provincial mental health and addictions funding.

3. The National Housing Strategy provides some support in terms of capital grants and loans. However, it is also noted that a significant portion of the NHS funds go towards supporting market-rent housing development. We recommend considering separating out loan funding for market-rent housing development into a separate economic development strategy and **having all NHS funds support affordability and deep affordability**.

4. Second to the previous point, we recommend consideration of **a dedicated supportive housing stream within the NHS** to ensure that organizations who wish to house Canada's most vulnerable are guaranteed some portion of operating funding out the outset of a development. This could include direct funding for operations or funding to support federal-provincial agreements that would guarantee provincial health dollars.



RECOMMENDATIONS 2

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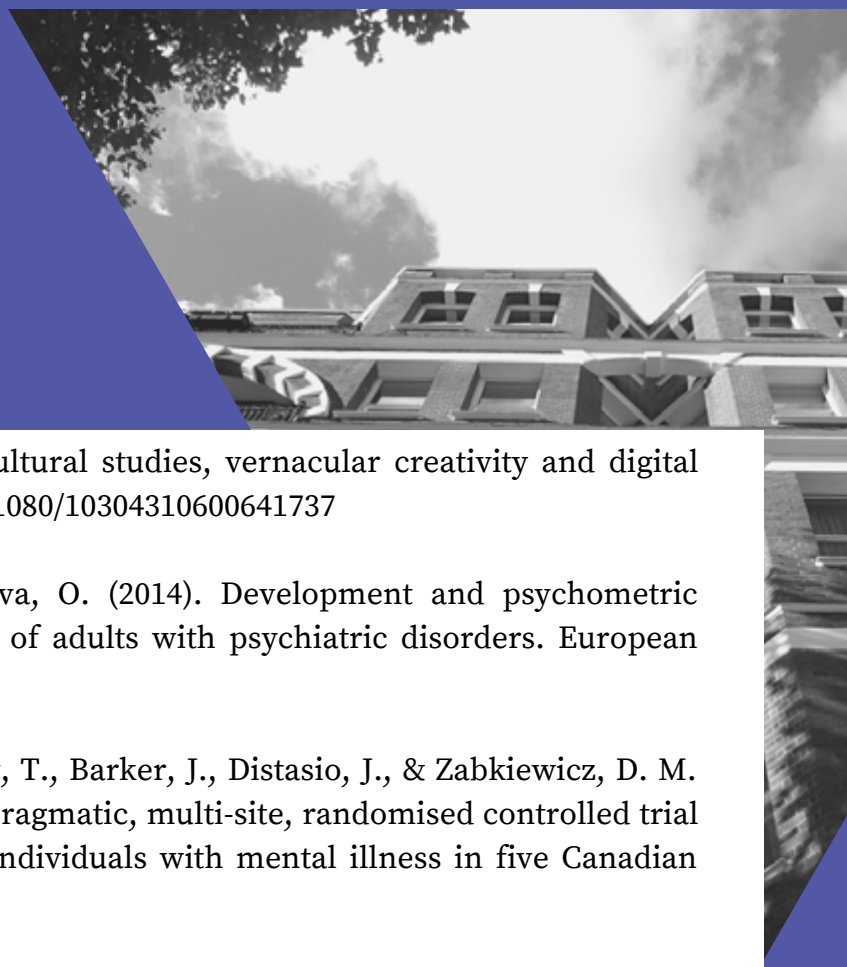
Given the success of the model in providing positive housing outcomes for those with extensive histories of homelessness and high support needs, we would recommend that other organizations who perhaps provide affordable housing without current on-site supports, or even those who work in the sector but not necessarily providing housing, **consider taking up delivery of permanent supportive housing**. While this report highlights the challenges with doing so, the necessity is also large if we are going to see progress in ending homelessness in Canada. There are increasing tools available to do so, including the Best Practice Guideline generated as part of this project, but also resources such as tools for addressing NIMBYism developed by BC Housing and others, and development consultants focused on this model such as flourish.ca. We need more partners in PSH if this is to be scaled coast-to-coast-to-coast.

6

In terms of future research, discussions with staff at times focused on the issue of highest acuity and balancing out buildings so that staffing is sufficient for the level of need of the entire building, as well as decreasing resident-to-resident conflicts. Indwell staff noted a smaller, transitional development in a neighbouring city that allowed for all residents to be highest acuity, something that would not likely work well at Woodfield Gate. Alternatively, larger new developments would include more mixed acuity to reduce the intensity of support needs in one space. Whereas transitional models have become framed as not ideal as they do not provide permanent housing, there may still be space in the sector for these models to be done well if it means accommodating more of those directly off by-name lists. **Future research should explore if and how transitional supportive housing might be offered as part of a process of permanent housing.**



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Appendix A: Semi-Structured Interview Guide – Phase 1 Residents

Can you start by telling me a bit about yourself:

- What brought you to staying at Indwell?
- Where were you staying last before moving to Indwell?
- How did you learn about Indwell?
- What drew you to Indwell?
- What particular support needs do you feel you have in order to ensure best housing outcomes?

Let's talk about the COVID-19 pandemic:

- What was it like for you when you first heard that everything was going to be shut down for the pandemic?
- How did this effect your daily life?
    - In what ways is your life still the same?
- Over the last 5 months of the pandemic, what emotions have you gone through?
- Have you felt a sense of isolation during this time? Have you felt a sense of belonging during this time?
- Have you been able to meet your support needs during the course of the pandemic?
- Has the pandemic impacted on your ability to be social and connect with others?

Let's think about the experience of being in supportive housing during a pandemic:

- What supports do you receive through Indwell versus what supports you receive from other services? Is there differences in accessing these different supports?
- Has living at Indwell impacted your experience of the pandemic?
- When you need assistance (from either Indwell or other agencies), how soon is that assistance available? Can you give examples?
- Have staff continued to keep in touch with you in spite of limitations imposed by the pandemic?
- If you could change one thing about the experience of living at Indwell, what would that be?
- If you could say what is best about Indwell, what would that be?

Demographics considerations:

1. Do you want to tell people about any experiences you have had with homelessness, such as how many times or how long?
2. Do you want to tell people your age?
3. Do you want to tell people about how long you have lived in London
4. Do you want to tell people your income source?
5. Do you want to identify yourself as part of a distinct racial or ethnic group?
6. Do you want to identify your gender?
7. Do you want to identify yourself as a person living with a general or particular chronic health condition?

Appendix B: Semi-Structured Interview Guide – Phase 2 Video Narratives

Narrative Moment 1:
While you are now staying at Indwell, this is a new building. We would like to help you tell the story of your life that starts as far back as you would like.

1. Did you want to start by telling us about what life was like for you growing up?
2. Where are some of the places you have lived over the years?
3. Who are some of the people you have lived with?
4. What are some of the most meaningful accomplishments in your life?
5. What are some of the challenges you have faced through your life?
6. Have you had any challenges related to your health, both physical and mental?
7. What has been most helpful for your wellbeing over the years? What has been least helpful for your wellbeing over the years?

Narrative Moment 2:
Let's think about transitions next, and coming to Indwell:

1. Where were you staying last before moving to Indwell?
2. How did you learn about Indwell?
3. What drew you to Indwell?
4. What particular support needs do you feel you have in order to ensure best housing outcomes?
5. How have things looked for you financially in moving to Indwell?
6. What worries did you have through the transition?

Narrative Moment 3:

1. What has life been like for you at Indwell?
2. What has been working well for you? What has not been working well for you?
3. In terms of friendships, how would you describe your social network? Who do you connect with the most? Are you satisfied with your network of friendships?
4. Belonging is a very personal concept. Do you feel a sense of belonging here in Indwell?
5. What about the neighbourhood, when you leave the building, do you feel a sense of belonging in this neighbourhood?
6. Do you engage in social or recreational activities on-site at Indwell? What about outside in the broader community?
7. Do you ever feel a sense of stigma or discrimination in London as someone who lives in a supportive housing building? If yes, what does this look like?
8. Overall, what does Indwell mean to you?

Appendix B: Semi-Structured Interview Guide – Phase 2 Video Narratives

Demographics considerations:

As part of telling your story, you will want to think about the information you give that can help viewers or readers understand more about you.

1. Do you want to tell people about any experiences you have had with homelessness, such as how many times or how long?
2. Do you want to tell people your age?
3. Do you want to tell people about how long you have lived in London?
4. Do you want to tell people your income source?
5. Do you want to identify yourself as part of a distinct racial or ethnic group?
6. Do you want to identify your gender?
7. Do you want to identify yourself as a person living with a general or particular chronic health condition?

Appendix C: Semi-Structured Interview Guide – Phase 3 Community Integration: Community Partners & Housing Administrator(s)

Getting to know them:

- Can you tell me a bit about your educational and employment background?
- Have you worked in housing or mental health services?
- What drew you to working in your particular field?

Supportive Housing:

- When you think about affordable housing developments in London, what do you think of? [Can give examples of Indwell, London Housing, the new veterans housing, or others in their immediate neighbourhood.]
- Do you think London spends too little, too much, or just enough on new affordable housing?
- When you think about the people who need supportive housing, what are the kinds of challenges they might be facing?
- Do you have any concerns living near housing projects like Woodfield Gate (Indwell)? What concerns do you think others might have?

Integration of Indwell:

- When did you become aware that Woodfield Gate was moving into the development on Dundas Street? How did you feel when you heard this?
- Have you had any interactions with staff or residents of Woodfield Gate? Tell me about those interactions.
- [If negative:] What might have changed this experience for you?
- What do you think Indwell can do to ensure their residents are well integrated into the London community?
- What can affordable housing developers in London do in general to increase acceptance of new developments into neighbourhoods?
- What should affordable housing providers know about community members potential concerns?
- What do you think belonging or integrating within one's community means for Indwells tenants?

Demographics considerations:
We are hoping you might share a bit more information about you.

1. Do you mind sharing your age?
2. Do you identify as a person who is experiencing poverty?
3. Do you want to identify yourself as part of a distinct racial or ethnic group?
4. How do you identify your gender?
5. Have you ever donated time or money to housing or mental health services?

Appendix D: Phase 1 Woodfield Gate Participant Demographics

Table 1: Woodfield Gate Resident Participant Demographic Characteristics (n= 20) n (%)	
Participant Characteristics	
Sample size	20
Gender	Number of participants
Male	9 (45)
Female	7 (35)
Other	1 (5)
No response	3 (15)
Age Group (Mean= 44; Range= 39)	
26-40	9 (45)
41-64	8 (40)
65+	1 (5)
No response	2 (10)
Ethnicity	
White (Caucasian)	4 (20)
Latin American	1 (5)
Other	4 (20)
No response	11 (55)
Primary Income	
Ontario Disability Support Program	10 (50)
Canada Pension Plan	2 (10)
Other	7 (35)
Miss	1 (5)
Secondary Income	
Employed	4 (20)
Unemployed	7 (35)
Other	1 (5)
No response	8 (45)
Mental Health Conditions	
Yes	12 (60)
No	10 (50)
No response	6 (30)
Physical Health Conditions	
Yes	4 (20)
No	10 (50)
No response	6 (30)
Substance Use Conditions	
Yes	2 (10)
No	12 (60)
Other	6 (30)
Years Living in London, Ontario (Mean= 5; Range= 9)	
1-2	3 (15)
3-4	1 (5)
5-9	1 (5)
10+	13 (65)
Other	2 (10)

Appendix E: Phase 1 Indwell Leaders and Staff Participant Demographics

Table 2: Woodfield Gate Staff & Leader Participant Demographic Characteristics (n= 8) n (%)

Participant Characteristics	
Sample size	8
Gender	Number of participants
Male	3 (37.5)
Female	5 (62.5)
Other	0 (0)
No response	0 (0)
Age Group	
26-40	2 (25)
41-64	6 (75)
65+	0 (0)
No response	0 (0)
Ethnicity	
White (Caucasian)	7 (87.5)
Other	0 (0)
No response	1 (12.5)
Length of time working in supportive housing	
< 5 years	2 (25)
5-10 years	3 (37.5)
10-20 years	2 (25)
20+ years	1 (12.5)

Appendix F: Phase 3 Participant Demographics

Table 3: Participant Demographic Characteristics (n= 17) n (%)	
Participant Characteristics	
Sample size	17
Gender (n= 17)	Number of participants
Male	3 (18)
Female	13 (76)
Other	1 (6)
No response	0 (0)
Age Group (n= 17)	
18-25	3 (18)
26-40	5 (29)
41-64	9 (53)
65+	0 (0)
No response	0 (0)
Ethnicity (n= 17)	
White (Caucasian)	15 (88)
Latin American	1 (6)
Black	1 (6)
No response	0 (0)
Worked in Supportive Housing (n= 7)	
< 5 years	5 (71)
5-10 years	2 (29)
10-20 years	0 (0)
20+ years	0 (0)
Not applicable	10
No response	0 (0)
Past or Current Experience of Poverty (n= 10)	
Yes	3 (30)
No	7 (70)
Not applicable	7
No response	0 (0)
Donated Time or Money to Housing or Mental Health Services (n= 10)	
Yes	10 (100)
No	0 (0)
Not applicable	7
No response	0 (0)