



Emerging Trends in Social Housing

April 2009

The Safer Nanaimo Committee (with representatives from the RCMP, Bylaw Services, Social Planning, Downtown Nanaimo Partnership, Vancouver Island Health Authority and the Downtown Business & Residential Communities) oversaw the creation of a report to council that outlined the best practices related to homelessness in Nanaimo. CitySpaces Consulting was contracted to perform the research and prepare a report which was adopted by the City in 2008. This best practices document supports a "Housing First" model for addressing homelessness and promotes a "harm reduction" philosophy with clear and specific requirements for support services.

Across Canada and the US, there has been increasing support for **housing first** and **harm reduction** approaches to address homelessness. Housing first approaches support the idea that individuals are better able to pursue their personal goals towards employment, treatment, and health and wellbeing when they are in stable housing. Harm reduction or "low demand" approaches combined with **supportive housing** have also been reported to be effective at addressing the needs of homeless people with substance use issues.

Psychiatry professor Mary E. Latimer of the University of Washington summarizes results from an influential Seattle study: "Our study suggests that homeless alcoholics who qualify to take part in Housing First can stay out of jails and emergency rooms, and cost the taxpayer a lot less money as a result. We also found that these benefits increase over time and that they are possible without requiring that participants stop drinking. And yet, the longer the participants stay in the housing program, the less they drink."ⁱ

Key Definitions

(Taken from the City of Nanaimo's *A Response to Homelessness in Nanaimo: A Housing First Approach - Relevant Best Practices*)

Housing First: Involves the direct placement of homeless individuals into stable housing. Support services are made available to tenants through assertive engagement, but active participation in these services is not required. A low demand approach accommodates substance use so that sobriety is not a precondition and relapse does not result in clients losing their housing.

Harm Reduction: An approach aimed at reducing the risks and harmful effects associated with substance use and addictive behaviours, for the person, the community and society as a whole, without requiring abstinence. Examples of harm reduction programs include needle exchange services, substitution therapy and safe consumption sites.

Continuum of Supports: A holistic approach to addressing the needs of homeless individuals within a community plan. It includes all supports and services that would be needed to assist a homeless person or someone at risk of becoming homeless to become self sufficient, where possible. The continuum includes homelessness prevention services, emergency shelter, outreach, addiction services, transitional housing and other support services.

Low Demand/Harm Reduction Model/Low Barrier: This trinity of concepts embodies the philosophy of a low-threshold to qualify for housing, which translates into removing traditional barriers to treatment that insist on a commitment to abstinence as a requirement of admission and as the only acceptable goal. Such a philosophy facilitates access to services even when people continue to

use drugs and are unwilling to enter traditional substance abuse treatment programs that require abstinence. It enables access to services such as safe housing, health care, psychological help, and safer means of drug use. **Low barrier housing with supports** is the key to addressing the public disorder resulting from homelessness, mental illness and addiction.

Barriers

The language of barriers can be confusing because two distinct but related types of barriers are created. These are barriers a client creates, and barriers a housing program creates.

Barriers Created By Clients

The Homelessness Resource Exchange defines three levels of barriers that homeless individuals create for themselves:

Level 1: No barriers/temporary crisis. Individuals at this level can usually find market housing because their behaviours and problems are temporary. The Barriers are time specific and pass.

Level 2: Low to moderate housing barriers. More persistent barriers that include:

- No rental history or a poor rental history (i.e., prior evictions, rent/utility arrears)
- Insufficient savings
- Poor credit history
- Sporadic employment history
- No high school diploma/GED
- Recent or current abuse and/or battering (client fleeing domestic violence housing situation)
- Head of household under 18 years old
- Large family (three or more children)
- Criminal background

Level 3: High Barriers Behaviours that are often entrenched and can include:

- Some/many of the barriers from Level 2
- No income
- Recent history of substance abuse or actively using drugs or alcohol
- Serious health problems/conditions

Barriers Created By Housing Programs

Barriers that housing providers create often relate to the barriers clients create, but generally involve eviction from housing because of behaviours related to mental illness or addiction.

The following chart was used in the document: *A Response to Homelessness in Nanaimo: A Housing First Approach Situational Analysis Prepared for City of Nanaimo*:

High Barrier	Medium-Low-Barrier	Minimal Barrier
<i>Conditional access - abstinence only</i>	<i>Active substance use – rules and restrictions apply to access housing/service</i>	<i>Substance use not prohibited</i>

The term "Minimal Barrier" is a new term that may or may not reflect wider use outside of BC. A search of the internet using Google brought up four results for "minimal barrier" and "low barrier housing". Three of the results were documents relating to Nanaimo (one being the above document) and one relating to West Vancouver. The term Minimal Barrier is used by a variety of Provincial health authorities. The Fraser Health Authority's MENTAL HEALTH 5 YEAR HOUSING PLAN states:

"'Minimal Barrier' housing is defined as access to flexible and non-judgmental service based on need, without restrictions to lifestyle, condition (e.g. Intoxicated), eligibility or number of times receiving the service, in a building that is accessible to everyone regardless of physical condition.

It is also acknowledged that acuteness of health needs, behaviour or level of intoxication may limit the ability of the provider to give service."

Recent conversation with professionals in government and health care suggest that the old terms used to describe types of houses are being replaced with new terms. The following table reflect the current nomenclature:

Old Terms	New Terms	Definition
Dry	High Barrier	Clients are not allowed to use substances while staying at the house and are discharged if they do so. There is a clear expectation that clients are not using any substances except prescription drugs. The goal is to establish new life patterns and new social networks and supports.
Damp	Medium Barrier	Clients are not allowed to use substances while staying at the house but are not discharged if they fall off the wagon a few times. In other words, there is some grace, but an expectation is made that clients will work towards sobriety.
	Low Barrier	Clients are not allowed to use substances onsite, but may do what they choose off site. They must retire to their rooms if they return to the program under the influence.
Wet	Minimal Barrier	Clients are allowed to use alcohol and marijuana in their private suites, but are monitored by social workers. They have access, if they choose, to psychiatrists, nurses, support workers, and others support services. There is some expectation that progress towards stability and

		possibly sobriety may occur at some future point.
	Zero Barrier (No Barrier)	Clients are allowed to use alcohol, marijuana, and other street drugs in their private suites, with security measures in place and regular check-ins by social workers or support workers. The goal is to keep the client alive if possible, and intercede only when their life is threatened.

Currently Crescent House and Samaritan House offer Low Barrier housing, according to the above glossary, while Safe Harbour House generally offers Moderate to Low Barrier housing and Hirst House offers Moderate Barrier housing.

In the past ICCS has limited its service standards to Low Barrier housing, believing that wet housing was too likely to enable a client to continue in their addictions. The evidence, from Portland and other locations, suggests that with adequate support, individuals in Minimal and No Barrier housing do tend to stabilize and some begin to make progress on matters of substance use, criminal behaviour, and vagrancy. The level of support seems to be the key component to their recovery.

The terms “No Barrier” and “Zero Barrier” are the newest terms, and show up occasionally in non-governmental literature and web pages. It is fair to say that most calls for proposal in Nanaimo in the near future will not require zero barrier units.

Interestingly the landmark document **Home Again, Citizens Commission on Homelessness, December 2004 A 10-year plan to end homelessness in Portland and Multnomah County** does not use the term “barrier” at all, but instead proposes 160 new units of **permanent supportive housing** with 300 additional units to be developed later. It is probably fair to say that the “barrier terms” have arisen in the last 5 years.

Support

The implementation of any Housing First model depends on key supports in the community or directly in the housing program. Some of those supports are reported to be:

ACTS and FACTS: Assertive Community Teams (ACT) and Forensic Assertive Community Teams (FACT) have demonstrated greater success in keeping homeless people housed and in connecting them with treatment and other services than traditional models. These are essentially enhanced versions of existing teams ICCS deals closely with such as the Intensive Case Management Services team.

Outreach Services: Outreach services connect homeless, addicted and mentally ill people with housing and supports and help them navigate the complex web of services. Outreach teams can also work as part of prevention programs to reach individuals and families living in sub standard conditions to assist them in transitioning to more permanent housing.

Substitution Therapy: In substitution therapy substances in which the body is deficient are replaced. Problems that arise from loss of blood or other fluids, minerals, proteins, vitamins, and hormones can be managed through substitution therapy. The concept has been expanded recently to include drug substitutes. A study published in the June 28th edition of *The Lancet* found that substitution therapy with the opiate drug, buprenorphine, tripled the length of time heroin users were able to stay “clean” compared with individuals on a placebo, and nearly quadrupled the proportion of participants who completed the trial without relapse. Substitution therapies are one tool to help stabilize people who use substances, thus reducing crime and public disorder related to the drug

trade. Substitution Therapy as also been proven to be more successful at getting people into treatment than the traditional detox entry points.

Consumption Sites: Properly staffed and supervised “consumption” sites reduce the spread of disease and provide a predictable point of contact for ACTS and FACTS.

Effective Working Group(s): A single, community-based coordinating body that includes businesses, governments, private foundations and donors, and agencies is more likely to attract funding and have success in driving integration than a fragmented system made up of multiple groups and agencies. Nanaimo has a working group, but the emergence of bodies like the SAFER committee suggest that other groups may and will form for specific needs and that communication between such groups is a challenge.

Level of Coordination: Interagency coordination can create long-term systematic changes and permanent supportive housing if regular meetings among all outreach efforts become integrated into the delivery of service.

Subsidized Housing: Most housing “projects” were not designed or financially structured to serve those with housing barriers. Rental assistance in private market housing reduces the burden of social housing costs and ensures individuals have adequate cash to cover other basic living expenses.

Housing Location and Design. Locating some housing away from the downtown core, but within walking distance of shops and services and transit stops insures individuals stay in the housing longer. Keeping housing projects small (under 35 units) retains a sense of community and fits in suburban location. Designing beautiful buildings that are residential in character and that blend within neighbourhood assure neighbourhood acceptance and pride in residence.

Tenant Selection. A mix or balance of tenant characteristics improves the fit into the building and community.

Peer Review. Using peer review meetings to evaluate area outreach programs.

Integration of harm reduction approaches. Integrating harm reduction into traditional drug and alcohol treatment programs reinforces the core values of the model and keeps all agencies working together on unified case plans. Expanding and providing alternative services for substance users, such as healing circles, learning circles, art therapy and acupuncture insures a wide opportunity to connect clients with systems and therapies that work for them.

Another term to be familiar with:

SAMI: A diagnosis of severe addictions and mental illness.

“VIHA Mental Health and Addictions staff have found that the group of high needs individuals with severe addictions and mental illness (SAMI) has changed significantly over the past ten years.

A large cohort of this population were once residents who had lived in institutional environments for many years and required comprehensive residential care because of their illness and the institutionalising effect of their facility-based care. The institutionalising effect also resulted in clients who were generally not resistant to other people directing their care and the way they lived their lives, and many community residential services have developed to meet the needs of this population.

A new population has emerged, or perhaps just increased, that has not had access to long-term institutional care but still suffers from the disabling effects of SAMI. Many of these new high needs clients misuse street drugs and alcohol and have not been socialised into an institutional lifestyle. Their behaviour may have resulted in incarceration or involuntary treatment, resulting in anxiety and suspicion of people who are trying to provide them with help. These clients are often not a

good match for existing traditional services, such as residential care or brokerage case management.

The challenge is to reform, redesign, develop and offer a variety of services to this new group that would be accepted by residents and deemed beneficial. Many residents challenged with SAMI, who frequent the downtown core, resemble this new group of clients and require not just an increase in existing services, but services specifically designed for them. This is where assertive engagement and outreach, through highly skilled and integrated service teams, is crucial." - *Victoria's Mayor's Task Force on Breaking the Cycle of Mental Illness, Addictions and Homelessness; Report From The Gap Analysis Team.*

ⁱ <http://www.miller-mccune.com/news/homelessness-more-evidence-on-the-wisdom-of-housing-first-1113>