Intensive Case Management Considerations to Improve Housing Stability Amongst Women Involved in High-Risk and/or Exploitative Situations

FINAL Report

A Research Project by:

OrgCode Consulting, Inc. and E4C

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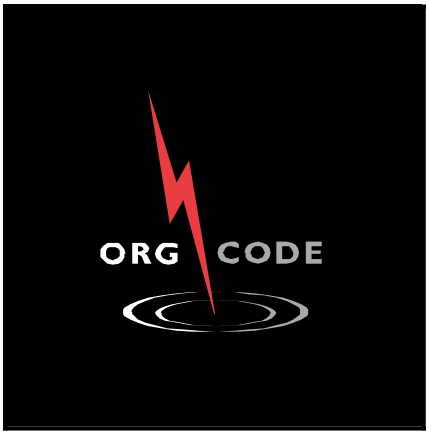

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Table of Contents

Executive Summary

For women, homelessness, involvement with sex work, substance use, and trauma are closely connected. Sexual exploitation is linked to women's entry into homelessness, and also impacts their capacity to become stably housed again. If the needs of this population – estimated to represent approximately one quarter of the Canadian homeless population – are to be met, there is an urgent need for services that are designed to address these interconnected factors and support them in ending their homelessness.

However, the needs of chronically homeless women with multiple barriers, including mental illness, histories of trauma, and past or present involvement in high-risk behaviours such as street-based sex work and substance use, are often not being met by existing programs delivering homelessness services. While there are many programs that offer supports for homeless women, they are more likely to be tailored for women who are fleeing domestic violence, and may not be able to provide appropriate supports for a woman who may use crack cocaine heavily, or who is coping with a serious mental health condition such as Bipolar Disorder, or who has significant physical health issues as a result of her long-term lack of stable housing. Agencies that serve chronically homeless individuals in general may not offer specialized supports or expertise to address the unique needs of their female clients. Those unique needs are rooted in the women's experiences of trauma as well as the distinctive risks that face this population, such as sexual exploitation and violence. The few programs that do provide supports specifically for chronically homeless women and women who have been involved in high-risk behaviour typically do so in the context of a linear model, requiring compliance with numerous conditions in order to progress through different transitional forms of housing toward a state of 'housing readiness', when the client is deemed able to maintain independent housing. There is a growing body of evidence, however, that Housing First approaches, which are based on principles of consumer choice and harm reduction, can more effectively provide supports to chronically homeless individuals with multiple barriers to end their homelessness.

Edmonton's E4C housing program appears to be nearly unique in that it provides supports to women who have experienced chronic homelessness and sexual exploitation through a Housing First approach. Within this model, women who are accepted into the program receive a rent supplement that enables them to move into an apartment, and then receive supports from a follow-up support worker using an Intensive Case Management approach. The Housing First model has been shown to be a successful approach to providing supports for chronically homeless individuals who face multiple barriers in accessing and maintaining housing, but there is little data available to show whether the model is equally successful with chronically homeless women who have past histories of high-risk behaviour and sexual exploitation. In addition, some research that has examined housing programs designed specifically to assist this population suggests that one reason why few service providers are adopting Housing First for chronically homeless women is a belief that women who continue to be involved in street-based sex work and substance use cannot be safely supported in the scattered-site approach that characterizes Housing First interventions.

In order to expand the existing body of evidence on how to best support chronically homeless women who have been involved in high-risk behaviour to become stably housed and end their homelessness, a nine-month, qualitative research project to engage with clients receiving housing and support through the E4C Housing First program was initiated. This study followed twelve clients between February-March of 2012 and September-October of 2012, and gathered information about their lives and histories, their patterns of substance use, high-risk behaviour, and involvement with emergency services, both before

and during the study period. In addition, the research examined how the participants' quality of life was affected by becoming housed, using a range of indicators. The project aimed to answer four research questions:

1. What are the characteristics of the population? This includes age, past and present involvement with service delivery systems, and housing history.
2. Was involvement in high-risk and/or exploitative situations triggered as a result of clients' homelessness, or did involvement in these situations predate homelessness?
3. What aspects of Housing First/ICM are currently working well, and how might amendments be made to improve service delivery and housing stability specifically for women?
4. Based on the available literature, which evidence-based or evidence-informed practices should be considered for working with this population?

The findings suggest that the Housing First model can successfully be applied to women who have experienced chronic homelessness and are coping with multiple barriers, with some caveats. First, the follow-up sample size was limited because many of the original participants did not respond to the request for a second interview, although they remain involved with the program. Second, not all of the women remained stably housed throughout their involvement with the program. However, the participants' housing stability during the study period did not appear to be related to whether or not they continued to be involved in substance use and high-risk behaviour. In addition, the participants expressed strong appreciation for the fact that they can receive housing and supports "even if I make a mistake".

The significant findings that emerged from this research included:

1. T**he study participants have high needs and have experienced chronic homelessness.** The study participants reported histories of trauma and abuse.
2. **Substance use was identified as the primary trigger for homelessness.** The majority of clients experienced sexual abuse as children, but their involvement in exchanging sex for money began after becoming homeless and/or beginning heavy use of substances such as crack cocaine.
3. **The Intensive Case Management service delivery approach is effective.** The supports provided by the clients' housing support workers were identified as the best aspect of the services provided through E4C.
4. **The harm reduction philosophy helps women remain housed.** The study participants emphasized importance of a non-judgmental approach that supports vulnerable women in their housing regardless of whether substance use or sexual exploitation continue.
5. **Being housed had positive impacts on the women's quality of life and sense of wellbeing.** This is true even if their substance use or sexual exploitation continue
6. **Being housed has a positive impact on service utilization.** Participants reported decreased use of emergency services and increased use of preventative and primary care after becoming housed.
7. **Participants expressed a desire to offer and/or receive peer support with other women who have had similar life experiences.** Although few 'best practices' for Housing First interventions for women were available in the literature, the opportunity to provide mutual support was cited as a valued element in another housing intervention for women (Fotheringham *et al*, 2011).

8. **Although participants' reported increases in income over the study period, without a rent subsidy they would be at risk of homelessness.** Continued income supports and rent supplements will be necessary for most of the clients to maintain their housing.
9. **E4C clients continue to face discrimination from other service providers.** There may be ongoing opportunities to raise awareness of the Housing First program's approach and impact, in order to improve collaboration between service providers.

A more systematic examination of the acuity and experiences of clients who are re-housed because of an eviction while receiving housing supports may be a useful avenue for future research. Although data from the follow-up interviews in this study are limited by the small number of participants, the results related to housing stability suggest that evictions may occur for clients who have ended their substance use and involvement with sex work, while other clients who do engage in these risky behaviours may remain housed. A deeper understanding of the multiple factors that can lead to conflicts with landlords or neighbours and ultimately result in evictions may help to ensure that clients of E4C and similar programs are able to maintain stable housing.

In the future, expanding opportunities for program clients to engage with one another in group settings represents an important opportunity to both meet their expressed need to give back and support other women who have had similar life experiences, while also addressing a feeling many of the study participants expressed agreement with: "I am lonely."

Introduction

Research Problem

It is a truism that chronically homeless women tend to be invisible, and indeed this population is currently not well-served by the available array of housing programs. The services that target women in particular are more likely to be tailored to the needs of women who are leaving a situation involving violence and/or other forms of abuse by an intimate partner, and who may be accompanied by dependent children. The few services that engage specifically with women who have been homeless for extended periods of time, including women who are substance users or who have compromised mental wellness and those who have been sexually exploited, typically follow linear, 'treatment first' approaches to service delivery in which clients are believed to move along a "Continuum of Care" with independent housing as the end goal. These approaches have been questioned and there is a growing body of evidence that suggests that chronically homeless individuals with multiple barriers, including substance use and mental illness, experience better outcomes and are more likely to end their homelessness if they are able to access independent housing immediately, through a Housing First approach to service delivery. However, most of the available evidence in support of the Housing First approach has not examined whether it can be generalized to chronically homeless women who have experienced sexual exploitation and have histories of high-risk behaviours, including substance use and exchanging sex for money.

E4C represents one of the only known Housing First/Intensive Case Management teams that focuses exclusively on chronically homeless women with histories of high-risk behaviour and provides services intended to meet their unique needs (see Appendix 1, and Fotheringham *et al*, 2011 and Davis, 2004, for examples of programs that provide housing services for this population). In order to add to the available evidence about whether the Housing First service delivery model can be effective for this population, a team of researchers, including E4C program staff and OrgCode Consulting, Inc., funded by Homeward Trust Edmonton, initiated a study to follow clients receiving Housing First and Intensive Case Management supports through E4C.

Four primary research questions were identified:

1. What are the characteristics of the population? This includes age, past and present involvement with service delivery systems, and housing history.
2. Was involvement in high-risk and/or exploitative situations triggered as a result of clients' homelessness, or did involvement in these situations predate homelessness?
3. What aspects of Housing First ICM are currently working well, and how might amendments be made to improve service delivery and housing stability specifically for women?
4. Based on the available literature, which evidence-based or evidence-informed practices should be considered for working with this population?

Potential Contribution of the Current Research

The current research has the potential to lead to improved services for chronically homeless women, through its examination of how this population fares in a Housing First program over time. Because the E4C Housing First program is relatively unique and serves a population with very specific needs, this

research will increase scholarly understanding of how transferable the principles of Housing First are among different groups who have different experiences of homelessness, and will add to the currently limited body of evidence and best practices for providing services to chronically homeless women. In addition, by soliciting the opinions and feedback of the service users about the services they receive through the E4C Housing First program and what they like and dislike about the program, potential areas for improvement within the program itself can be identified.

This research project also helps to address concerns that variations on the Housing First and Intensive Case Management models are being implemented in advance of sufficient evidence that they are superior to more standard treatment-first approaches to address homelessness (Johnsen & Teixeira, 2010). This research, while a small study, will add to the body of research that is evaluating these models, and also extend it through examination of a population that is currently under-served by both Housing First and standard interventions.

Research Context

A Lack of Specific Services for Chronically Homeless Women

Women without children comprise approximately one quarter of the Canadian homeless population; this group tends to be older and exhibits higher incidence of substance use and mental illness (Hwang, 2001; Richter & Chaw-Kant, 2005). Furthermore, there is evidence to suggest that women's experiences while homeless are not identical to those of men, and homeless women face a distinct set of risks.

The majority of programs that focus on women who are experiencing homelessness are targeted at women, or women and their children, who have been the victims of domestic violence (Tutty *et al*, 2009). Although many chronically homeless women will have experienced violence from intimate partners or - in the case of sexually exploited women - "dates", evidence from the United Kingdom suggests that single women without dependent children are less likely to be able to access these services (Bowpitt *et al*, 2011). This indicates that there may be a serious gap in the services available to a large sub-group within the broader population of people experiencing homelessness.

Women experiencing chronic homelessness and/or women who are involved in high risk or sexually exploitative situations have far fewer options for services that cater to their distinctive needs. In addition, a review of programs across North America and the United Kingdom suggests that most of the available services are primarily transitional and therefore inherently time-limited. They require varying degrees of compliance that may make it impossible for some women to begin in the first place. (See Appendix 1 for brief descriptions of the programs)

Targeting services for chronically homeless women also requires consideration of what kinds of housing environments may be of greatest benefit and, conversely, which environments pose the potential for harm. The low-income and/or transitional housing environments in which sexually exploited women may live influence their ability to negotiate their own safety, and the highly structured environments of shelters and single-room occupancy dwellings, particularly those that are co-ed, can increase the degree of risk these women face (Lazarus *et al*, 2011). In particular, women who have active addictions or women who are still involved in sexually exploitative work may be forced to leave their housing in order to access or use drugs or meet with "dates", which may compromise their safety. On one hand, this research supports the low-barrier character and harm reduction philosophy of Housing First approaches to helping homeless individuals access housing; however, it is also possible that women-only housing with flexible rules may offer more safety than independent, scattered-site apartments (Lazarus *et al*, 2011). Additional research may help to determine whether Housing First services can enable sexually exploited women to access housing that is and remains safe. An interesting and related finding suggests that when homeless individuals become housed, they experience "ontological security" - feelings of stability and well-being that arise from the sense that one's social and physical environment is constant (Padgett, 2007). For a population whose life experiences typically involve disruption and instability, as is the case with many chronically homeless women involved in high-risk situations, the ontological security provided by stable, permanent housing may be of considerable benefit in creating conditions that enable recovery.

Link Between Sexual Exploitation and Homelessness

A scan of the relevant literature on housing interventions for street-involved women, especially those who have been sexually exploited, suggests that homelessness and sex work are intertwined. Sexual exploitation is linked to entry into homelessness and to substance use, but also impacts women's ability to get out of homelessness because past involvement in sex work is itself a barrier to accessing housing and housing services (Davis, 2004; Duff *et al*, 2011). Kurtz and colleagues (2005) argue that clients' histories play a role: past experiences of trauma, including physical, sexual and emotional or psychological abuse, increases susceptibility to substance use, homelessness, and "associated street survival strategies" such as sex work, while the experience of living on the streets itself results in further trauma.

The available evidence does indicate that chronically homeless women, particularly those who have been sexually exploited, have distinctive experiences of homelessness and face unique barriers in accessing housing and homelessness services (Davis, 2004). For example, Davis (2004) found that many shelters and housing programs were reluctant to admit homeless women who were involved in sex work because program workers did not believe they would be able to adequately meet these women's complex needs, citing concurrent substance use in particular. This highlights the need for programming developed in response to the particular needs of these women.

Social services, however, are rarely designed to address the interconnected issues of past experience of violence and trauma, mental health disorders, and substance use. Furthermore, they are also not commonly designed to address these related issues with an understanding of how they are impacted by gender or diversity (BC Centre for Excellence in Women's Health, 2009).

Housing First & ICM - Successful Models for Ending Chronic Homelessness

Housing First approaches are becoming more common across Canada and the US, particularly as a model for service delivery for individuals with multiple barriers. The approach separates the need for housing, which is viewed as a fundamental right, from the need for treatment for substance use or mental health disorders, which is understood as a voluntary choice (Padgett *et al*, 2006). 'Linear treatment' or "Continuum of Care" models typically graduate clients through several phases of progressively more independent living environments, with the expectation that at each phase, clients will either demonstrate increased 'housing readiness' through compliance with treatment requirements and sobriety conditions, or face the possibility of moving backward through the system or losing support entirely if they do not do so. In contrast, in 'Housing First' approaches, clients are placed directly into independent housing (Johnsen & Teixeira, 2010). Typically, the clients are assisted to access a standard tenancy and will have the same legal rights and obligations as any other tenant (Goering *et al*, 2011). Because clients are not required to comply with sobriety conditions in order to access housing or services in the Housing First model, it is consistent with harm reduction approaches to addressing issues such as substance use (Johnsen & Teixeira, 2010). The Housing First model emphasizes respect for consumer choice in all areas, including the location and type of housing and furnishings, the degree of engagement with the offered supports, and when and where clients will meet with their support workers (Johnsen & Teixeira, 2010; Goering *et al*, 2011).

The Housing First approach involves combining immediate access to subsidized housing with access to supports that help clients to address other issues in their lives, including substance use and mental illness (Padgett *et al*, 2006; McNaughton Nicholls & Atherton, 2011). Within that broad definition, individual Housing First programs may follow different models; for example, New York City's Pathways to Housing

program targets clients who have serious psychiatric disorders and provides them a choice of independent scattered-site housing in combination with Assertive Community Treatment (ACT), while Toronto's Streets to Homes program serves homeless individuals with wider variation in their specific needs and intensity and provides supports with an Intensive Case Management (ICM) approach (Goering *et al*, 2011). The major difference between ACT and ICM, the service delivery model provided by E4C, is that the former is characterized by clients' involvement with a coherent team of specialists and the latter by a connection to a single caseworker (Goering *et al*, 2011). A client receiving ICM supports will be assisted by their case manager in linking to other specialists and services, such as counselling or addiction treatment, on an as-needed basis. Although ICM and ACT share many practices, one area of difference is an emphasis on providing comprehensive treatment and rehabilitation in the case of ACT, while ICM is rooted in case management practices and focuses on client strengths and empowerment in the process of linking and coordinating services (Shaedle *et al*, 2002).

Support for the effectiveness of the Housing First approach comes from case studies, the outcomes from several large, randomized trials, and multi-site comparative studies. Current evidence suggests that Housing First interventions may lead to reduced hospitalization and use of emergency services (Gulcur *et al*, 2003) and increased housing stability and program engagement in the long-term (Gulcur *et al*, 2003; Padgett *et al*, 2006; Pearson, Montgomery & Locke, 2009). Typically, housing retention is stronger in Housing First interventions when compared to more standard linear model interventions, but clinical outcomes related to mental illness and substance use are mixed (Johnsen & Teixeira, 2010). Comparisons of 'treatment as usual' and Housing First approaches, including some experimental research in which clients were randomly assigned to one of the two service delivery models, suggest that although clients receiving supports through settings such as 'sober living' facilities are more likely to be engaged in addiction treatment, they report essentially identical rates of substance use when compared to clients who are supported in independent housing (Tsemberis, Gulcur and Nakae, 2004; Padgett *et al*, 2006).

Housing First approaches for chronically homeless women are supported by effectiveness studies from the US that compared outcomes for male and female clients of three programs; this research found that while women were more likely to temporarily depart from program housing, they were also more likely to remain engaged with the program than male clients (Pearson *et al*, 2007; Pearson, Montgomery & Locke, 2009). An interim evaluation of a Housing First program in Massachusetts for women and men found that hospitalizations and use of psychiatric facilities decreased for both sexes (Meschede, 2007). Housing First approaches have also been recommended for women through attempts to theorise and classify the specific needs preferences of women who are experiencing or who have experience with homelessness. For example, one study found that homeless women had the resilience and adaptability to live independently, but needed social supports that would help them to access stable, permanent housing (Bukowski & Buetow, 2011).

However, while these findings suggest that the overall approach can be effective for women, they do not address the question of whether chronically homeless women with histories of high-risk behaviour can benefit from Housing First. One reason for this gap in the research may be the limited nature of services available to this population. Edmonton's E4C program represents an essential avenue to learn more about how women who fit this profile fare when they receive supports through a Housing First service delivery model.

Research Approach

This research project involved three main sources of data: a literature scan, baseline and follow-up interviews with E4C clients, and group interviews with the E4C housing support workers.

Literature Scan

A scan of the available literature on the characteristics of chronically homeless and/or sexually exploited women, and women's experiences with Housing First programs and intensive case management was carried out in order to identify existing programs delivering Housing First/Intensive Case Management services to chronically homeless women, particularly those involved in high-risk situations, and to identify evidence for such programs' effectiveness in the academic or grey literature. The goal was to contextualize the E4C Housing First program and identify best practices for Housing First and Intensive Case management supports for women that have been adopted in other jurisdictions. (See Appendix for descriptions of the housing programs for women for which detailed information about their service delivery model, client population, and/or client outcomes were available). However, with the exception of a research report that compared the available outcome data for a number of different UK-based housing interventions for sexually exploited and chronically homeless women (Davis, 2004), evidence concerning the effectiveness of these programs was scant. In addition, the literature scan revealed only one organization delivering a Housing First intervention targeting this specific population; the majority of the housing programs offered forms of transitional housing, with some variation in the degree and nature of conditions that clients were required to meet in order to access that housing.

Key words used to identify relevant literature included the following, in different combinations:

"Housing First"
"Intensive Case Management"
"Women"
"Homelessness"
"Chronically homeless"
"Chronic homelessness"
"Sexual exploitation"
"Sex work"
"Street-based sex work"

Client interviews

Semi-structured interviews, ranging in length from one to two hours, were carried out with women accessing housing and intensive case management through the E4C Housing First program. The baseline interviews were conducted in February and March of 2012 with 12 participants, and follow-up interviews were conducted with 4 participants in September and October of 2012. Interview participants were contacted by the E4C Program Director or by their case manager.

All of the baseline participants indicated that they were willing to participate in a follow-up interview, and 11 of the 12 were contacted and asked to participate in the follow-up interview; however, only 6 responded to the request, and 2 of these participants canceled their interviews. Four of the remaining

baseline participants did not respond to the request for an interview, and one participant had left Edmonton. The remaining participant could not be reached. The Program Director or case manager was present during all of the interviews to ensure that the participants had a familiar and trusted person to whom they could turn for support if necessary; one possible explanation for why four of the baseline participants did not respond when contacted for a follow-up interview may be the fact that the clients had not yet developed relationships with the new Program Director, who took over in the middle of the study period.

Participants received a $15 honorarium upon completion of the baseline interview, and a $25 honorarium after the second interview.

Consent

Participants were verbally informed of the purposes of the research project and its potential to help improve service provision for other women who have had similar experiences, and were asked to verbally consent to participate before proceeding with the interview. The participants were also clearly informed that they could choose not to answer questions if they wished, and that they could end the interview at any time, before the interview began. Overall, the women who participated were very open in their responses and answered all questions. One participant became distressed partway through a series of questions dealing with sexual exploitation, and the interviewer chose to move on to the next portion of the interview rather than complete that line of inquiry.

During each interview, participants' responses were recorded with detailed notes, which were transcribed as soon as possible after each interview. Because the interview included questions about current illegal activities, the responses were not audio recorded.

Interview Approach and Analysis

The baseline and follow-up interviews enabled the research team to develop a clear understanding of the characteristics of the client population, learn more about the factors that led to their homelessness and how they were able to end their homelessness, understand how their quality of life was affected by becoming housed, and elicit their perspectives and opinions about the Housing First and Intensive Case Management supports they receive through E4C.

The interview guides for the baseline and follow-up research were developed through collaboration between E4C staff, OrgCode staff, and persons with lived experience, and were designed to elicit detailed information about the participants' life experiences as children and adults. The interviews included a mix of open-ended questions (e.g., "Tell me about all of the times in your life that you've been homeless"), closed-ended questions (e.g., "Are you currently using drugs other than tobacco?") and rating or ranking questions (e.g., "How would you describe your relationship with your landlord? Excellent, Good, Okay, Poor, or Terrible?").

Areas of focus in the interviews included the participants' histories of housing and homelessness as children and as adults, self-reported past and present use of substances including drugs, alcohol and tobacco as well as changes in their patterns of substance use since moving into housing, health and wellness, relationships, and their experiences receiving housing supports through the E4C Housing First program. The assessment of housing stability included tracking both the frequency with which and reasons why clients were re-housed; e.g., did the client move because of an eviction, or the participant's choice to move into housing deemed more suitable or affordable? The follow-up interview built on the

findings from the baseline study by focusing on changes in quality of life indicators and high-risk behaviour during the intervening six months. Participants were also asked to identify whether there had been any significant change in the type of supports they needed or were receiving during that period. These outcomes are consistent with the outcome indicators used in other research (see Goering *et al*, 2011).

The open-ended questions revealed critical events or time periods in the clients' lives, including the first time that they exchanged sex for money and the times when they have been homeless in the past. For example, in order to identify commonalities and differences in how the study participants first became involved in sex work, they were asked to "Tell me about the first time you exchanged sex for money," with additional probes to learn whether the participants were housed or homeless at the time, the reason that they did so, and who got them started. The open-ended responses were grouped and categorized by theme.

Staff Interviews

The E4C case management staff were also interviewed as part of this research project, using an informal group interview format. The purpose of the staff interviews was to develop a deeper understanding of how services are provided to clients and the particular challenges that arise. Four of the five support workers were able to participate in two group interviews. They were asked to discuss the elements of the Housing First program that are working well, aspects of the supports or services they offer where there are opportunities for improvement, and identify current barriers that impact their ability to effectively support their clients. Their responses were grouped by theme and provided additional data on how the Housing First service delivery model could be amended to improve service delivery specifically for women.

Potential Limitations

The single most significant challenge in this research was a high rate of non-participation at both baseline and follow-up. The target number of participants in the baseline study was eighteen, and at least eighteen clients were contacted; in total, twelve women participated. Six additional women agreed to participate in the baseline study, but either canceled or could not be reached at the scheduled time. In addition, a significant number of the baseline participants did not participate in a follow-up interview; one of the original participants was no longer in contact with the ICM team and could not be reached, and one client was no longer in the city. In total, only four of the baseline participants also completed a follow-up interview. The small sample size for both sets of interviews represents a serious limitation for the research; the clients who agreed to participate in one or both may not be representative. However, the four participants who were interviewed at baseline and follow-up did report a wide range in their involvement with high-risk behaviours before and during the study period, as well as their outcomes. The variation in their responses and experiences suggest that the clients who participated in both interviews do not only represent those who experienced a high degree of 'recovery'.

In addition to the difficulties with participant recruitment and retention, it is important to note that this research is a case study. While the participants had spent varying lengths of time in the program, and there was considerable variation in their self-reported patterns of substance use and/or involvement in sexually exploitative situations, the possibility remains that the clients who chose to participate in the study differed from those who did not in ways that might have affected the results.

However, this research project nonetheless offers an important opportunity to draw some preliminary conclusions about how women who have experienced chronic homelessness, who have complex needs including both mental health and substance use issues, and who have life histories of sexual exploitation, may benefit from Housing First supports.

Research Findings

Client Characteristics

The majority of the twelve women who participated in the baseline study were born in Canada, and half were born in Alberta; nine of the twelve reported that they grew up primarily in Edmonton. One third of the participants identified as Métis (3) or Aboriginal (1); other participants identified as Caucasian (2), Canadian (1) and South American (1). The remaining four clients indicated that they did not identify with a particular ethnic or cultural community. The women's ages range from 28 to 52 years old; their average age was 41.

While their educational backgrounds varied, the study participants typically left the school system before graduating from high school, a finding that is consistent with the disruption and abuse that characterize the childhoods of many of the participants. At baseline, the majority of the participants reported that they had not completed high school past the 10th grade, and six had not completed any education beyond the 8th grade. Two of the participants completed high school; both of these women had received at least some post-secondary education at the baseline interview. During the follow-up interviews, some clients indicated that they were working toward additional education, including one of the two who had some post-secondary education.

Early Experiences of Trauma and Disruption

Although the circumstances and specific situations varied, all of the study participants had adverse childhoods, and all of the women reported that they were abused in some way as children. The predominant theme that emerged when the women considered the involvement of their biological parents in their upbringing could be characterized as neglect and absence; addiction and abuse were also very common.

Only two reported that both of their biological parents were present during their childhoods and involved in their upbringing, and of these two, only one described the relationships with and between her parents as healthy and positive. The other described her mother as "present", but her father was the primary caregiver. Two additional participants also reported that they had good relationships with their fathers, although the father was not always the participant's primary caregiver, and the fathers of two of these three study participants passed away while the participants were children. Two participants lost both parents as young children; in one case, both parents died, and in the other, the client's father left after her mother's death. Abandonment was the more common reason for absent parents; in total, half of the study participants reported that one of their biological parents either left or was never involved in their life at all; in one case, one parent left with the study participant's older siblings, leaving the participant with a parent who abused alcohol.

Parental addictions and mental illnesses affected the study participants' childhoods. One quarter of the study participants reported that one of their parents had an addiction to drugs or alcohol that impeded their ability to adequately care for their children; in two of those cases, this parent was the primary caregiver, and one of the participants was removed from her mother's care at a young age because of the resulting neglect. Parental mental illness was also cited as a factor in the neglect or abuse experienced; one client indicated that her mother, who was the sole caregiver, had untreated bipolar disorder, and as a result, there was no routine or affection in the family and verbal abuse was frequent. Two study

participants whose mothers were the primary caregivers reported that they were sexually abused by their mothers' boyfriends or family, and that they did not have good relationships with their mothers, who in both cases were described as having ignored or attempted to cover up the abuse.

All of the clients who participated in the interview reported that they experienced some form of abuse when under the age of 18. Ten of the women were sexually abused, either by family members or by their caregivers while in foster care, and one other was raped at a friend's house. Eight of the women (66.7%) reported psychological or emotional abuse by family members, which included name-calling and put-downs (e.g., "dirty Indian", "stupid", "you'll never amount to anything"), manipulative behaviour and threats (e.g. pitting the client against her siblings, threatening to kill the client or her family members), and enabling other forms of abuse (e.g. working to prevent others from finding out about the sexual abuse by other family members). Four of the clients (33.3%) indicated that they were victims of physical abuse in addition to sexual abuse. While most of the abuse was at the hands of family members, two clients specifically noted that they experienced sexual and/or physical abuse while in foster care.

The majority of the study participants (8, 66.7%) have received some degree of professional support as a result of the abuse, but one third reported that had not received such support. Of the eight who have received some support, three also described it as “limited”. Five of the women (41.7%) felt that they have not recovered from their experiences of abuse, and four (33.3%) stated that they haven't fully recovered but have made some progress towards recovery. Two stated that they do feel they have recovered from the abuse.

All of the women who participated in the study have long histories of involvement with service delivery systems. Just over half of the participants (7, or 58.3%), reported that they spent at least one year in foster care when under 18; two of these participants were placed in foster care on two separate occasions. Four were in foster care as teenagers, three between the ages of 2 and 6, and two between the ages of 7 and 12. On average, the participants spent 2.6 years in foster care, although they reported a range between 1 and 7 years. Abuse by family members - whether physical or sexual - was the most commonly given reason for placement in foster care (4 clients, 57.1% of those who spent time in foster care). 2 others (28.6%) were placed in foster care by their caregivers; in one of these cases, the caregiver did so after the client told her that she was being sexually abused by family members. Neglect or abandonment were also factors. Two participants said that they did not know the reasons why they were placed in foster care and were too young to remember.

Half of the participants (6, or 50%) spent time in a juvenile corrections facility when under 18. The length of time spent in a facility ranged from 30 days to 4 years, although the client who was in custody for 4 years indicated that she was in and out several times. Two years was the most common length of time in custody (reported by 3 clients), and theft was cited as the most common reason for placement in a corrections facility, with 5 of the 6 (83.3%) reporting that this was they reason they were incarcerated. Two participants were also placed in custody for assaults, two for mischief, and one for drug use. Three of these clients indicated they were incarcerated on 2 or more charges, and three gave only 1 reason for their incarceration.

History of Housing and Homelessness

The participants responses indicate that substance use and homelessness were very closely connected. The majority of the women (8, 66.6%) described their substance use as the primary reason they became homeless. Two women (16.7%) also indicated that their involvement in sex work was also closely linked to their experience of homelessness; one of these women also specifically noted that it made it difficult for

her to access shelters and services, including income supports. Three of the women (25%) also experienced homelessness as children, when their families lost their housing.

The majority of the participants (10, or 83.3%) indicated that they stayed in shelters when homeless, and just under half (41.7%) indicated that they also "couch-surfed" with friends or family. Half of the women indicated that they would stay with "dates", at their homes or in motels, when they could. One quarter of the participants reported that they slept rough at least some of the time.

The length of time the women had been homeless ranged from 2-3 years to over 20 years; the most commonly reported length of time spent homeless was 2 years (reported by five of the participants). An additional 3 women (25%) had been homeless for 3-5 years, and one participant reported that in total she had been homeless for about 8 years. One quarter of the participants reported that they had been homeless or at risk of becoming homeless for 20 years or more; although all of them had housing some of the time, it was never safe or stable. This is consistent with the histories of homelessness reported by participants in other studies of the Housing First service delivery model (e.g., Tsemberis, Gulcur and Nakae, 2004).

For many of the study participants, making the decision to end their drug use was instrumental in helping them to get out of homelessness (5, or 41.7%). However, finding the right program or service was also essential for the majority of the women (7 of 12, 58.3%): five of these women specifically mentioned the role that E4C played in helping them to both get housing and seek out treatment and support to end or reduce their substance use as a key factor in ending their homelessness.

Most of the clients who were interviewed for the baseline study had been in their current housing for six months or less at baseline. Four of the study participants reported that they had lived at their current address for 1 month or less at baseline, and four reported that they have lived at their current address for 1-6 months. Two participants had been at the same address for 6-12 months, and two others for more than 2 years.

Eight participants reported that they have lived in more than 1 home since joining the E4C program, but the majority indicated that they were re-housed for positive reasons (e.g. moving to a larger apartment or finding a less expensive place). Three clients were evicted from their housing while receiving supports through E4C, and one client lost her housing supports through the program as a result of choosing to live with a roommate.

Two of the four participants for whom both baseline and follow-up data are available remained in the same housing throughout the study period, and two were re-housed following an eviction during the study period. The same two clients also reported that they had been evicted from the housing they received through E4C in their baseline interviews. Interestingly, of these two participants, one was using drugs and engaged in street-based sex work regularly during the study period, while the other was not. Of the two clients who maintained their housing, one woman did not engage in either sex work or drug use during the study period and the other reported that she had done on two occasions, both times after using drugs. These findings must be interpreted with caution because the number of responses is so small, but they nonetheless suggest the possibility that women can remain stably housed while they are involved in street-based sex work and while their substance use continues, and also that ending involvement in this work is not sufficient to enable an individual to become stably housed.

The following table illustrates the women's average responses when asked to express their agreement with a number of statements related to their housing stability and their ability to take care of their basic life

needs, on a scale of 1 to 10, where 1 represented complete disagreement and 10 represented complete agreement. The responses indicate that while the participants were only slightly in agreement that they are able to manage all aspects of their lives, they were very confident that they had the skills necessary to maintain their physical living environment and to take care of such basic needs as food and clothing.

Table 1: Average Agreement With Housing Stability-Related Statements at Baseline

I am stably housed.	9.3
I will never become homeless again.	8.3
I am good at managing all parts of my life.	6.8
I am good with money.	6.5
I know how to take care of an apartment.	9.1
I know how to take care of my basic needs.	9.3

The follow-up participants indicated somewhat less agreement with the statement “I am stably housed”, but their agreement with the other statements showed a marginal increase.

Table 2: Average Agreement With Housing Stability-Related Statements at Follow-up

I am stably housed.	8.75
I will never become homeless again.	8.75
I am good at managing all parts of my life.	7.75
I am good with money.	6.75
I know how to take care of an apartment.	9.5
I know how to take care of my basic needs.	9.5

Involvement in High-Risk Behaviour

In general, the women who participated in the study reported that their first experiences with exchanging sex for money occurred while they were homeless. Most of the women (9 of 12) were homeless the first time they exchanged sex for money, and one was in the process of being evicted. Two of the women indicated that they were housed the first time they exchanged sex for money. Although the circumstances varied, and two of the women did not recall much about the first time they did so, several themes did emerge. The ages at which the women began to exchange sex for money ranged from 12 years old to mid-twenties; not all of the women indicated how old they were, but of those who did, five (41.7%) were teenagers. Three of the women (25%) said that the first time they exchanged sex for money - or, in one case, directly for access to crack - they were not actively planning to do so; they were offered cash in exchange for a sexual act and accepted the offer. In contrast, 4 (33.3%) said that they made a conscious decision to exchange sex for money, for a range of reasons, including needing money for drugs and needing money to pay for shelter.

Eight of the women (66.7%) said that they exchanged sex for money either because they needed money immediately, or because they saw it as an easy way to get money. Two others did not mention money, but explained that they viewed their bodies as something for sale: one added that she was “raised that way”. Only two of the participants said that they exchanged sex for money specifically for drugs, although they all answered "yes" when asked if they had ever exchanged sex for money, knowing they were doing it to get money for drugs. One woman said that in addition to exchanging sex for access to drugs, she did it because she was lonely.

Peer and family examples appear to be significant factors in becoming involved in sexually exploitative situations. Five of the participants indicated that they began exchanging sex for money because of other "working girls" in their lives; for three, the "other girls" were also family members. One woman explained that her family forced her to start exchanging sex for money by threatening to throw her out unless she gave them money for rent and other expenses, and she had no other way to earn it. Four of the women said it was the man who offered them money in exchange for sex who got them started, and of those four, two reported that the man was also their dealer.

At baseline, three participants (25%) said that they are still involved in exchanging sex for money, although they described it as an irregular activity. One participant indicated that she would exchange sex for money every couple of weeks, while another reported that she did so once every 3-4 months. All 3 indicate that they work from the street at least some of the time, and one also arranges “dates” by phone. One woman explained that she exchanges sex for money now only when she goes to visit with friends who are still involved in street-based sex work. It was difficult for the women to clarify how much money they bring in through this work in an average month: for example, one of them said that she only does it when she needs and wants the money and this varies from month to month; she said that may bring in $5000.00 in a week and $2000.00 in a night, but would not estimate a monthly amount. The client who said she exchanges sex for money once every 3-4 months said she brings in about $300.00 when she does so. None of the three women give another person a cut of what they make through this work.

All of the women said that there are sexual acts that they will not do in exchange for money. Two of the three stated that they always use protection; conversely, one woman said that she does engage in sexual acts that she thinks may put her health or safety at risk, while the other 2 indicated that they don't engage in activities that may be unsafe. All three of these women reported that they have had "bad dates" in the past.

All but one of the women have had paid employment other than sex work in their lives, but the majority were not working at either baseline or follow-up. Most of their past work has been in the hospitality industry (5, 45.5%) and the service industry (5, 45%). Interestingly, however, four (36.4%) women also indicated that they have worked in human services in capacities that include addiction counselling and housing support. Five of the women said that they have had "straight jobs" and been involved in exchanging sex for money during the same periods in their lives. One participant had a ‘straight job’ at baseline that she also maintained at follow-up.

Use of Alcohol and Drugs

The baseline interview findings indicate that all of the study participants have histories of drug and alcohol use that date back into childhood.

At baseline, all of the women indicated that they have used alcohol in the past or currently use it; two thirds of the participants still consumed alcohol when they were first interviewed, and four indicated that

they no longer used alcohol. The average age at which the women had their first drink was 13.8 years old.

Among the participants who were still using alcohol at baseline, five (62.5%) reported that they drink at least once every week; other responses included at least once every few months (1), at least one time per year (1), and every day (1). The amount of alcohol the participants consume at one time varied considerably. Most participants reported that they drink either 1-3 drinks (4 clients, 33.3%) or 3-6 drinks (4 clients, 33.3%). 1 indicated that she consumes 5-10 drinks, and 3 (25%) consume 10 or more drinks in one session. For most of the women (10, or 83.3%), their drink of choice was hard liquor, followed by beer (4, or 33.3%). All of the participants said that they have never consumed Listerine, cooking wine, rubbing alcohol or another type of alcohol not meant to be drunk.

Eleven of the women (91.7%) said that they have blacked out from drinking in the past and that they have engaged in activities while drunk that they regretted when they were sober. Most of the women reported that they have never sold any of their possessions (9, 75%), not paid their rent (9, 75%) or not paid other bills (8, 66.7%) or exchanged sex for money (9, 75%) knowing they were doing it to get money for alcohol.

Nine (75%) of the women indicated that their use of alcohol has gone down since they moved into housing; three (25%) report that it has stayed the same.

All of the clients who participated in the follow-up interviews report that they drink alcohol; three drink it once or twice per week, while the fourth reported that she drinks once or twice per year. Two of the participants who reported that they drink regularly in the follow-up interview reported an increase in either the frequency or the amount that they drink when compared to their responses at baseline; the reported drinking patterns of the remaining two participants did not change between the baseline and follow-up interviews. Interestingly, the two participants whose description of their alcohol use in the two interviews indicated an increase in frequency or amount at follow-up both also reported that their use of alcohol had gone down since becoming housed.

The majority of the study participants' responses indicate that they are more likely to abuse substances other than alcohol. However, some of the participants' comments do indicate that consumption of alcohol have led them to engage in other risky behaviour, including substance use and street-based sex work.

All of the participants reported that they smoked cigarettes at baseline, smoking an average of 9.3 cigarettes per day, and that they had been smoking since they were children. Five participants reported that they smoke half a pack of cigarettes per day (approximately 12-13 cigarettes).The women spent an average of $42.09 on cigarettes each week. Four of the women (33.3%) said that they sometimes collect used cigarette butts to roll their own cigarettes. One woman reported that she is in the process of quitting, and is using nicotine patches, but still smokes one cigarette per day.

All of the participants have used drugs other than alcohol or cigarettes in the past, and five of the twelve (41.7%) reported that they were still using drugs at baseline. Crack cocaine was the most frequently used drug, but several of the women have used other drugs as well, including intravenous heroin and powder cocaine as well as others. Eleven participants (91.7%) indicated that their use of drugs has gone down since moving into housing; the other participant indicated that her drug use stayed the same, but this participant had quit prior to moving into her housing and had not relapsed in that time. The average age at which they began using drugs was 15, and their ages when they first tried drugs range from 12 to 25,

with 12 years old being the most common response (6 of the 12 women, 50%), although several participants specified that they used only marijuana, not crack or another "hard" drug, at this age.

Of the seven women who have quit using drugs, they have been quit for periods that range from three years to two and a half months, not counting relapses. Four clients stated that they have been quit for more than a year, but half had experienced relapses.

Of the five women who are currently using drugs, four still use crack cocaine; one woman said that she still uses drugs, but only marijuana. However, they reported that their use has gone down since moving into housing. For example, one client explained that while she still uses an "8-ball" (1/8 of an ounce) of crack cocaine when she uses, she now does so once or twice a month, rather than every day. Similarly, another client indicated that while she used to consume enough crack cocaine at a time to be high for days, she now consumes enough to be high for 12-14 hours. Four of the five said that they use drugs at least once per week (including the participant who only uses marijuana), and of those, one woman said she now uses 2-3 times per week, and another said she uses about 4 times per week. The remaining woman said that she now uses drugs about twice per month.

All of the clients have used crack cocaine, either currently or in the past. 9 of the 12 (75%) have used or currently use marijuana. Two clients reported that they injected heroin in the past, and two reported that they used methamphetamine in the past. An additional 4 clients named other drugs, including LSD, mushrooms, and Talwin and Ritalin. It was difficult to ascertain accurately how much of each drug the women used each time they used, particularly for the small subset of women who indicated that although they used one drug primarily (crack cocaine in both cases), they also tried many other drugs but did not use them regularly; the interviews concentrated on their primary drug of choice. In addition, several of the women who were heavy users were not able to articulate how much they had to consume, and explained their consumption in terms of how long they would be high: for example, one client said that when she used crack, she would consume at least enough to be high for 2 days, and might use enough to be high for a week; another explained that she would be "up" for 5-6 days at a time.

Seven clients (58.3%) reported that they have blacked out as a result of using drugs, and ten (83.3%) reported that they have found themselves engaging in behaviour while stoned that they regretted when sober.

Nine of the women (75%) have sold their possessions knowing they were doing so to get money for drugs; eight have not paid their rent in order to have money for drugs, and eleven (91.7%) have not paid other bills in order to have money for drugs. All of the women said that they have exchanged sex for money knowing they were doing it to get money for drugs (with the caveat that one woman explained that she only exchanged sex directly for drugs). Seven clients (58.3%)have sold drugs, and seven (58.3%) have delivered drugs. Most (10, 83.3%) have been used for drugs or alcohol in the past, and most (9, 75%) have used other for access to drugs or alcohol.

At follow-up, the participants' use of substances other than alcohol or tobacco varied considerably. Three of the follow-up participants reported at baseline that they stopped using drugs prior to the beginning of the study period; two of these participants had ended their drug use approximately a year and a half before the baseline interviews, and also reported in their second interviews that they were not using drugs, although one then added that she will sometimes smoke marijuana. The third participant described herself as having quit using drugs several months before the baseline interview, but at follow-up, reported that she had relapsed twice during the study period, both times after consuming enough alcohol to become drunk; during this period, she used both crack cocaine and methamphetamine, and would use

enough to be ‘up’ for two days. Another participant continued to use crack cocaine throughout the study period; this participant reported using drugs more frequently during the study period (4-5 times per month, compared to the 2 times per month reported at baseline), but also indicated that the quantity she used decreased (from 3.5 grams at baseline to 0.5 grams at the follow-up). The two participants who ended their drug use reported consistent use of supports to help them stay quit between the baseline and follow-up interviews. All four clients reported that their drug use decreased after they became housed.

Health & Wellness at Baseline and Follow-Up

At baseline, the interview findings suggest that the women participating in the E4C Housing First program have a high incidence of physical health ailments and significant mental health issues. Only two participants reported that they have neither a physical ailment nor a mental health issue, while half reported that they have been diagnosed with both physical and mental health issues. Two thirds of the study participants (8, 66.7%) reported that according to a doctor, they currently have a physical ailment, and two thirds (8, 66.7%) reported that according to a mental health professional, they have a mental health issue. Nine of the women (75%) are currently taking medication for either a physical or a mental health issue. While all of the participants indicated that they currently have a doctor whom they see regularly, only half reported that they have a psychiatrist or psychologist whom they see regularly.

All of the twelve women who participated in the interviews have had a sexually transmitted infection or disease in the past, and two thirds have a chronic physical illness such as HIV (2, 16.7%) or hepatitis (7, 58.3%; one of these women was also HIV+). 2 of the 12 (16.7%) are HIV positive; all but one of the ten who reported that they are not HIV+ had been tested within the past year at baseline, and all but one of the participants who reported that they are not positive for hepatitis had been tested within the past year.

Two thirds (8, 66.6%) of the participants reported that according to a mental health professional, they had a mental health issue at baseline; four participants reported that they had been diagnosed with co-occurring disorders. All of the mental health diagnoses reported by the study participants were Axis I disorders, with mood disorders being the most prevalent.

Five participants reported that they have been diagnosed with Bipolar Disorder; one of these qualified it as "mild” in both her baseline and follow-up interviews. Two of the participants who have a diagnosis of Bipolar Disorder reported that they have at least one other diagnosed mental health issue. Anxiety disorders are also common: four participants reported that they have been diagnosed with an anxiety disorder, including 2 diagnoses of post-traumatic stress disorder and 3 diagnoses of "anxiety" which was not otherwise specified. One participant reported that she had a diagnosis of ADHD, and one reported a diagnosis of "memory loss". Two of the women reported that they had been diagnosed with schizophrenia; both of these participants reported that they had at least one other diagnosed mental health issue.

At baseline, six of the study participants currently have a psychologist, psychotherapist or psychiatrist who they see on a regular basis; however, two of the participants who indicated that they have a diagnosed mental health issue (bipolar disorder, schizophrenia, and an anxiety disorder) also reported they are not regularly seeing a psychologist, therapist, or psychiatrist.

At follow-up, the four participants all reported the same mental health diagnoses that they reported at baseline; these diagnoses included Bipolar Disorder (2), schizophrenia (1), and anxiety (1). All reported

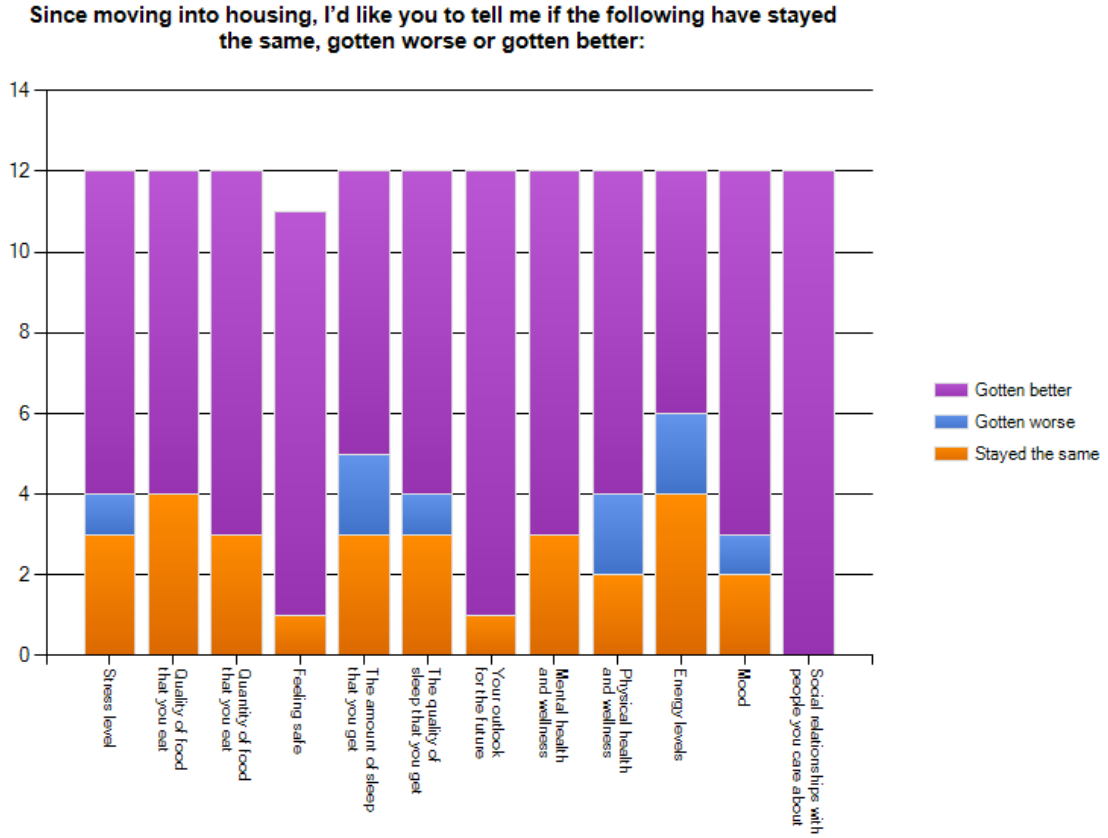
that they see a mental health professional such as a psychologist, psychiatrist or psychotherapist on a regular basis.

The study participants were not asked to report on present self-harm or suicidal behaviours at baseline; however, at baseline, six of the women (50%) respectively reported that they had intentionally hurt themselves and/or thought about suicide in the past. Just over half (7, or 58.3%) have attempted suicide in the past. At follow-up, all of the participants reported that they had not intentionally hurt themselves, thought about suicide, or attempted suicide during the study period.

Overall, at baseline, the study participants felt that moving into housing had either a positive or a neutral impact on their health and wellness, with five participants (41.7%) reporting that their health improved after they were housed, and five (41.7%) reporting that their health stayed the same. Two participants reported that their health got worse after moving into housing, but their interview responses suggest that their health issues may have been more significant: both reported that they have been diagnosed with physical ailments, and one was positive for both HIV and hepatitis. However, both of these participants still reported that they experienced either improvements or no change in the quality of life indicators other than those associated with physical health (physical health and wellness, energy levels, quantity and quality of sleep), suggesting that their pre-existing physical ailments are the reason why they reported that their health declined after moving into housing. Both of these participants also reported fewer meaningful daily activities than did the other study participants, and indicated they are only able to engage in the activities they enjoy sometimes, with one citing her health as the reason for her inability to engage in those activities as often as she would like.

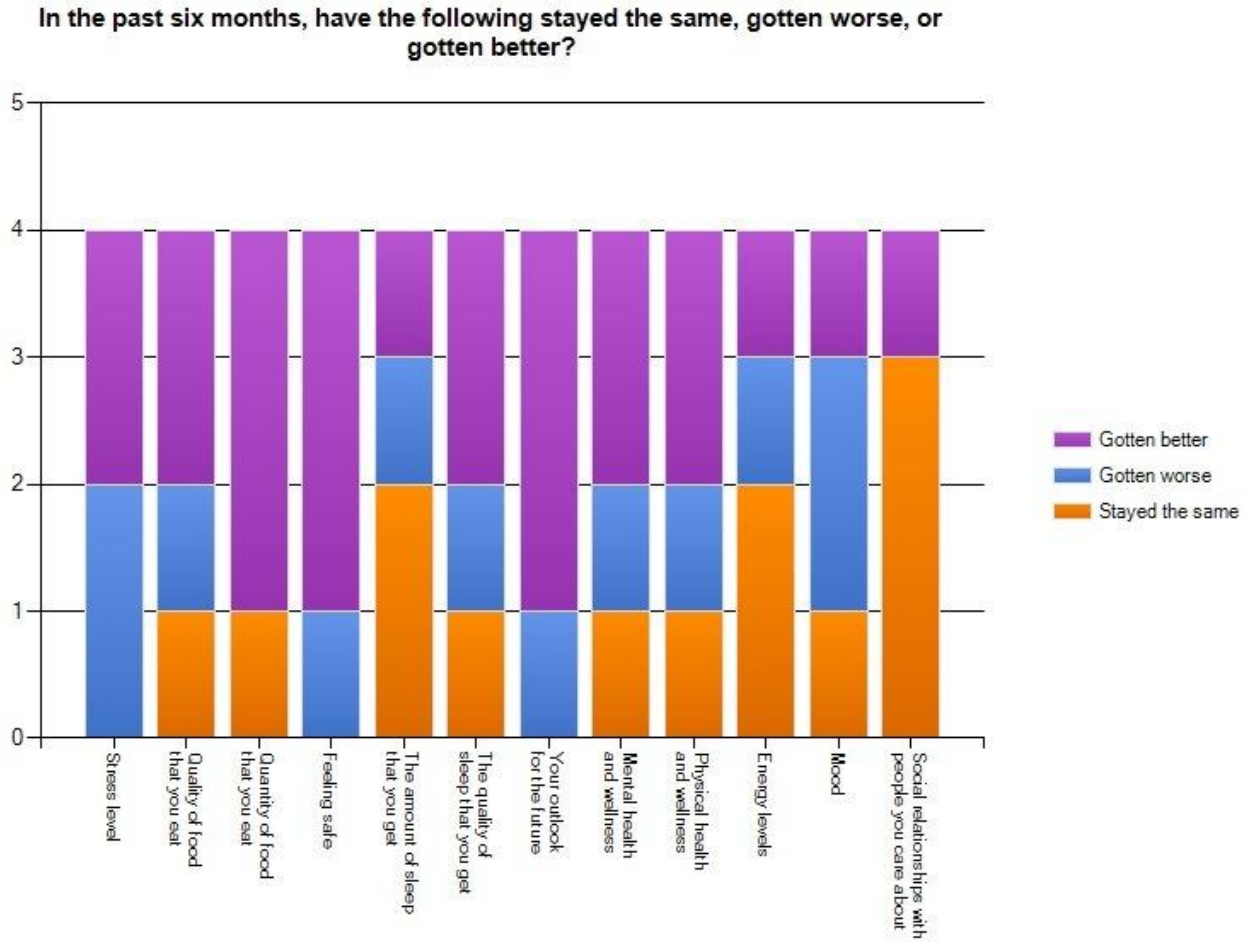
Figure 1 illustrates how the women's quality of life indicators changed since they moved into housing through the E4C Housing First program.

Figure 1: Baseline Quality of Life Indicators



At the follow-up interview, two of the four participants reported that their stress level and mood had gotten worse, and the majority of the participants indicated that the amount of sleep that they get and their energy levels had either stayed the same (2) or gotten worse (1). However, most clients (3) indicated that their feeling of safety and outlook for the future improved between the baseline and follow-up interviews. The least change was reported for social relationships, which stands in significant contrast to the responses at baseline, when all clients indicated that their relationships with people they care about got better after becoming housed. Figure 2 illustrates how the clients' quality of life indicators changed during the study period.

Figure 2: Quality of Life Indicators at Follow-up



The follow-up participants described their health as either having stayed the same (50%) or gotten better (50%) between their first and second interviews.

All of the women reported that they have previously been in a physical fight with another person, but at baseline, most had not been in a physical fight recently: six (50%) said that their last fight was more than a year ago, and an additional three (25%) said that it had been 6 months to one year since their last fight. Two reported that they had a fight in the last 1-6 months, and two had a fight within the last month. At follow-up, two of the participants reported that they had been in a physical fight within the past 6 months.

Service Utilization at Baseline and Follow-up

The baseline interview results, like earlier research on the Housing First approach, indicate that clients' use of emergency services decreases; in addition, the interview data suggest that involvement with Housing First may also be helping the study participants to access more primary and preventative health care. Overall, the women reported that their use of primary care health services, including family doctors, psychiatry, and health professionals such as dentists and optometrists, either stayed the same or increased. In contrast to the women's use of family doctors, which typically stayed the same or increased

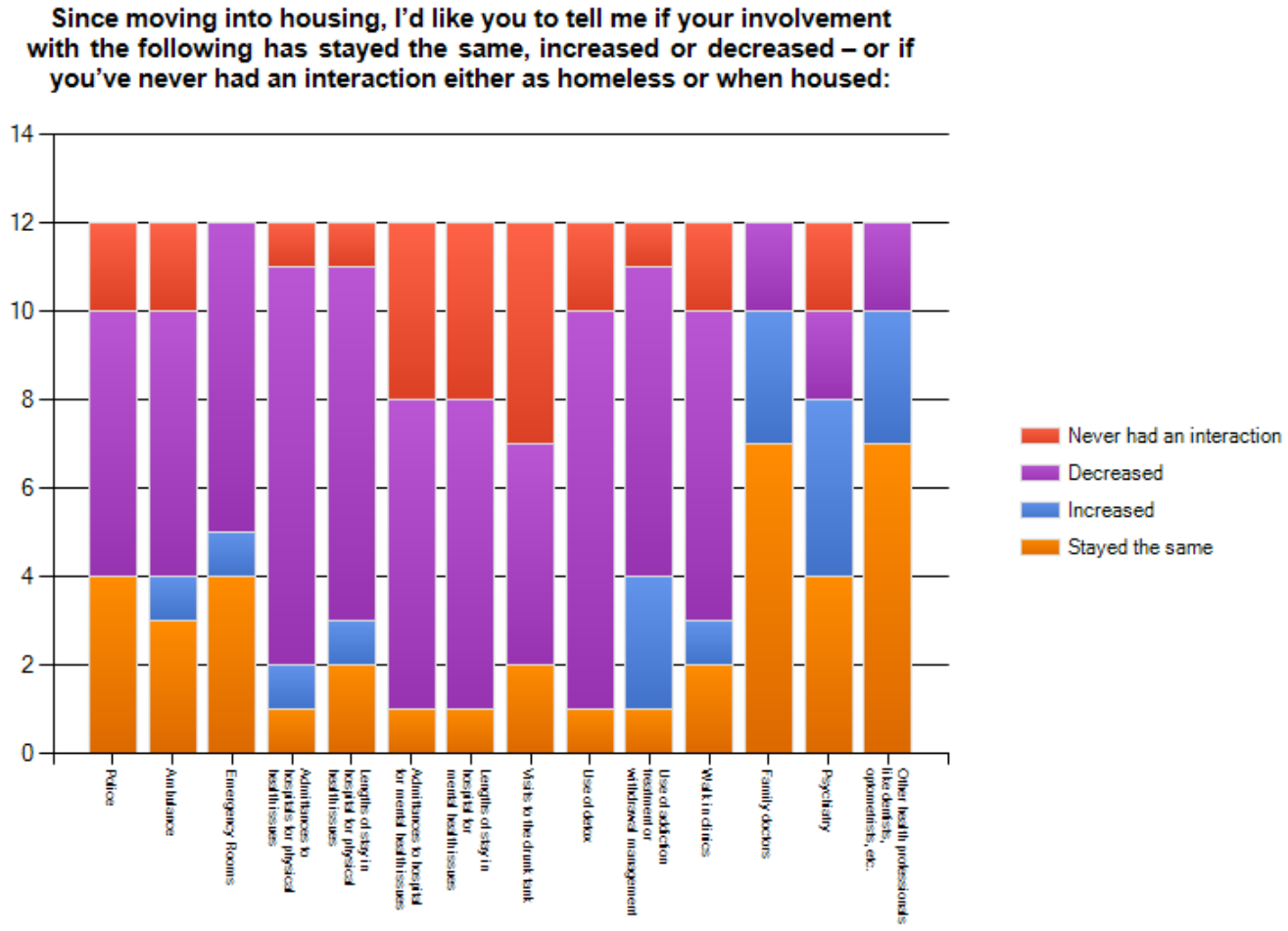
after the participants became housed, seven of the women reported that their use of walk-in clinics decreased, and only one participant reported that it increased after becoming housed.

Despite the fact that somewhat less improvement in physical health was reported, compared to mental health and wellness, the women's responses at baseline indicate that after moving into housing, both their admittances to hospital and their lengths of stay in hospital for physical health issues decreased. 9 women (75%) reported a decrease in the number of hospital admissions related to physical health, and only one client reported an increase after moving into housing. The results were very similar for length of stay, with two thirds of the clients reporting that their lengths of stay in hospital decreased after becoming housed, and only one participant indicating an increase. Of the eight participants who reported that they had been hospitalized for mental health issues, seven reported that both their numbers of admissions to hospital for mental health issues and their lengths of stay in hospital for such issues decreased after moving into housing; one participant reported that both had remained the same. Interactions with the police, ambulances, and emergency rooms also showed an overall decrease since the women moved into housing.

The majority of participants reported that visits to the "drunk tank" and detox decreased, which may reflect the reported decrease in overall use of drugs and alcohol that occurred after the participants became housed. Interestingly, just over half of the women also reported that there had been a decrease in their use of addiction treatment or withdrawal management (7 women, 58.3%), compared to three (25%) who reported that they increased their use of these services and one who reported no change in her use of these services. These results are consistent with research that has found that Housing First clients engage less with such services (e.g., Tsemberis, Guclur & Nakae, 2004), but may also be explained by the fact that a number of the study participants also relied on informal supports from friends and family in order to address their substance use. Although it was not brought up by the participants in the baseline interviews, it is possible that having stable housing enabled them to draw on those informal supports more consistently or effectively; future research may shed additional light on ways that stable housing may indirectly affect patterns of substance use and treatment through affects on relationships and other factors.

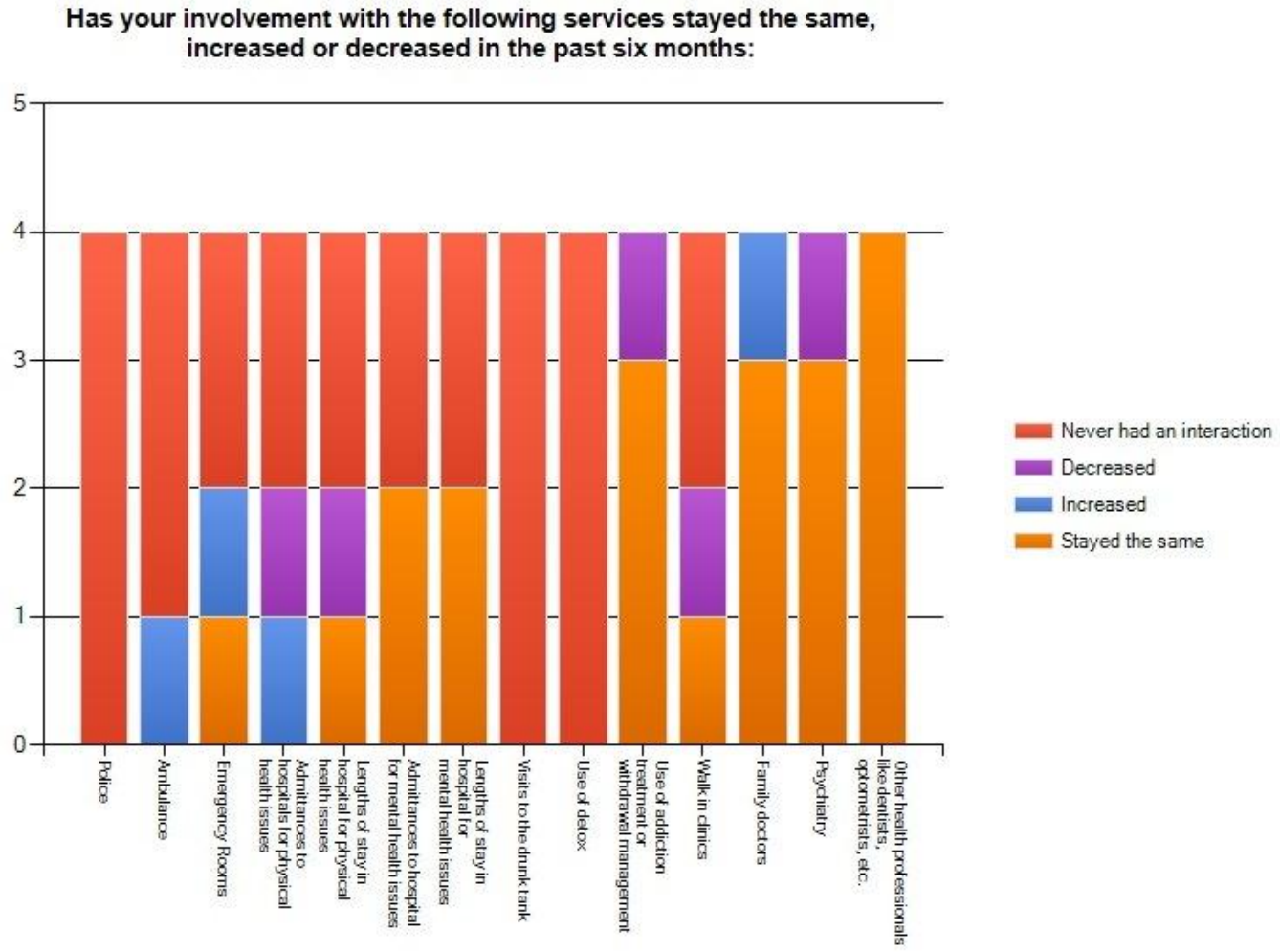
Figure 3 illustrates how the women reported their use of services, including emergency services and primary or preventative health care services, were affected after they became housed through E4C.

Figure 3: Service Utilization at Baseline



During the follow-up interviews, the participants reported that they had no interactions with the police, and none had been taken to a "drunk tank" or made use of detox. The majority of the participants for whom follow-up data are available also reported that they either did not use emergency services such as ambulances or emergency rooms, or that their use of emergency services remained the same. Consistent with the baseline findings, at follow-up, the clients were making more use of regular health care providers instead of visiting walk-in clinics. Figure 4 illustrates how service use changed during the study period.

Figure 4: Service Utilization at Follow-up



Meaningful Daily Activities and Community Integration at Baseline and Follow-up

One goal of the study was to examine whether the participants increased their use of community amenities like swimming pools or gyms, and engaged in community-based activities such as volunteer work after becoming housed through the Housing First program. Overall, the findings suggest that the study participants are able to take advantage of community amenities, and have meaningful daily activities that they enjoy, although they do face some barriers that can restrict their access to these activities. Regular involvement in volunteer work was somewhat less common, and the participants were more likely to report that their ability to volunteer was affected by their past or present substance use and high-risk behaviour.

At baseline, the participants reported that they engage in a range of leisure activities, including watching movies and/or TV (8 women, 66.7%) and reading (6 women, 50%). Creative activities including art, crafts and writing (4 women, 33.3%), and listening to music (3 women, 25%) were also mentioned several times. Many women also said they enjoy exercise and going for walks (5 women, 41.7%). None of the

women reported that they either have no free time, or that they do not do anything in their free time. At follow-up, all of the participants mentioned that they enjoyed exercise, particularly swimming; watching movies or TV and reading were also common activities. When asked to rate how happy all of the activities make them on a scale of 1 to 10, where 1 was not at all happy and 10 was very happy, the average response at baseline was 8.9, and the most common rating was 10; at follow-up, the average was 9.25.

Half of the six participants who used community amenities like swimming pools or gyms at baseline reported that they could do so as often as they like, and half reported that they could do so only sometimes. Of the six clients who did not use community amenities, most cited practical barriers as their reasons for not using such amenities, rather than discomfort with the public environment. Transportation, the cost of using the facilities themselves, and the cost of basics like swimming suits were all mentioned as reasons why the clients do not use these facilities. All four participants in the follow-up interviews use community amenities, including one of the two participants who reported that she did not use them at baseline but would begin to do so as soon as she obtained a Leisure Pass.

At both the baseline and follow-up interviews, the most common reasons why the participants reported that they are unable to engage in their preferred leisure activities or use community amenities as often as they would like were lack of time, due to other commitments including child care or work, and lack of transportation. In addition. health-related barriers were cited by one participant at baseline, and one participant at follow-up. Most of the baseline participants (7, or 58.3%) and follow-up participants (3, or 75%) indicated that they are able to engage in the activities that they enjoy as often as they would like.

Participants were less likely to be engaged in volunteer work than they were to use community amenities; four participants reported that they volunteered at baseline, and no participants were involved in regular volunteer work at follow-up, although two said that they periodically help out organizations or individuals. Of the four who were volunteering regularly at baseline, three were involved in other programs helping the homeless in Edmonton. Seven participants also indicated that if they could do any kind of volunteer work they wanted, they would work with a homelessness service provider or an agency providing treatment for substance use; three women specifically said they would volunteer for E4C/Crossroads. In the follow-up interviews, one participant said she would like to volunteer for Crossroads but cannot because it conflicts with her child care responsibilities, and one participant said that if she could do any kind of volunteer work that she wanted, it would be with E4C, because the program helps women who have been abused and treats them with dignity. Other responses at follow up included working with hospitalized children or helping senior citizens. Past substance use and/or criminal records were the most commonly cited barriers to volunteer work, which particularly impacts those who wish to volunteer in a human services setting. Other barriers included health and lack of self-confidence, as well as the need to “take care of myself first”.

Financial Situation In the Program

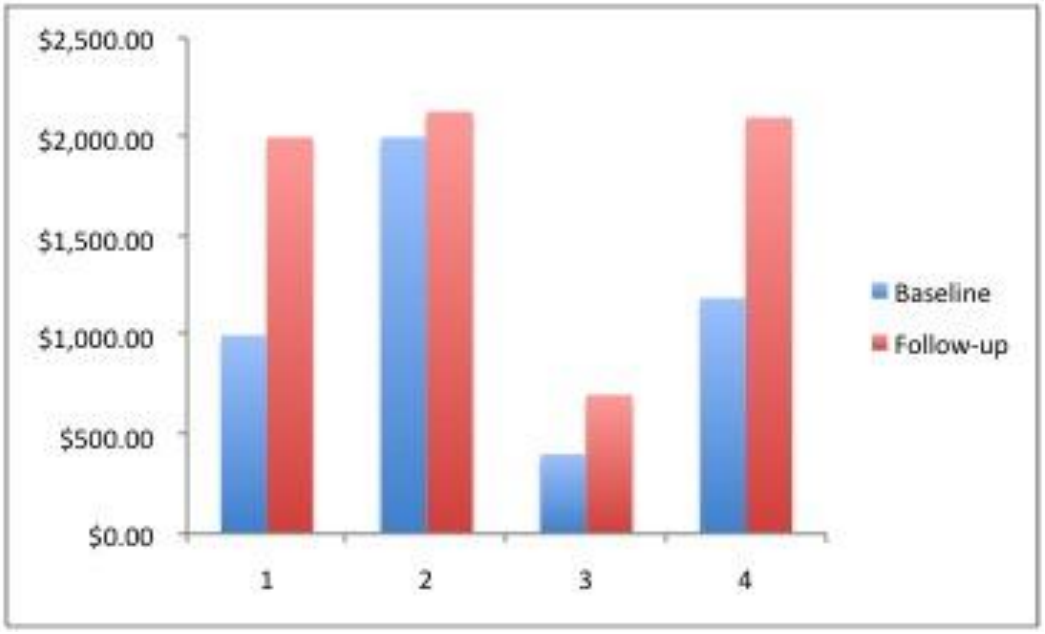
The baseline interviews revealed a considerable range in the amount of money the participants had access to each month; participants reported monthly income from all sources that ranged from $300.00 to $3000.00, with an average of $1195.17 and a median of $1144. While two of the participants had access to more than $2000.00 each month, just under half had access to less than $1000.00 per month, and one quarter indicated that they had access to less than $500.00 each month.

At baseline, clients’ reported rents ranged from $500.00 to $1100.00 per month, with an average of $814.08 and a median of $775.00; their reported utility costs ranged from $0.00 to $500.00 per month,

with an average of $205.18 and a median of $150. The participants occasionally had difficulty responding to this question, because most have their rent paid through a third-party deposit directly to the landlord, and because the clients typically pay 30% of their income toward their rent, with the difference covered by a subsidy. However, based on the reported rents, five of the study participants reported that their rents were higher than their incomes in the baseline interviews, and when utility costs are included, just over half the participants reported monthly shelter and shelter-related costs that exceed their total monthly income.

At follow-up, the clients' financial situation appeared to have improved. The following table illustrates total reported income at baseline and follow-up for the four clients who participated in both interviews.

Figure 5: Change in Monthly Income Between Baseline and Follow-up



The clients' average income at follow-up was $1757.50, while their average rent and utility costs were $799.50 and $267.50 respectively.

These results indicate that while they have gained access to housing through the E4C program, many of the participants may still struggle to pay for necessities with the funds that are available to them, and without the financial supports received through the E4C program, the study participants would face significant challenges in maintaining their housing. The follow-up findings, however, do indicate that although all of the clients would pay more than 30% of their income toward housing-related expenses without the rent subsidy they receive through the program, most have also been able to increase their access to income support while in the program.

One important finding from the baseline survey was that the majority of the participants were confident that they had the knowledge and skills to take care of an apartment and their own basic needs, although they expressed less agreement in their ability to manage all aspects of their lives, including money.

Impacts of Housing First ICM

When compared to their experiences while homeless, the study participants typically reported that their sense of personal well-being increased after becoming housed through the E4C Housing First program, while drug and alcohol use as well as emergency service use decreased, although just under one half of the participants continued to use drugs and/or alcohol to varying extent.

Overall, participants focused on the service delivery model and the program approach as the critical elements of the E4C Housing First program. When asked what part of their housing supports they liked the best, eleven of the participants emphasized that one of the things they most like about the program is having a housing support worker, which suggests that the Intensive Case Management service delivery model is an effective approach for helping this population. The specific contributions of the support workers include “always being there for me”, advocacy on behalf of their clients, and listening to clients’ problems without judgment while helping to trigger new ways of thinking about those problems. One participant described the role of her worker as “a professional friend” - an individual with whom she has a personal connection, but also one who can model a healthy interpersonal relationship while helping her to access necessary services. Five of the women also stressed the importance of the program’s non-judgemental nature and harm reduction philosophy, which means that relapses into drug use and other mistakes are accepted, and they can be open about the problems they're having and how they're dealing with them. In addition to their support workers, two of the women also specified that the financial supports they receive through the program have been invaluable, because AE&I is not enough money to live on; having their bills and rent paid, even for a few months, gave them a chance to make a fresh start. Four of the participants also noted that they liked that they were able to access housing quickly, and get a "good" place through the program, which suggests that the ‘consumer choice’ component of Housing First is positively perceived.

When asked what part of their housing supports they liked the least, at baseline the majority of the participants (8, 66.7%) said that there was nothing they do not like about their housing supports. However, one of these women noted that while she has no concerns about the program itself, there should be some changes to the ways that women are referred; for example, whenever the police arrest a woman for prostitution, she should be provided with information about the program. Typically, the changes that were suggested had to do with increasing the availability of the follow-up support workers. One participant stated that the only thing she does not like about the program is that she can't see her support worker as often as she would like; another noted that she would specifically like it if her support worker could help her to get to her appointments, the food bank, and other service needs. One participant said that the problem with directly into housing is that it can be overwhelming to figure out what to do with the free time, especially if it's hard to get to one's other supports and services; taken together with the client who wished for more help getting to appointments, this suggests that limited access to transportation is a barrier that may prevent some Housing First clients from making use of services that would otherwise be available to them.

Client Perspectives on Improving Housing First/ ICM Services

Although only a minority of the clients articulated elements of the program that they said they do not like or that they liked less than other aspects, several of the women did offer suggestions for how the program could change to better meet the needs of other women who have experienced homelessness and sexual exploitation. Ten of the baseline participants made suggestions, while two indicated that there was nothing they would want to change about the program. The suggested changes included some related to the program's capacity to serve clients: for example, one woman noted that now that she is in housing,

she is very happy with it, and she was able to access it fairly quickly, but she was in a bad situation while waiting to get into housing; another woman emphasized that the program needs to be expanded in order to serve more women. Two policy changes were suggested: first, that the support workers should accompany their clients to appointments at first, both to help with transportation and to act as an advocate and moral support; second, it should be possible for women to continue to receive housing supports even if they want to live with a roommate. There were also several suggestions related to the supports provided through the program: 2 women noted that they would find a peer support group helpful - a theme that also emerged when the women were asked what kinds of volunteer work they would be interested in - and another mentioned that more help dealing with relationships would be of benefit.

At baseline, the study participants expressed strong agreement with the statement “Housing First and supports from y worker have made a huge difference in my life”, with an average score of 9.5 on a 10-point scale. The participants also agreed strongly with the statements “I feel I had a choice in where I live” and “I feel I have a choice in the type of support services I receive” (both with an average score of 9.8 on a 10-point scale). These responses indicate that the E4C program is consistently following the principles of the Housing First approach and empowering its clients.

The follow-up participants generally expressed satisfaction with the E4C Housing First program and the supports that they receive. One participant, however, showed a considerable change in her attitudes toward the program between the baseline and follow-up interviews; this participant described her experience with her support worker during the study period as “I haven’t heard anything” and “I’m pissed off about it”, and also expressed strong disagreement with statements such as “Housing First and supports from my worker have made a huge difference in my life”, “I like the neighbourhood I live in”, and “I feel my support worker really listens to me”; this participant also was ambivalent about her agreement with the statement “I feel I had a choice in where I live.” In comparison, at baseline, the participant expressed strong agreement with all of these statements. This participant’s response is an outlier when compared to those of the other follow-up participants, but it is informative in several ways. First, it highlights the importance of the relationship between client and support worker; this client was re-assigned to a different support worker during the study period, but the transition was not completed and the client believed that her support had been ended without warning. It also highlights how important housing choice can be; the client was also concerned that her neighbourhood and apartment were not safe, but felt that she had no ability to move.

As was the case in the baseline interviews, the majority of the follow-up interviews suggested that the participants were satisfied with the kinds of supports they receive through E4C. Three of the four participants - including the participant who felt that her supports were ended without warning - indicated that there was nothing that they did not like about the supports received through the E4C Housing First program. The remaining participant noted that she didn’t like it that her rent increased when her income supports increased; this participant described it as “unfair” and felt that the program would be better able to support vulnerable women if they were able to keep increases in their income. The participant who had the negative transition experience when her support worker changed indicated that this process should be adjusted to ensure that no other clients are placed in a similar situation. The remaining two participants did not suggest changes to the program itself, but felt that it needs to expand so that more women can be helped and the support workers can spend additional time with their clients.

Staff Perspectives on Housing First/ICM

Among the follow-up support workers, there was a broad consensus that the harm reduction model is a realistic approach to helping the clients of program to make changes at their own pace, and relapses or evictions will not result in the clients becoming homeless again.

The relationship-building and trust-building aspects of their work are also very important, and both the staff and the client interviews were clear that this part of their work is very successful; the relationships built between the clients and caseworkers also help to teach the clients how to engage in supportive, healthy relationships. The support workers act as advocates for their clients, but also emphasized in the discussions that their role is to empower the women they work with to become advocates for themselves, by modelling how to effectively engage with other people in different contexts, counselling and role-playing, and teaching tools and exercises that can help the clients to cope with anxiety. Although the program is not a crisis service, the support workers are frequently the "first responders" when clients are in crisis. In that role, they can help clients to identify their own needs through reflection, and then offer resources to help the clients meet those needs.

One concern that emerged from the staff discussion is that there are clients who are accepted into or referred to the program who may not have the capability to live independently, which is problematic given the lack of supportive housing and other appropriate options. Some of the support workers felt that these clients are "set up to fail" when they are placed in inappropriate housing or when the supports available through the E4C program are not adequate to meet the very high level of need these clients have.

Some workers also felt that sometimes women are accepted into the program who are not ready to live on their own; they were concerned that for these women, cycling through repeated evictions may be harmful and may also damage the program's relationships with landlords, which are key to its continued ability to house other clients. One suggestion was that there should be additional screening in the intake process to try to identify women who may be better able to succeed in different programs, and that potential clients should be given clearer expectations about the intake process. Another suggestion was that, particularly for clients who have been evicted more than once, it might be beneficial to work with them in a setting like Crossroads to address the issues that led to the eviction before re-housing, to increase their chances of success once they are re-housed.

Several concerns with self-care emerged through the discussions with staff. While there is already supervision around self-care, one suggestion was that this should be built in to the program itself, so that staff changes will not result in changes to the way self-care is addressed and promoted; on-the-job retreats, mental health days, and regular staff get-togethers should be policy. The caseloads are heavy and expectations of staff are high. It would also be helpful to have a third party to whom the workers could talk without breaking confidentiality: having a third party would help ensure that the workers always have someone with whom they can talk about and work through their own feelings about their work instead of "venting" about clients.

The support workers also made several specific suggestions for additions to the work they do in the program, some of which echoed the findings from the client interviews. In particular, more group work was identified as a potential tool to help the clients to increase their independence while supporting them in building relationships with one another as well as with their support workers. Some of the work that currently happens one-to-one could instead be done in groups. Cooking and self-defence/safety classes were also mentioned as opportunities to teach life skills and promote socialization. At the same time, there was a sense that more one-on-one counselling should also be part of the program, although it

would be helpful if staff had more training in cognitive-behavioural therapy techniques as well, since they are well-suited to helping clients acquire practical skills and strategies for dealing with the anxiety and stress they may feel.
In addition, clients should be provided with a written document that will orient them to the program, with an outline of what will happen and when, so that they know what to expect; this would also help to address the anxiety that many clients feel about "graduation" from the program.

The support workers also indicated that there are systemic barriers that present challenges in helping their clients to access appropriate services and housing. For example, other agencies and community resources, such as AISH, are often willing to collaborate with the support worker, but are not willing to work with their clients directly. This places a heavy load on the workers, and also reduces the clients' opportunities to reach for greater independence. The support workers also reported that they frequently have issues when dealing with the Capital Region Housing Corporation: they often have to assist their clients in filling out the complex application, which requires visits to many places and duplicates work already done by E4C, since the information is all entered in the ETO system. There were also several cases of CRHC losing applications; in at least one case, the worker and client had dropped it off in person. Their clients have to be extremely proactive to get into this housing, and they are not prioritized by the CRHC.

Discussion and Conclusions

This research has identified the characteristics of the clients receiving services through E4C, and has also identified substance use as the primary cause of their homelessness. In addition, although relatively few specific suggestions for improving the E4C Housing First/ICM service delivery model emerged from the interviews, there was support for adding peer support to the program. This change would reflect the emphasis on community and mutual support that is suggested as a benefit of transitional housing arrangements.

It is important to note that the Housing First program operates within a broader social and political environment that has implications for the program's capacity to serve its clients. Several of the suggestions that emerged from both the client interviews and the conversations with staff highlighted areas where action and advocacy by other parties may be necessary, as well as areas where there is an issue that has not yet been resolved.

The key themes that emerge from this research include:

1. **The study participants are typically older and experience multiple barriers to housing, including mental illness and substance use.** The women receiving services through E4C have histories of trauma and have experienced physical and sexual abuse; the majority are coping with mental illness and approximately one half are actively using substances. A smaller number remain actively involved in exchanging sex for money.
2. **Substance use was identified as the primary trigger for homelessness.** The majority of clients experienced sexual abuse/exploitation as children, but their involvement in exchanging sex for money began after becoming homeless and/or beginning heavy use of substances such as crack cocaine. In addition to being a primary trigger for homelessness, substance use also was described as the primary factor that either prevented the participants from either maintaining their housing, or prevented them from accessing housing while they were homeless.
3. **The Intensive Case Management service delivery approach appears to be an effective way to support women.** The assistance provided by the follow-up support workers was identified as the best aspect of the services provided through E4C by the clients. The support workers also emphasized the relationships they form with the clients as one of the key ways that they are able to empower and support their clients to make positive life changes without placing demands or conditions. This is a particularly significant finding in light of the fact that ICM is a less expensive intervention (Goering *et al*, 2011), and it is also consistent with the available research that suggests that women who have experienced homelessness benefit from a close relationship with a service provider (Fotheringham, *et al*, 2011). It also addresses the argument that congregate living arrangements with on-site staff are more effective because they allow constant access to program workers (Fotheringham, *et al*, 2011). The study participants typically had access to their support workers by phone, and were able to ask for help when it was needed, in addition to meeting regularly. Although there was a desire for additional assistance, particularly transportation, the participants did not suggest that they needed more continuous access to their support workers. The exception was from the participant who was not properly transitioned to a new support worker after a staffing change at E4C; this participant's responses at the follow-up interview, in which she expressed very strong dissatisfaction with the supports she received, indicate that it is essential for the program coordinator to ensure that there is consistent follow-up with each client, and that all staff are familiar with the procedures to verify that each client is regularly engaged with her support worker. Ensuring that clients understand the limits of what the support worker can provide, and ensuring that there are review mechanisms in place to verify that all clients are engaging regularly with their support workers may help to increase clients' satisfaction with the E4C program.

4. **The harm reduction philosophy helps women remain housed.** The study participants emphasized the importance of a non-judgmental approach that supports vulnerable women in their housing regardless of whether substance use or sexual exploitation continue. The women who were actively using substances throughout their involvement in the program also reported that their use decreased.
5. **Being housed had positive impacts on the women's quality of life and sense of wellbeing.** This finding held true even when substance use and sexual exploitation continued, although the follow-up interviews suggest that involvement in the Housing First program does not lead to continued and persistent improvement, particularly with regard to mental and physical health, over time. This is consistent with other research into Housing First interventions.
6. **Being housed has a positive impact on service utilization.** Participants reported decreased use of emergency services and increased use of preventative and primary care after becoming housed. This is consistent with the findings of other examinations of Housing First interventions.
7. **Participants expressed a desire to offer and/or receive peer support with other women who have had similar life experiences.** The support that the E4C clients and staff expressed for more peer support opportunities is also consistent with the emphasis placed on a "community of women" in research into transitional housing projects (Fotheringham *et al*, 2011), and would help to address issues of loneliness and isolation, particularly as many of the women indicated that some or all of their friends continue to be involved in high-risk behaviours.
8. **Although participants' reported increases in income over the study period, without a rent subsidy they would be at risk of homelessness.** Continued income supports and rent supplements will be necessary for most of the clients to maintain their housing. The shortage of appropriate housing options for women who need intensive supports is also an issue. Additional permanent support housing is urgently needed. Further, it must be accessible to women who are still active substance users, as most Housing First clients are ineligible for this form of housing and yet require ongoing, intensive supports to remain housed. E4C cannot increase the supply of permanent supportive housing; advocacy at the level of the community-based organization and municipal government is necessary to secure funding. Similarly, Edmonton does not have an adequate supply of low-cost housing, and women in the E4C Housing First program are not able to access what is available.
9. **E4C clients continue to face discrimination from other service providers.** There may be ongoing opportunities to raise awareness of the Housing First program's approach and impact, in order to improve collaboration between service providers. For example, one of the suggestions from the client interviews was that the police should refer "working girls" who are arrested to the Housing First program, but the police have advised the Program Director that this is not seen as a priority. There is value in continued advocacy from the E4C Housing First program staff to encourage the police to treat their clients with dignity and respect in the event that they are arrested, but currently, there has been no buy-in from the police with regard to the benefits of the Housing First program. The SAMHSA multi-site study on comprehensive interventions for women with past experiences of violence and trauma and co-occurring disorders found that the process of integrating multiple service providers was complex, particularly when different organizations embraced differing, and sometimes conflicting, values or approaches. Some study sites adopted practices such as values clarification exercises and team building exercises in order to increase inter-agency understanding and cooperation; relationship building between the service providers was also seen as a crucial element in strengthening inter-agency ties and awareness, as was taking time to develop a common language and philosophy (Huntington, Moses and Veysey, 2005). One of the themes that emerged from the discussions with the E4C support workers was a perceived lack of support from other agencies and organizations, including the police and the Capital Region Housing Corporation. Currently, the resources to strengthen relationships between E4C and other services and to educate them about the program, its approach and values, and the strength of its service delivery model, are not there. However, if and as opportunities to increase awareness of the E4C program arise, they should be seized.

Avenues for Future Research

Further research may help to achieve a more systematic and complete understanding of why women receiving supports through E4C and similar programs are evicted, in order to ensure that clients are offered appropriate services or interventions to help them maintain their housing. Although the results from this research project must be interpreted with caution because of the small number of clients who participated in a follow-up interview, the two follow-up participants who experienced eviction during the study period differed significantly in their involvement with risky behaviour, and at baseline, both described their relationships with their landlords as “Okay” or “Good” and their relationships with their neighbours as “Good” or “Excellent”. Both also agreed strongly with the statement “I am stably housed” at baseline.

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Appendix: Examples of housing programs serving street-involved women and/or sexually exploited women

A number of the housing programs designed specifically around the needs of chronically homeless women describe themselves as "housing first" or "housing-first", but are in fact transitional housing, though they may use a low-barrier or harm reduction approach. A typical model is SRO with shared kitchen facilities; substance use is permitted but not within common areas, in order to protect women trying to stop using from triggers; access to the housing, particularly for male guests, is controlled. These interventions should not be characterized as Housing First. Data on outcomes for clients are limited.

Brigid's Place

Ottawa; operated by the Shepherds of Good Hope. Identified as a low-barrier, high tolerance, housing-first transition home for women. Single-room occupancy with shared kitchen facilities. Began in 2008; first program in Ottawa specifically designed for chronically homeless women living with concurrent mental illness, substance use or other challenges.
http://www.shepherdsofgoodhope.com/programs/supportive-living/brigids-place/

Halifax YWCA WiSH program

Provides scattered supported housing for up to 24 single adult women who have experienced chronic homelessness. Many are mental health consumers, many are in recovery, all have experienced abuse. YWCA provides each woman with a fully furnished apartment and an array of supports including financial management and case planning. Don't directly provide addiction treatment and so forth.
http://www.ywcahalifax.com/homelessness/wish

Nanaimo Willow WAI

Provides "medium barrier" (dry, but women can remain in the program if they relapse) housing to women in recovery who have been involved in the sex trade. The program admits women who are in recovery and commits them to a 6 month day program, then provides assistance with transition to other housing upon completion.
http://havensociety.com/wp/?page_id=10

The Mary Dover House

Calgary; operated by the YWCA. Transitional housing specifically for women. This program does not take a Housing First approach, but served as a case study to develop recommendations for women-specific Housing First services through an exploration of women's experiences within the home (see Fotheringham *et al*, 2011).

The Vivian Transitional Housing Program for Women

Vancouver; Operated by RainCity Housing; described as "Housing First" but serves as low-barrier transitional housing for street-involved women, with an average stay of 2 years. Opened in 2004 by the Triage Emergency Services and Care Society, which also identifies as Housing First; they had found that there were very few services that were designed specifically around the needs of chronically homeless women (including sexually exploited women).