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Housing First in Canada: A New Approach to Homelessness and Best Practices for Municipal Implementation

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RUNNING HEAD: Housing First in Canada

Housing First in Canada:
A New Approach to Homelessness and Best Practices for Municipal Implementation

MPA Research Report

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Abstract

This paper examines the Housing First approach to homelessness, which provides people living on the street with permanent homes before offering them optional supports. This stands in stark contrast to the traditional approach to housing, where people need to meet preconditions, such as sobriety, before being assisted to obtain housing. This paper examines the history, causes, and impact of homelessness, and the rise of Housing First in Canada. It uses case studies from Medicine Hat and Toronto to explore the implementation of Housing First in two Canadian cities. The paper concludes by providing best practices and offering cautions for municipalities considering Housing First. The case studies indicate that data collection, stakeholder engagement, a systems approach, and support from all levels of government are important components for any municipality considering Housing First.

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Introduction

Despite being one of the wealthiest countries in the world, homelessness remains a problem in Canada. Some studies have found that 235,000 Canadians experience housing instability every year, with 5,000 of those sleeping outside and 180,000 seeking refuge in emergency shelters (Richter, Gaetz, & Gulliver, 2014, p. 41). Other studies suggest that the total number may be as high as 1.2 million (Wellesley Institute, 2010, p. 4), and that 18% of Canadian households have “extreme housing affordability problems, putting them at risk of becoming homeless (Richter, Gaetz, & Gulliver, 2014, p. 5).

The social, economic, and health consequences of homelessness on an individual cannot be understated. Some considered homelessness to be a “spiritual, social, and economic disgrace” (Philip Mangano, as cited in Laird, 2007, p. 76), and a costly one at that. Estimates suggest that Canada spends \$7 billion dollars on homelessness annually (Gaetz, Donaldson, Richter, & Gulliver, 2013, p. 8). Homeless people experience higher rates of mental health problems and infectious diseases than the general population, and substance-abuse related injuries are particularly high (Wellesley Institute, 2010, p. 3).

Researchers point to stagnating and declining incomes, lack of affordable housing, psychiatric hospital closure, and the decline of the welfare state as drivers of homelessness in Canada. The traditional approach to the problem aim to alleviate or stop for homelessness are often ineffective, and can even have a negative impact on participants. They manage the problem rather than addressing the root causes or providing permanent solutions. These approaches usually require people to meet certain conditions before they are deemed “worthy” of housing (Off, 2014, min. 0:43-1:38), and are sometimes referred to as the “treatment first”, “continuum of care”, or “streets first” approach (Gaetz, 2013, p. 5, Flavo, 2010, p. 2, and Laird,

2007, p. 75). These conditions can include “completion of time in transitional housing, outpatient, inpatient, or residential treatment; sobriety or abstinence from alcohol or drug use; medication compliance; psychiatric symptom stability; and willingness to comply with a treatment plan to address these issues” (Gilmer, Stefancic, Sklar, & Tsemberis, 2013, p. 913).

Fortunately, a new approach to addressing homelessness is proving successful. Rather than requiring people to meet conditions before they are provided with housing, “Housing First” first provides people with permanent homes and then provides them with related supports. After examining the history, causes, and impact of homelessness, this paper will investigate the rise of Housing First in Canada by examining how and why the program gained recognition. It will then analyze the uptake of the program in Toronto and in Medicine Hat in order to identify best practices for other municipalities. Through a discussion of the successes in cities large and small, this paper will aim to provide a general guide for Canadian municipalities.

Background Information

Defining Homelessness

Homelessness has long been a challenge, but Hulchanski (2009, p. 2) notes that before the 1980s, there were so few people without shelter in Canada that the word “homeless” was not used in the way it is today. Most people had housing, although it may have been in poor condition (p. 2). According to a report from the Social Planning Council of Toronto (1960, as cited in Hulchanski, 2009, p. 2), the most critical housing-related problem at the time was transient single men who, although they had no place to call a *home*, a “social, psychological space”, they still had housing; it was just poor-quality rooming housing provided by charities or churches. (Social Planning Council, 1960, as cited in Hulchanski, 2009, p. 2). Until the 1970s,

the word “homeless” was used to describe someone with a low-quality residence who moved often and paid low rent (Hulchanski, 2009, p. 2).

But even that situation was improving; more Canadians were moving from low-quality houses to new homes in the suburbs, and more rental properties were being built, which provided more options for low-income residents (p. 3). That definition changed from referring to someone without a home to referring to someone without any place to sleep. Nonetheless, the new definition of homelessness came in a variety of forms, with, cities in Canada defining homelessness according to their own needs and perceptions. In Calgary, for example, people “who (did) not have a permanent residence to which they (could) return whenever they so choose” were considered homeless, while in Vancouver, people who “did not have a place of their own where they could expect to stay for more than 30 days and for which they paid rent” were considered homeless (Hopper, 2012, para. 11).

In 2012, however, a movement to arrive at a single definition of homelessness was led by researchers at York University, who worked with community groups, homeless people, national organizations, and government to create a definition that could be used across the country (York University, 2012, para. 2). York’s Canadian Homeless Research Network (now the Canadian Observatory on Homelessness) agreed upon the following definition for homelessness:

Homelessness describes the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household’s financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination. Most people do not choose to

be homeless, and the experience is generally negative, unpleasant, stressful and distressing (Canadian Observatory on Homelessness, 2012, p. 1).

This definition can account for a range of living situations, and includes people who are:

- 1) Unsheltered, or absolutely homeless and living on the streets or in places not intended for human habitation;
- 2) Emergency Sheltered, including those staying in overnight shelters for people who are homeless, as well as shelters for those impacted by family violence;
- 3) Provisionally Accommodated, referring to those whose accommodation is temporary or lacks security of tenure, and finally;
- 4) At Risk of Homelessness, referring to people who are not homeless, but whose current economic and/or housing situation is precarious or does not meet public health and safety standards.¹

(Canadian Observatory on Homelessness, 2012, p. 1).

According to Tristin Hopper (2012), this definition is based on the European model, which is relatively broad, including roofless, houseless, insecure, and inadequate categories (para. 19). In the United States, by way of contrast, programs funded by the Department of Housing and Urban Development use a definition with a more limited scope; they include people without “fixed, regular, and adequate nighttime residence(s),” people living in shelter, those who will reasonably expect to lose their housing within 14 days, and people who had experience long-term housing instability (Homeless Emergency Assistance, 2009, P.L. 111-22, Section 1003). . The U.S. Department of Health and Human Services, on the other hand, uses a broader definition that includes people who are forced to stay with family and friends, and previously homeless

¹ For a detailed typology of each category, see Appendix 1.

people who are about to be released from institutions (Public Health Service Act, 2009, Section 330). It seems wise for agencies within the same country to use the same definition, or addressing the problem will prove difficult. This may explain why the narrower definition employed by the Department of Housing and Urban Development is under revision (Byrne & Culhane, 2015, p. 996)

The broader definition adopted by the York researchers is not without its critics, especially for the inclusion of people “at risk of homelessness”. Alberta MP Peter Goldring, who also sits on the Edmonton Committee to End Homelessness, said that people “are really not in desperate need until they’re holding that eviction notice in their hand” (Hopper, 2012 para. 3). But homeless research Stephen Gaetz, who helped create the definition, believes that a broad classification will help to address underlying causes of the problem (Hopper, 2012, para. 4). The researchers believe that “communities, researchers and governments... will be better able to measure homelessness, identify goals and intervention to address it, and measure which strategies are working” with the new definition (York University, 2012, para. 2). They assert that a common language will help with enumerating the problem, evaluating outcomes and progress, coordinating services, and developing policy responses (York University, 2012, para. 8).

The History of Housing and Homelessness in Canada

As discussed earlier, homelessness in Canada did not always look the way it does now, and was not always such a formidable problem. According to the Multifaith Alliance to End Homelessness (2016), urban renewal that started in the 1950s led to the demolition of cheap shelter and affordable “skid row” hotels. The labour market also changed. After World War II, there were more labour jobs for transient people, but they have been replaced by machinery. In

the 1960s, psychiatric hospitals began closing as new drug treatments were developed and, although attitudes towards people with mental health problems was changing, most communities did not replace the hospitals with adequate community support and follow-up (History of homelessness, 2016, para. 1, 2, 3).

The Canadian government had once shown strong commitment to housing in Canada; after World War II, they helped to ensure affordable housing was available to veterans by creating government-insured mortgages, funding social housing, and investing in subsidized rental housing development (Gaetz, 2010, p. 21). They also subsidized private-sector housing and introduced or improved social assistance programs, including universal health insurance, unemployment insurance, pensions for seniors, and the Canada assistance plan (Hulchanski, 2009, p. 3).

Although not constitutionally protected, there was support for the idea that Canada should ensure that citizens could meet their basic needs and had access to appropriate shelter (Gaetz, 2010, p. 22). In 1965, Prime Minister Lester Pearson acknowledged that “it is only a very rare soul that can expand in a hovel. This objective of decent housing simply has to be achieved in our democratic society” (Hulchanski, 2009, p. 3). The now defunct Ministry of Urban Affairs called housing an “elemental human need”. In 1973, Minister H. Peter Oberlander stated “when we talk about people’s basic needs – the requirements for survival - society and the government obviously have an obligation to assure that these basic needs of shelter are met” ... “good housing at a reasonable cost is the social right of every citizen of this country” (Hulchanski, 2009, p. 3-4).

Hulchanski (2009, p. 3) explains that in 1984, the first cuts to social housing occurred. By 1987, in the International Year of Shelter for the Homeless, the Association of Housing and Renewals claimed that “a significant component of the homelessness problem is that housing has not been a high priority for government at any level” and that “in all regions of the country, the demand for housing that is adequate and affordable... greatly exceed(s) the availability of government funds to carry out effective social housing programs” (Ahern & Lang-Runtz, 1988, p. 122).

The cuts continued throughout the 1990s as liberal-democratic governments embraced neoliberalism and new public management and tried to run like a business. They cut welfare and social services in the name of efficiency and individual self-reliance (Laird, 2007, p. 76). In 1993, the federal government stopped providing funding for the construction of new social housing, and in 1996, they transferred responsibility for most existing federal housing to the provinces (Hulchanski, 2009, p. 4). The provinces responded by cutting funding for housing and other welfare programs (Canadian Alliance to End Homelessness, 2016, para. 3).

But soon after, the federal government increased their participation and started to fund homelessness again. According to Human Resources and Skills Development Canada (2008) the government announced the National Homelessness Initiative (NHI) in 1999, pledging \$753 million over three years to help improve community access to homelessness programs, services, and support (p. 1). The funding targeted 61 communities with severe short-term emergency needs and long-term homelessness planning by municipal and community partners (p. 1). In 2003, an additional \$405 million was pledged for the next 3 years, with a \$135.8 million extension until 2007. This phase focused on maintaining gains in emergency care and implementing longer-term housing solutions (Human Resources and Skills Development

Canada, 2008, p. 1). Zach Taylor and Neil Bradford (2015) explain that the funding extensions continued in 2008, when it was renamed the Homelessness Partnering Strategy (p. 205). Almost 2 billion dollars was allocated over five years (p. 205). In 2013, the government funded the program for another 5 years. The program now requires that communities produce a 10-year plan to end homelessness with clear outcomes, identification of supports required to help people leave the street, and engagement with other actors; still, the funding is flexible so that local needs can be considered (Taylor & Bradford, 2015, p 205). But this type of short-term funding extensions make it difficult to plan for long-term changes. And even with this funding, Canada is the only G8 country without a comprehensive national housing strategy, and many academics and front line workers believe that more government intervention is needed (History of homelessness, 2016, para. 4).

Still, many actors have tried to address the problem. Local governments and NGOs have responded with important emergency services like shelters and soup kitchens, and rent and energy banks to help pay bills, but the billions of dollars invested in these programs do little to resolve the underlying problems (Richter, Gaetz, & Gulliver, 2014, p. 11). A new approach to the problem is needed.

The Extent of the Problem

Before discussing a new approach, it is important to have a good understanding of the extent of the problem. There is considerable variance in how many people are considered homeless. Although estimates vary, Stephen Gaetz, Tanya Gulliver, and Tim Richter (2014, p. 5) estimate that over 235,000 Canadians experience homelessness every year, with 5,000 being unsheltered, 180,000 staying in emergency shelters, and 50,000 receiving provisional accomodation with friends, in hotels, or institutions like hopsitals and jails. There are 35,000

homeless people in this country on any given night. In 2014, 18% of Canadian households also had “extreme housing affordability problems,” defined as the presence of a low income combined with spending more than 50% of income on rent (Richter, Gaetz, & Gulliver, 2014, p. 5).

Richter, Gaetz, and Gulliver (2014, p. 13) note that although a small portion of this group (10,000 to 30,000 people) suffer from chronic, episodic homelessness, they incur a disproportionate amount of emergency expenses through their increased contact with police and hospitals. If this group received housing and supports, only a small emergency homelessness system would be needed to support people suffering from short-term homelessness (Richter, Gaetz, & Gulliver, 2014, p. 14).

Factors Leading to Homelessness

So how do people become homeless? Homelessness does not result from one factor, but “arises from a confluence of factors including housing and labor market conditions, poverty, social and racial inequality, personal vulnerabilities, and precarious life circumstances” (Petrenchik, 2006, p. 11). These can broadly be divided into structural, culture, or intrapersonal causes (Petrenchik, 2006, p. 13). So there are many ways to frame this problem and present related policies to the public and to policy-makers.

Deinstitutionalization is often associated with an increase in homelessness. According to a government report (2006), new medications, high maintenance costs, more emphasis on community treatment, and more restrictions on involuntary treatment lead to the closure of psychiatric hospitals (p. 152). This started in the 1950s, and by 1970, many people with mental illness who would have been in a psychiatric hospital were in jail or living on the street (p. 152). Many people who lived in psychiatric hospitals lacked the life skills to transition to life outside

of an institution, and people with severe mental illness could not manage with the fragmented or inadequate community services (Government of Canada, 2006, p. 153).

According to Richter, Gaetz, and Gulliver (2014), homelessness has also increased because there are fewer affordable housing units available (p. 10). In 1982, Canada produced 20,450 new social housing units, but that number dropped to 1,000 in 1995 and currently sits at around 5,000 annually. While Canada's population has grown by 30% over the last 25 years, the annual national investment over the same period has *decreased* by 46% (Richter, Gaetz, & Gulliver, 2014, p. 5). As explained above, federal funding cuts in the 1990s reduced provincial transfer payments and cancelled the federal affordable housing programs (Gaetz, 2010, p. 22).

Around the same time, "earnings for full-time middle-income earners stagnated, and declined for those at the bottom" (Gaetz, 2010, as quoted in Gaetz, 2011, p. 18). This was most likely to impact women, visible minorities, and new Canadians, and put them at higher risk of becoming homeless (Gaetz, 2011, p. 19). When combined with wage suppression and part-time jobs without benefits, poverty increased and more people ended up on the streets or in emergency shelters (Hulchanski, Campisi, Chau, Hwang, & Paradis, 2009, pg. 5). Compared to the United States, United Kingdom, and Australia, Canada is behind on homelessness national responsiveness and lacks a culture of planning required to address this type of wicked problem (Gaetz, 2011, p. 19).

Individual Impact of Homelessness

As noted earlier, there are numerous populations in Canada that are at higher risk of experiencing homelessness. These include people from different ethno-cultural backgrounds, children, families, new Canadians, victims of violence, the elderly, and Aboriginal people

(Canadian Observatory on Homelessness, 2012, p. 1). Among the consequences experienced by those who are homeless are costs to individual health and well being. Homeless people experience higher rates of mental health problems and infectious diseases than the general population, and substance-abuse related injuries are particularly high (Wellesley Institute, 2010, p. 3). In addition to poverty, stress, and social isolation, they have less access to healthy food, spend more time in crowded conditions where diseases can spread, and are often exposed to dampness, extreme heat and cold, and pollution (Khandor & Mason, 2007, p. 23).

Numerous studies have been undertaken that examine the relationship between homelessness and health. A 2007 study by Khandor and Mason surveyed the homeless population in Toronto and found that three quarters had one or more chronic health conditions. Additionally, they were 29 times more likely to have Hepatitis C than the general population, 5 times more likely to have heart disease, and twice as likely to have diabetes (p. 4). Moreover, studies show that the longer people are homeless, the more their physical and mental health are affected (Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2009, Discussion section). Similarly, a 1 year study by Hwang, Wilkins, Tjepkema, O'Campo, & Dunn (2009) followed people living in shelters, rooming houses, and hotels across Canada to see the impact of these living conditions on mortality. They found that:

The probability that a 25 year old living in shelters, rooming houses, or hotels would survive to age 75 was only 32% for men and 60% for women compared with 51% and 72%, respectively, in the lowest income fifth. To put this in context, men living in shelters, rooming houses, or hotels had about the same probability of surviving to age 75 as men in the general population of Canada in 1921 or men in Laos in 2006. (Discussion section, para. 1)

Many of these early deaths are related to alcohol, mental disorders, smoking, violence, injuries, and suicide (Hwang, Wilkins, Tjepkema, O'Campo, & Dunn, 2009, Implications section, para. 1). Khandor and Mason's 2007 survey of homeless people in Toronto found that 1 in 10 had attempted suicide in the previous year (p. 4). Thirty-five percent of people surveyed had received a mental health diagnosis, though accurate diagnoses are rare because of inconsistent health care (Khandor and Mason, 2007, p. 25). While people may be more likely to become homeless after trauma, the experience of being homeless can also create trauma (Gulliver-Garcia, 2016, p. 16). Additionally, the risk of being a victim of violent crime is also far greater than people with housing (O'Grady, Gaetz, & Buccieri, 2011, p. 18). In Toronto, Khandor and Mason found that 35% of homeless people surveyed had been physically assaulted in the previous year, and one in five women had been raped or sexually assaulted in the same period (2007, p. 4).

While policy makers have long grappled with how to address the health-based consequences of homelessness, studies a 2005 literature review about the health of homeless people suggested that "interventions providing coordinated treatment and support for homeless adults with mental illness and/or substance abuse usually result in greater improvements in health-related outcomes than does usual care" (Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005, p. 311.e6). These supports included case management, supportive housing, and work therapy; few of the studies involved providing housing, and the ones that did were largely abstinence-contingent (Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005, p. 311.e4). Overlooking housing in a study about the health of homeless people seems to be a common oversight at the time. Housing is an important foundation for good health.

Societal Costs of Homelessness

Homelessness does not only impact the individuals experience it. The societal costs of homelessness include both direct costs, such as emergency shelters, day programs, and meal programs, as well as indirect costs, such as increased use of health services, policing, and the justice system (Gaetz, 2010, p. 3-4). The final tally for housing varies significantly, depending on the specific mechanism used for residential placement. In 2007 in Toronto, for example, the Wellesley Institute calculated that the average monthly cost of providing someone with a hospital bed was \$10,900, while jail placement cost \$4,333 and rent cost just \$1,932 (p. 7). In that same year, Canada spent between \$4.5 and \$6 billion dollars on emergency services for homeless people (Gaetz, 2012, p. 3). More recent estimates suggest that Canada spends \$7 billion dollars on homelessness annually (Gaetz, Donaldson, Richter, & Gulliver, 2013, p. 8). And, in 2008, the City of Calgary calculated that they spent \$134,642 every year for each chronically homeless person (Calgary Homeless Foundation, p. 2).

The most telling costs come from looking at emergency room use. Homeless people do not visit ERs only because of injury and illness, but also because it is difficult for them to access other forms of health care, and because they are looking for food, shelter, and safety (Gaetz, 2012, p. 9). A 2010 report by Stephen Hwang and Melford Henderson analyzed emergency room costs of homeless people in Toronto compared to low-income controls. Seventy-three percent of homeless people visited the emergency department during the study, with an annual rate of 2.1 visits per person and a cost of \$1,464 (p. 41). The control group visited ERs 0.2-0.3 times annually, and their costs amounted to only 13% of the homeless people's visits (Hwang & Henderson, 2010, p. 42).

Apart from direct costs, homelessness also affects our national reputation. Philip Mangano, Executive Director of the US Interagency Council on Homelessness, calls the problem a “spiritual, social, and economic disgrace” (as cited in Laird, 2007, p. 76). More than one international tourist, business-person, and politician has surely been surprised at the sight of homeless people in one of the richest countries on earth. In a recent United Nations report about Canada from the Economic and Social Council (2016), the committee was “concerned at the increasing number of homeless persons... the lack of adequate measures to prevent homelessness, [and] the shortage of adequate emergency shelters” (p. 8). They also discussed the “persistence of a housing crisis”, and noted the “absence of a national housing strategy, the insufficient funding for housing, the inadequate housing subsidy... [and] the shortage of social housing units” (United Nations, 2016, p. 7).

The Canadian Observatory on Homelessness (2012) considers the persistence of homelessness to be a societal failure to provide appropriate systems, funding, and support (p. 1). Hulchanski (2009, p. 7) calls for action on three levels: individual and family; community and municipal, and federal and provincial. What has been done traditionally to provide housing for homeless people, and what is being done now?

Housing Models

The Traditional Housing Model

According to Gretchen Locke, Jill Khadduri, and Ann O’Hara (2007), there are three types of housing for people who are homeless: emergency shelters, transitional housing, and permanent supportive housing (p. 10-3). There are different approaches within each category, which vary by their physical setup, the ideal tenure of clients, whether they are voluntary or

required, whether supports are intensive or limited, and the degree of choice clients have about where to live and which services to accept (p. 10-3). Since the set-up is often dependant on the amount of funding available, client choice is often disregarded (Locke, Khadduri, & O'Hara, 2007, p. 10-3). Because a client's idea of what constitutes a home will vary by "cultural background, social class, ethnic or minority status and personal values", it seems likely that increasing personal choice will increase the likelihood that someone will stay in housing (Ridgeway & Zipple, 1990, p. 17).

Traditional interventions and policies that aim to alleviate or stop homelessness are often ineffective, and can even have a negative impact on participants. This is explained by the fact that, traditionally, policies have aimed at managing the problem rather than addressing the root causes or providing permanent solutions. The system has been called "fragmented and poorly coordinated", and leaves many people marginalized (Stergiopoulos, Hwang, O'Campo, & Jeyaratnam, 2011, p. 4). In a 2007 interview with Nan Roman, president of the US National Alliance to End Homelessness, asserted that "results are better if you put people into housing first and then work on supports... it can be cost effective and work for almost everybody" (Laird, 2007, p. 75). After conducting case studies on homelessness in a five Canadian cities, Gordan Laird (2007) concluded that spending more time in shelters is likely to worsen people's physical and mental health, so better outcomes are seen if people are housed permanently as soon as possible (p. 75). But he explains that, in the past, "paternalistic attitudes towards low income and homeless people assumed that candidates for income assistance and affordable housing needed to improve themselves and exhibit middle-class characteristics before housing was granted" (Laird, 2007, p. 10). These traditional approaches criticized by Laird usually require people to meet certain conditions before they are deemed "worthy" of housing (Off, 2014, min.

0:43-1:38). A provider of housing services determines when and whether a person is ready for housing (Flavo, 2010, p. 3). This is sometimes referred to as the “treatment first,” “continuum of care,” or “streets first” approach in which housing is contingent on meeting certain requirements (Gaetz, 2013, p. 5, Flavo, 2010, p. 2, and Laird, 2007, p. 75).

Traditional interventions usually require people to meet some receive addictions treatment or receive mental health treatment before they are provided with housing. But there is criticism of this approach. Requiring people to obtain any type of service or treatment as a condition of receiving housing undermines their independence and their right to make decisions for themselves, and situates them as “perennial patients, helpless and dependent, with hopeless futures” (Judge David L. Bazelon Centre for Mental Health Law, as quoted by Allen, 2003, p. 503). There are also therapeutic, ethical, and legal concerns around forcing people to obtain treatment (Allen, 2003, p. 504). Some leases force participants to sign that they agree to receive services or face eviction (Monahan et al., 2001, p. 1199). Treatment may be required for people to avoid jail or hospitalization (Monahan et al., 2001, p. 1200). This type of coercion can push people away from the system and undermine the creation of a therapeutic relationship (Allen, 2003, p. 505). These requirements could also be considered discriminatory and violate landlord-tenant laws (Monahan et al., 2001, p. 1203). And people may be less likely to stay in housing with restrictions.

Gaetz (2013, p. 30) notes that there is no national data available to measure the effectiveness of these traditional approaches. But a 2012 analysis of Canadian shelter use by Aaron Segart indicates that between 2005 and 2009, 150,000 people used shelters annually in Toronto (p. 27). There was no reduction in use over this time period, and no indication that the money spent on the problem reduced the need for shelters (p. 27). During this time, the average

length of stay actually increased; in 2005, 12.6% of people stayed in shelters for one month or more, but by 2009, that number had risen to 16.7% (Segaert, 2012, p. 24). The traditional approach to addressing homelessness was not preventing the problem, saving public funds, or allowing homeless people to live with dignity and make their own decisions.

With the lack of progress made with traditional approaches came a call for a “shift in focus, from crisis management... to permanent solutions” (Gaetz, 2013, p. 31). As early as 1990, Rideway and Zipple suggested a new housing paradigm was needed, criticizing residential treatment programs and insisting on social integration, permanent housing, flexible levels of service, and more client control (p. 27). Prevention services, like rent and utility assistance, were also considered important, as they would ease strain on emergency systems and on individuals (Locke, Khadduri, & O’Hara, 2007, p. 10-11). But ending homelessness would mean ensuring housing stability and appropriate housing that is affordable, safe, maintained, accessible, and of appropriate size (Canadian Observatory on Homelessness, 2012, p. 1). Researchers recommended that this be accompanied by targeted prevention strategies (like rent subsidies and affordable housing) and an emergency system to support people in crisis (Gaetz, 2013, p. 31). The traditional approach was not flexible, and did not take into account that many homeless people have an employment history and some ability to live independently, nor did it leverage these strengths to help people obtain housing (Laird, 2007, p. 75).

A Shift in Approaches

As the housing crisis continued, a scholarly consensus emerged around the idea that a more flexible approach was needed. Decades of research have shown that “without adequate housing, adequate income, and adequate support services, people will struggle to remain housed” (Gaetz, 2013, p. 33). Some participants will choose not to continue in the program, become

incarcerated, disappear, or pass away (At Medicine Hat Community Housing Society, 2014, p. 33).

In 2000, the National Homelessness Initiative (NHI) provided \$135 million annually to Canadian homelessness services and support programs, but the federal government insisted that the funds were not to be used for permanent housing (Flavo, 2010, p. 9). In fact, no level of government made an organized attempt to move homeless people into permanent housing, largely because of the bureaucratic challenge of completing an application with a homeless person and then locating them much later, when housing finally became available (Flavo, 2010, p. 9). In short, there was no support for immediately providing homeless people with permanent housing.

Yet, even without federal support, the Housing First approach developed, guided by the belief that the most effective way to eliminate homelessness is to move people to permanent housing as soon as possible (Laird, 2007, p. 75). According to Jeannette Waegemakers Schiff and John Rook (2012), there are three programs that contributed to the development of what is now called Housing First. The first, Houselink, is a community-based organization that started in Toronto in 1977 (p. 5). Their program focused on housing people who were released from psychiatric facilities and who did not have substance abuse problems; their program did not have a treatment requirement (p. 5). Another organization, Beyond Shelter, first used the name “Housing First” in Los Angeles in 1988 (p. 6). The program rapidly re-housed families into permanent housing, avoiding the use of shelters and transitional housing (p. 5). Finally, a program called Pathways to Housing developed in New York City 1992 (p. 5). As with the Houselink program in Toronto, the program focused on people with a history of mental health problems and did not exclude people with a criminal history (p. 5).

Although some programs in Toronto in the 1990s did not require participants to be abstinent before obtaining a home, the Housing First approach became more popular in Canada after the turn of the century. Toronto's Streets to Homes (S2H) program, launched in 2005, became Canada's best-known example of the Housing First approach (Laird, 2007, pg. 76). Toronto has the largest homeless population in Canada, and, according to Nick Flavo (2010), the program started there was the "largest and most developed example of the (Housing First) approach of any Canadian municipality" (p. 1).

One of the earliest controlled studies about the efficacy of Housing First was published by Sam Tsemberis (the founder of Pathways to Housing), Leyla Gulcur, and Maria Nakae in 2004. They randomly assigned 225 participants with severe mental illnesses to two groups – one to receive housing contingent on sobriety and psychiatric treatment, the other to receive immediate housing without any pre-conditions (p. 651). People who were provided with housing immediately had an 80% retention rate, challenging the idea that some homeless people were not housing ready and needed to receive treatment before succeeding in housing (p. 654). People who were in the mandated group, however, were only housed 30% of the time (p. 655). The participants' perceptions of control and autonomy were much higher for people who did not have preconditions, and this may have contributed to their housing tenure (p. 654). Even though treatment was required for one group, the actual use of substances and presence of psychiatric systems did not vary significantly in the outcomes of the two groups (p. 655).

This research sparked more interest in Housing First, and more research was conducted. In 2012, Waegemakers Schiff and Rook summarized analyzed data to examine Housing First's success in Canada and the United States. Most of the 35 studies they analyzed looked at single adults in urban locations with mental health problems (p. 11). The data showed that Housing

First programs were nominally less expensive to run than traditional emergency programs, but none of the studies considered the substantial societal savings from the reduced use of the health, housing, and justice sectors (p. 10). One gap in the research was that none of the studies considered diversity or ethnicity (p. 11). There were few quantitative studies, but the ones that were conducted showed promising results for Housing First, including 68-80% housing retention. Yet, while heartened by the rigorous scientific evidence showing that the approach worked, the authors were nonetheless concerned that Housing First was quickly becoming a best practice principally because it was a popular political decision due to the cost savings obtained (Waegemakers Schiff & Rook, 2012, p. 17).

So it was important that the Canadian government establish the effectiveness of the approach in a Canadian context. According to the Mental Health Commission of Canada (2016), it received \$110 million from the federal government in 2008 to conduct a pilot program in five cities, Vancouver, Winnipeg, Toronto, Moncton, and Montreal, using the Housing First approach (para. 1). The At Home/Chez Soi program ran from 2009 to 2013, with the goal of establishing whether Housing First was effective and how much it cost to implement (A cross-Canada section, para. 1). Each of the five cities in the study had a different focus. In Vancouver, the focus was on homeless people with substance abuse problems; in Winnipeg, on the Aboriginal homeless population; in Toronto, on ethno-racialized groups; in Moncton, on people living in smaller communities, and in Montreal, on a vocational study that was included (A Cross-Canada section, para. 2).

After following more than 2000 participants for two years in the largest Housing First trial in the world, the Mental Health Commission's final report (2014) noted several important findings:

- 1) Housing First is effective in Canadian cities of different sizes and ethno-racial compositions.
- 2) Housing First works to end homelessness more quickly and more effectively than traditional approaches. Eighty-four percent of people remained housed in Housing First, compared to 54% in other programs. The housing quality in Housing First was usually better and more consistent.
- 3) Housing First is cost effective, with every \$10 invested saving \$9.60 for high needs participants, and \$3.42 for people with moderate needs. The cost of the intervention was \$19,582/person/year. Over the two years of the study, every \$10 invested resulted in a savings of \$21.72, because of fewer hospital stays, less ER and doctor's visits, less frequent police involvement, fewer incarcerations, and less time in crisis housing.
- 4) Most Housing First participants also need other supports and treatment services.
- 5) Housing First can lead to other positive outcomes, such as better quality of life and improved community functioning (Mental Health Commission, 2014, p. 5).

These findings challenge the idea that chronically homeless people's needs are too complicated and too costly to address. The success of the pilot project suggests that homelessness can be eliminated through the adoption of Housing First across the country (Gaetz, Scott, & Gulliver, 2013, p. 14). Indeed, in light of these results, demanding treatment and sobriety before providing housing seems costly, ineffective, and dehumanizing (Mental Health Commission of Canada, 2015, p. 6).

Based on these results and the results of programs in other Canadian communities, the federal government recognized Housing First as a legitimate approach to homelessness in cities

both large and small (Employment and Social Development Canada, 2015, Housing First section, para. 4). In April 2013, they announced almost \$600 million in funding for their Homelessness Partnering Strategy (HPS), with a focus on a Housing First approach (Employment and Social Development Canada, 2015, para. 2). The 61 designated communities across Canada that receive funding from the HPS are now required to integrate Housing First into their existing homelessness approaches (Richter, Gaetz, & Gulliver, 2014, p. 14)². As of April 1, 2015, the larger designated communities are required to invest at least 65% of their HPS funds in Housing First, and as of April 1, 2016, communities receiving more than \$200,000 were required to invest at least 40% of their funding in the program (Richter, Gaetz, & Gulliver, 2014, p. 14). According to Employment and Social Development Canada (2016b), this intervention is meant to assist the costly chronic and episodic homeless population (Description sect, para. 1). However, once 90% of people in that group are housed, cities can focus on the group with the next highest needs, which may include people who are currently in transitional housing or people who have experienced two or more periods of homelessness in a year (Employment and Social Development Canada, 2016b, Descriptoin sect., para. 3).

Housing First

The Housing First intervention is a dramatic change from traditional policies where homeless people moved from emergency shelters to transitional housing, and, once they met certain conditions, to permanent housing (Murray, 2005, p. 3). Housing First, by way of contrast, is a “recovery-oriented approach to homelessness that involves moving people who experience homelessness into independent and permanent housing as quickly as possible, with no preconditions, and then providing them with additional services and supports as needed”

² For a list of designated communities in Ontario, see Appendix 2.

(Gaetz, Scott, & Gulliver, 2013, p. 3). Waegemakers Schiff and Rook (2007) additionally suggest that the location and type of housing should be chosen by the participant, even if it is normally limited by availability and affordability, and that support services should be available, but not mandated (Waegemakers Schiff & Rook, 2007, p. 7).

A large part of Housing First's appeal is the flexibility it provides. According to Stephen Gaetz, Fiona Scott, and Tanya Gulliver (2013, p. 5), Housing First can be implemented according to local needs and national context. This allows "cultural, policy and structural differences in social, health, welfare and housing supports" to be taken into account (Gaetz, Scott, & Gulliver, 2013, p. 5).

Gaetz, Scott, and Gulliver (2013) explain that Housing First differs from other approaches in several aspects.

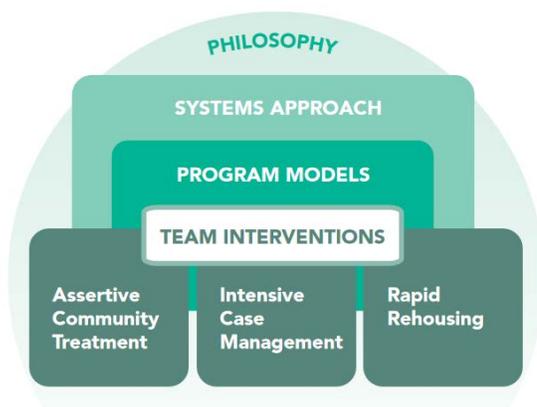
- 1) As a *philosophy*, Housing First focuses on providing people with permanent housing and related support. It is based on the belief that everyone deserves housing, and people who are without housing will have better outcomes if they are provided with housing as soon as possible.
- 2) As a *systems approach*, Housing First is imbedded within integrated service delivery that cuts across many sectors, including emergency services.
- 3) As a *program model*, Housing First can take many forms, and is applied in different ways to different contexts. Some are modelled more closely to the Pathways model and focus on people with mental health and addictions challenges, while others address the needs of any homeless person. Programs may require more or less supports, and vary in target population, length of time, and type of housing offered.

Housing options may include private, scattered sites, social housing units, or shared, congregated models.

- 4) As a *team intervention*, Housing First uses teams to meet the needs of target populations. Populations are defined based on demographic characteristics, such as age or ethnicity, or based on physical, mental, or social challenges faced. Teams should include members with the appropriate skills and experience, with defined caseloads so that individual client needs can be met. One of the challenges of Housing First is matching the appropriate team to the needs of the client, and providing all of the resources needed. Assertive Community Treatment (ACT) teams, Intensive Case Management teams, and Rapid Rehousing teams, which are sometimes considered distinct from Housing First, are often utilized in Housing First models³.

(Gaetz, Scott, & Gulliver, 2013, p. 7-8).

These components are shown below:



(Gaetz, Scott, & Gulliver, 2013, p. 7).

³ For descriptions of these teams, see Appendix 3.

Gaetz, Scott, and Gulliver (2013) explain that in order to be considered a Housing First program, a program should contain the following components:

1. Immediate provision of permanent housing without any pre-conditions – sobriety or abstinence are not required, and participation is voluntary.
2. Self-determination and choice – clients have some choice about housing (location and type) and supports (what services they receive and when they start), subject to resource constraints such as availability.
3. Recovery focus – Housing First is not just concerned with housing, but also with well-being, and ensures access to supports related to clients' health, social, recreational, educational, and occupational goals.
4. Personalized, client-centred supports – every individual and his or her needs are unique, so a range of voluntary, individualized, and culturally-appropriate supports should be offered. These often include mental health services, life skills instruction, and income supports.
5. Social and community integration – housing that doesn't stigmatize or isolate clients, and access to meaningful social, cultural, and vocational activities.

(Gaetz, Scott, & Gulliver, 2013, p. 6).

Ensuring that each Housing First program abides to these principles is critical. Some authors have found that the original model has been “simplified, diluted and... subjected to change,” arguing that “the paradigm often only has a partial relationship with the wide range of new and remodelled homelessness services that have been given the ‘Housing First’ label” (Pleace & Breherton, 2012, p. 5). Some organizations that do not provide or arrange housing call

their programs “Housing First”; some offer only transitional housing (Pleace & Breherton, 2012, p. 6). New York’s Pathways to Housing has responded to these alterations by developing a 38-item fidelity scale to be used as a guide for developing Housing First programs (Stefancic, Tsemberis, Messeri, Drake, & Goering, 2013, p. 240). They emphasize that Housing First programs should “eliminate barriers to housing access and retention, foster a sense of home, facilitate community integration and minimize stigma, use a harm-reduction approach, and adhere to consumer choice and provide individualized consumer-driven services that promote recovery” (Stefancic, Tsemberis, Messeri, Drake, & Goering, 2013, p. 240).

Case Studies

Through a discussion of the challenges and successes of Housing First in cities large and small, best practices can be established. First, Medicine Hat, which used Housing First to end homelessness in their community, will be examined. Then, Toronto, with the first and largest program in the country, will be studied.

Medicine Hat

In 2015, Medicine Hat used Housing First to end homelessness in their community (Medicine Hat Community Housing Society, 2014, p.8). As a result, no one spends more than 10 days in a shelter, or on the street, because after 10 days, individuals are provided with housing (Off, 2015, para. 2). How did they manage this feat?

In 2001, Medicine Hat joined “7 Cities on Housing and Homelessness”, a group of Alberta cities working to address homelessness (Turner & Rogers, 2016, p. 502). According to Alina Turner and Jaime Rogers (2016), being part of the 7 Cities collective reaffirmed the need for a new approach to housing in Medicine Hat, as Calgary, Edmonton, and Lethbridge had

already launched their own plans to end homelessness using traditional approaches to the problem (Turner & Rogers, 2016, p. 503).

However, by 2007, the Alberta Secretariat for Action on Homelessness (2010, p. 2) reported that there were 11,000 homeless Albertans. The cost of managing the problem in that province alone was \$13.6 billion. The same strong economy that attracted people to the province put strain on the affordable housing system that had just experienced significant cuts. If left unchecked, the number was expected to grow to 21,000 by 2019 (Alberta Secretariat for Action on Homelessness, 2010, p. 4). Luckily, Housing First pilots were also underway in the 7 Cities, and early results suggesting that the approach was successful (Turner & Rogers, 2016, p. 503).

So, in 2008, the Alberta Affordable Housing Task Force recommended establishing a Housing Secretariat and adopting a ten-year plan to end homelessness in Alberta's seven largest cities using the Housing First approach (Alberta Secretariat for Action on Homelessness, 2010, p.2). Alberta became the first province in Canada to commit to ending homelessness, and the provincial government provided \$231 million for housing and related supports to Medicine Hat (Alberta Secretariat for Action on Homelessness, 2010, p.4). Turner and Rogers (2016) suggest that the cost-savings associated with Housing First were a powerful factor in securing investment (p. 503). In 2009-2010, Medicine Hat received \$780,000 to address homelessness, but by 2014-2015, they received \$2.8 million, an increase of 260% (p. 503). The 7 Cities group and their advocacy for additional funds is largely credited with this dramatic increase (Turner & Rogers, 2016, p. 504).

Not everyone agreed with the Housing First approach. Turner and Rogers (2016) report that the use of the Housing First model in Medicine Hat "challenged practices and beliefs across

the [non-profit] sector and broader community. The use of tax dollars to assist those with complex addictions and mental health issues . . . was met with resistance and challenged during the early adoption of the approach” (p. 503). People in the broader community felt that homelessness was a choice (Turner & Rogers, 2016, p. 503). The issue had already been framed societally as one that homeless people themselves were responsible for. The Housing Secretariat mandated that programs move to the Housing First model; some organizations in Medicine Hat found that this was not a good philosophical fit, chose not to transition, and became defunded (Turner & Rogers, 2016, p. 503).

Even so, Medicine Hat took on the challenge of ending homelessness. A consultant was hired to help manage the new approach, recommend specific steps, introduce common systems, and instill performance management systems (Turner & Rogers, 2016, p. 503). The community took a social investment perspective, in which community-driven approaches were used to address root causes homelessness and create the appropriate service mix for their specific community (Stone, 2011). Community consultation and planning led to the launch of a 5-year plan on October 29, 2009, when 75 citizens from across many organizations and sectors pledged to end homelessness and created a Housing First committee (Medicine Hat Community Housing Society 2014, p.8).

The Housing First committee evolved into the Community Council on Homelessness, a subcommittee of the Medicine Hat Community Housing Society (MHCHS). The Community Council on Homelessness was charged with governing and implementing the plan. The Council’s role included making funding recommendations and overseeing federal and provincial funding (Turner & Rogers, 2016, p. 504). The Council was made up of representatives from the government, non-profit, and business sectors, and included people working in health, income and

developmental supports, fundraising, police, and poverty reduction (Turner & Rogers, 2016, p. 504). This diversity may be why the program developed such a well-coordinated approach (Turner & Rogers, 2016, p. 505).

Although the City of Medicine Hat and 21 other primary stakeholders were involved in the project, the MHCHS led the implementation (Medicine Hat Community Housing Society, 2015a, para.3). The MHCHS had been delivering housing and related supports, and coordinating issues related to homelessness and affordable housing, since the 1970s, lending considerable knowledge and expertise to the program (Turner & Rogers, 2016, p. 502). Indeed, Peters (2015) notes that “no policy can be expected to be effective unless it has a clear conception of the socio-economic dynamics that are producing the problem” (p. 5). MHCHS’ decades of front-line experience and expertise surely played an important role in accurately depicting the homeless problem in the early stages of policy implementation. At the same time, MHCHS’s long-standing relationship with the community allowed it to leverage “existing organizational infrastructure, relationships, and coordination mechanisms,” encouraging involvement from political, private, and non-profit actors (Turner & Rogers, 2016, p. 502).

The first step in the system planning approach required identifying shared values to ensure stakeholders had the same understanding and objectives (Turner & Rogers, 2016, p. 597). This allowed programs operated by different organizations and levels of government to focus on delivering the same outputs and outcomes. The MHCHS also emphasized community engagement, a defined structure, standards of care, performance management, and coordinated intake and assessment as key drivers of their success (Medicine Hat Community Housing Society, 2014, p. 22). As B. Guy Peters (2015) notes, “the most important problems in governing cut across the conventional boundaries of policy (p. 19). He goes on to explain that

“to the extent that governments, and their counterparts in the private sector, can find ways to cope with cross-cutting problems, they are more likely to be successful” (Peters, 2015, p. 19).

Medicine Hat did an excellent job at engaging political, business, and non-profit stakeholders.

Turner and Rogers (2016) report that frontline staff found the new approach of meeting participants “where they were at”, even if they had addictions and mental health challenges, very motivating (p. 505). The early stages of implementation in Medicine Hat were “remembered as a period of risk taking and innovation” (p. 506). Frontline workers felt like “the old rules no longer applied – yet formalized processes were also lacking, leaving frontline staff, as well as leadership, with a certain amount of freedom to learn through implementation” (p. 506). With so many sceptics, stakeholders worked hard to produce evidence of their success (Turner & Rogers, 2016, p. 505). Turner and Rogers also explain that the success of the first cohort of participants was considered very important in the success of the entire program because the organizations needed proof that the approach worked. Data collection and analysis were not consistent in the beginning. But the MHCHS still collected some data, recognizing that early evidence about retention rates and cost savings would be an important factor in obtaining funding and community support (Turner & Rogers, 2016, p. 505). Evidence will be discussed in subsequent paragraphs.

Turner and Rogers (2016) note that a leadership change in MHCHS in 2011 led to more emphasis on system planning, performance management, and data-driven approaches. There was increasing emphasis on standardizing processes for funding allocation, monitoring outcomes and services quality, and system alignment. Part of this was because the Government of Alberta began requiring formal assessments, and many felt that it was a critical part of the success of the program because it helped address stakeholder concerns. The information was shared in public

forums and with the media, highlighting the cost-savings data, which gave the Housing First approach more legitimacy (Turner & Rogers, 2016, p. 507).

Because of this emphasis on data, as discussed below, Turner and Rogers (2016) report that the MHCHS required more flexibility and skills to ensure that data was collected, interpreted, and used systematically (p. 508). Program results and service quality were tracked through site visits, data tracking, and communication between MHCHS and other agencies (p. 508). All of this not only helped to make the program more coordinated, but also to increase the administrative burden and tension between service providers as the demands from the MHCHS increased. The MHCHS also required the agencies to adopt a set of standards that sometimes conflicted with their mission statements (Turner & Rogers, 2016, p. 507).

Turner and Rogers (2016) note that one of the key Housing First providers subsequently failed to renew their contact with MHCHS; they felt that the reporting requirements put too much burden on the staff (p. 506). But other programs stepped in to support program participants; this is a good example of how service providers worked together in a coordinated way, despite program changes (p. 506). Stakeholders thought this coming together was an important milestone for the program, as it marked the “culmination of a number of changes towards an enhanced formalization of the initiative” (Turner & Rogers, 2016, p. 506). As Peters (2015) notes, “almost all policies are embedded in complex patterns of cooperation and competition with other policies and organizations... these connections do influence the success and failure of any individual policy” (p. 7). The strong foundation that the MHCHS and other stakeholders laid in the beginning of the process seems to have paid off.

Between April 2009 and September 2013, 703 people were provided with housing, including 243 children (Medicine Hat Community Housing Society, 2014, p. 7). Participants in the Housing First program had 51% fewer days in hospital, 48% fewer days in jail, and 7% more court appearances (Medicine Hat Community Housing Society, 2014, p. 21). Seventy-two percent of participants in the program stayed in the housing provided (Turner & Rogers, 2016, p. 499). While the province's retention goal is 85% (Ending Homelessness in Medicine Hat, 2011, p. 3), some participants choose not to continue in the program, become incarcerated, disappear, or pass away (At Medicine Hat Community Housing Society, 2014, p. 33). Because many of these factors are beyond the program's control, completely eliminating homelessness is nearly impossible. But as one stakeholder explains, "we're not saying no one's ever going to become homelessness in Medicine Hat; what we're saying is that homelessness as a way of life will no longer be a reality though because of the systems we are putting in place" (Turner & Rogers, 2016, p. 508).

Turner and Rogers (2016) report that by 2013, the original goal to end homelessness in that year had not been met, and the MHCHS updated their plan (p. 508). An external consultant assessed the progress and compared their approach to best practices (p. 508). In November 2013, 50 participants, including service providers, public partners, government representatives, landlords, and community members met again to discuss the plan (p. 508). Service gaps and ways to increase coordination amongst agencies were identified, and a new goal of ensuring that no citizens spent more than 10 days on the street by 2015 was set (Turner & Rogers, 2016, p. 509).

In early 2014, Medicine Hat was on track to end homelessness by 2015 if \$12 million in new funding was found, and it was (Turner & Rogers, 2016, p. 508). In May 2015, Mayor Ted

Clugston reported that no one in the city spent more than 10 days in a shelter or on the street, because after that point, the city provided them with housing (Off, 2015, para. 2). Mayor Clugston has reported that it costs \$20,000 a year to provide someone with housing, while it can cost up to \$100,000 to support someone living on the street (Off, 2014, min. 0:38-0:45). This is consistent with the findings of The Mental Health Commission of Canada (Mental Health Commission of Canada, 2014).

Turner and Rogers (2016) also discuss the important role of politicians. Although city council members, Members of the Legislative Assembly, and Ministers had always supported the project, the current mayor of Medicine Hat has acknowledged that he did not initially favour the program (Maki, 2014, para. 5). However, when he did get on board, he brought increased media attention and created opportunities to bring the government and business sectors together. Politicians who championed the cause needed access to data and communications materials to explain the project to others; they required trust between the stakeholders, politicians, and business partners (Turner & Rogers, 2016, p. 508).

Despite all of these successes, Turner and Rogers (2016) paint a concerning picture for the future of homelessness in Medicine Hat. Almost 45% of homeless people surveyed in Medicine Hat in 2014 reported that they were new to the community (Turner & Rogers, 2016, p. 501). They could have been drawn to the community by the promise of free housing, which would put an unfair strain on local organizations and taxpayers. In fact, many communities known for their generous services for homeless people are reporting increases in the number of out-of-town service users (Hopper, 2016).

The recent drop in oil prices has also put more people in Alberta at risk of becoming homeless, and more investment is required for homelessness prevention. This, and indeed, the entire program, depends on funding from the provincial government; it is vulnerable to administrative and political shifts. Some stakeholders are worried that other social concerns might decrease attention and funding (Turner & Rogers, 2016, p. 510). Fortunately, the Federal government has recently renewed the Homelessness Partnering Strategy, which supports Housing First and Medicine Hat's approach (Employment and Social Development Canada, 2016a, para 1).

Peterson (1981) cautioned that this type of redistributive policy does not improve the city's economic position and can be harmful if it increases the taxes too much - well-off citizens could move to cities that direct more of their tax dollar towards their interests (p. 128-9). But Turner and Rogers (2016) report that the initiative has impacted the city positively overall. One municipal official noted that "ending homelessness is something Medicine Haters are proud of – not just the non-profit sector" (2016, p. 509). Medicine Hat has attracted attention and potential investors looking for a socially conscious community (Turner & Rogers, 2016, p. 509). Peters (1981) also states that "policies and programs can be said to be in the interest of cities whenever the policies maintain or enhance the economic position, social prestige, or political power of the city" (p. 123), noting that "improved standing in any one of these systems helps enhance a city's position in the other two" (Peters, 1981, p. 124).

But as Turner and Rogers (2016) note, it is difficult to attribute these successes directly to any one program. Medicine Hat's population only grew 1.2% from 2008-2013, while the other large cities in Alberta grew closer to 10% (p. 500). Medicine Hat's average rent costs were the lowest, but, given that their income was the lowest as well, this might not have been an important

mitigating factor (Turner & Rogers, 2016, p. 501). Clearly, it is important for any community considering the Housing First approach to look at their unique circumstances and adapt the program accordingly.

Toronto

Toronto has the largest homeless population in Canada, and its Housing First model is the largest and most developed in the country (Flavo, 2010, p. 1). In 1982, before the Housing First program started, there were approximately 3,440 homeless people in Toronto (Metropolitan Toronto, 1983, p. ii). By 1990, 26,529 people had used an emergency shelter at least once in the year, and, by 2002, that number rose to 31,985 (City of Toronto, 2003, p. 38). The number of people experiencing homelessness grew by 400% between 1980 and 2000 (Flavo, 2010, p. 7).

This put strain on existing emergency systems. In 2007, 55% of homeless people in the city reported that they were unable to get a bed at least once in the previous year, and it happened to those people 20 times on average (Khandor & Mason, 2007, p. 14). More beds were made available from mid-November to mid-April, but even so, one in three surveyed could not get a bed at some point during the winter (Khandor & Mason, 2007, p. 14).

This lack of facilities was having a disastrous effect on homeless people. According to a Street Health Report conducted in 2007, Toronto's homeless population had a number of poor health outcomes. More than half experienced serious depression and 1 in 10 had attempted suicide in the previous year (p. 4). In fact, three-quarters of the city's homeless population had a chronic health condition (Khandor & Mason, 2007, p. 4).

Despite the rising numbers and challenges, organizations in Toronto have been progressive with their approach towards homeless people. The City of Toronto has overseen

shelters in the city since the 1960s (Flavo, 2010, p. 8). In 1984, the Homes First Society opened Toronto's first government-assisted housing for single homeless people, even though homeless people were ineligible for provincial social housing until 1986, unless they had a disability (Dowling, 1998, p. 2). Throughout the 1990s, several organizations began programs to help chronically homeless, outdoor sleepers move directly into permanent housing, without requiring them to obtain treatment first (Flavo, 2010, p. 10).

The official approach taken by both the provincial government and the city changed after the turn of the century. Starting in 2000, the provincial government expanded supportive housing, and the number of units grew from 2,400 to 4,200 by 2005 (Flavo, 2010, p. 11). In 2001, the City of Toronto moved their focus from emergency support to helping people find shelter (City of Toronto, 2003, p. 50). While not a Housing First program, it was a shift towards more supportive housing, and it managed to place approximately 6,500 homeless people into permanent housing every year (Flavo, 2010, p. 11).

Still, programs struggled to obtain funding. According to the *Ontario Works Act*, the Province is responsible for paying 80% of shelter costs, with municipalities paying the remaining 20%. Nonetheless, the province capped the amount they would pay at \$33.60 per night per bed, for a total of \$42.(Flavo, 2010, p. 12). Because nightly costs in Toronto are closer to \$57, the city has been covering the difference at a cost of \$20 to \$30 million dollars annually (Flavo, 2010, p. 12).

Toronto needed a new approach, and, according to Flavo (2010), a number of events led to the adoption of Housing First. In 2002, the city relocated 100 squatters from a "Tent City," and provided them with large rent supplements and numerous supports (p. 13). In 2003-2004,

city council debated homelessness several times (p. 12). The council was concerned about the amount of money spent on homelessness and the fact that the problem was continuing to grow despite the large budget to address the issue (p. 13). Almost 100 people slept in front of Toronto City Hall every night (p. 13). Then, in 2004, 20-30 people were evicted from a bridge when a building nearby was demolished; they were not offered housing (p. 13). The story garnered considerable media attention. So in February 2005, under Mayor David Miller, the Streets to Homes (S2H) program was launched by the city with an annual budget of \$4 million (Flavo, 2010, p. 12).

S2H's mission was always to end homelessness by providing people with permanent housing without preconditions. Initially, their mandate involved working with people who had slept outside for at least 7 successive nights, but that was difficult to establish (Flavo, 2010, p. 13). S2H's scope expanded to include people who were spending most of their nights outside and were not already receiving housing services (Flavo, 2010, p. 13). Once an intake is complete, the S2H program averages 16 days for a client to receive a place to live (Flavo, 2010, p. 14).

Flavo (2010) explains that once a client has housing, he or she is offered support for one year (p. 17). This can include counselling, help with income support, assistance obtaining furniture and clothing, connections to other community resources, and help with landlords, transportation, and grocery shopping (Flavo, 2010, p. 17). If the client still requires supports after one year, the individual can be transitioned to other case management services (City of Toronto, 2007, p. 62).

Flavo (2010) reports that S2H is unique because it is run by the City of Toronto (p. 18). Compared to homeless programs run by community agencies, it has a large budget, a large client base, and more influence over other actors in the housing system and beyond (p. 18). The program has, for example, developed a relationship with the Ontario Disability Support Program (ODSP); applications to the program normally take 6-12 months to be approved, but applications from S2H participants can be approved in as little as 48 hours (p. 18). Several large, private landlords offer reduced rent in exchange for setting up clients on direct-payment and receiving some funds for unit maintenance costs (p. 19). Additionally, other non-profit housing providers within the city allow S2H clients to bypass subsidized housing wait lists (Flavo, 2010, p. 19).

The S2H program is considered successful. Flavo (2010) reports that about 600 people have been housed every year through the program (p. 20). Eight-seven percent of tenants remained housed, with 2-3% passing away and another 2-3% moving to other cities (p. 20). This is particularly impressive considering that 31% of the clients had never stayed in shelters before becoming S2H clients, and had been sleeping outside instead (p. 20). Seventy percent of S2H clients experienced improvements in their health, 69% reported better sleep, and 72% felt more personal safety (City of Toronto, 2007, p. 43). Clients' use of costly emergency services decreased as well; they spent 68% less time in jail and made 40% fewer hospital emergency rooms visits (City of Toronto, 2007, p. 51).

Future Directions

Best Practices

There are many lessons these Housing First case studies can provide for other communities. Turner and Rogers (2016) attribute Medicine Hat's success to a number of factors.

These include involving various sectors of the community through a community-wide systems planning approach; focusing on data, performance, and continuous improvement; and having a flexible coordinating organization to oversee the project (p. 514). The most important factor, from a municipal perspective, is developing champions to support the initiative at key moments, integrating the program with related systems, such as corrections and health, and involving stakeholders from a variety of sectors (Turner & Rogers, 2016, p. 513). Community engagement, a clearly defined structure, and coordinated intakes and assessments were also important parts of the city's success (Medicine Hat Community Housing Society, 2014, p. 22). But chiefly, Medicine Hat was able to provide housing for homeless people within 10 days because of the strong financial support from the province and the federal government, and the political momentum developed by connecting with other large cities in the province.

Toronto also has a strong program that can provide lessons for other municipalities that are considering Housing First. Flavo considers the Streets to Home program in Toronto to be a "model for other Canadian municipalities to emulate" (2010, p. 28). He notes that municipalities that have been successful with Housing First usually have a city councillor or bureaucrat to champion the program (Flavo, 2010, p. 26). According to a Housing First Toolkit based on At Home/Chez Soi pilot (2014), Toronto also ensured that both housing and clinical teams were included in meetings to keep up to date and review problems together (p. 104). This fostered "cooperation, sense of ownership, team-building, and clarity" (p. 105). The program included stakeholders and community partners like landlords, police, funders, and hospital staff to make referrals more seamless for clients (p. 199). These relationships were developed early in the program, and kept the stakeholders informed and engaged throughout the pilot (p. 199). Toronto also created compelling benchmarks and tracked relevant data, and found this especially useful

in conversations with funders (p. 199). Finally, Toronto used the personal stories of participants to highlight the impact of the program and encourage more funding (Polvere et al, 2014, p. 199). They developed a group of Persons with Lived Experience (PWLE) who had experienced homelessness, which, although time consuming, provided the project with a better understanding of the needs of the clients (Stergiopoulos, Hwang, O'Campo, & Jeyaratnam, 2011, p. 24-25).

Based on case studies in Vancouver, Victoria, Calgary, Edmonton, Lethbridge, Hamilton, and Fredericton, Gaetz, Scott, and Gulliver (2013) provide similar recommendations. They emphasize the importance of embedding Housing First into a broader strategy and an integrated systems plan (p. 6). They discuss the importance of engaging stakeholders, and underscore the importance of adapting the model based on the community's size, vacancy rate, demographics, and economy (p. 5). They also recommend consulting experts who have been involved with other Housing First programs (Gaetz, Scott, & Gulliver, 2013, p. 5).

Other literature focuses more on the macro-level changes required to create an environment where Housing First can succeed. Gaetz, Donaldson, Richter, and Gulliver (2013) recommend developing clear plans to end homelessness that are supported by all levels of government (p. 38). They believe that affordable housing is an important element of any plan to end homelessness (p. 38). They encourage an emphasis on chronic and episodic homelessness and Aboriginal homelessness because of the cost of supporting these categories of people in emergency services, the negative impact on people who are homeless for longer periods of time, and the distinct needs of these groups (p. 40-41). Like other researchers, they underscore the importance of data collection, monitoring, analysis, and research (Gaetz, Donaldson, Richter, & Gulliver, 2013, p. 41).

Role of the Municipality

Municipalities play a key role in the success of Housing First programs. Flavo (2010) suggests that champions are important if Housing First is to succeed, noting that they are present in most municipalities that have successfully implemented Housing First (p. 26). City councillors or administrators often fill this role (Flavo, 2010, p. 26). Local Housing First programs also need to be linked with related systems, such as corrections and health, and involve stakeholders from a variety of sectors (Turner & Rogers, 2016, p. 513).

Although housing is principally seen as a federal responsibility, many municipalities carry the burden of addressing homelessness with the support of federal funding. Flavo (2010, p. 28) also asserts that “provinces have to help municipalities both bridge the affordability gap for Housing First clients and ensure that long-term case management is available to those clients who need it. There is some sense that, because of significant costs savings to federal and provincial services like jails, hospitals, and shelters, these levels of government should be sharing more of the costs of Housing First (City of Toronto, 2009, p. 9). Medicine Hat and Toronto are powerful municipal examples, but Medicine Hat had the support of the Alberta government, and Toronto has a budget and political freedom pursuant to the *City of Toronto Act* that are unparalleled in other municipalities (City of Toronto Act, 2006).

Concerns

While Housing First Programs have had considerable success, there are concerns. First, Housing First alone is not enough to eliminate homelessness in Canada. Despite the robust program in Toronto, for example, the number of homeless people still increased from a 2006 population of 4,969 to a 2013 population of 5,253 (5.7%) (City of Toronto, 2013, p. 13). There were, however, significantly fewer people sleeping outside; in 2006, there were 736 people,

while in 2013, there were 447, a 39.3% decrease (City of Toronto, 2013, p. 13). This is the population targeted by the city's Housing First program, suggesting that the program may be more effective if it is expanded to other groups of homeless people, such as families or Aboriginal people.

Another concern pertains to fairness. Through the strong relationships developed between the Streets to Housing program in Toronto and ODSP, homeless participants can get approved to receive supports in less than 48 hours, and are often prioritized on subsidized housing waitlists (Flavo, 2010, p. 18). But people outside of the Streets to Homes program need to wait 6-12 months for ODSP and as many as 7 years for subsidized housing (Flavo, 2010, p. 18). Prioritizing some clients takes resources away from others, and adds even more time to the already lengthy process.

Third, there is concern about the sustainability of the Housing First approach. Toronto's Streets to Homes program did not have enough funds to support the demand, and eventually the Ontario Ministry of Health and Long Term Care made a funding commitment (Polvere et al, 2014, p. 198). Scholarship indicates that there is little research about the long-term impacts of the approach (Stergiopoulous et. al., 2016, p. 61). According to Carey Doberstein and Alison Smith (2015), many housing workers and analysts believe that funds would be better spent on affordable housing (p. 270-271). The private sector rental supplements that are often used can add up to more than the cost of building new housing, and there is no guarantee that private landlords will continue to house "difficult" Housing First clients (Doberstein & Smith, 2015, p. 271).

Finally, Housing First cannot address systemic issues. Flavo (2010) points out that although Housing First is proving successful in a number of cities, not all housing markets have a high enough vacancy rate to encourage private landlords to consider Housing First clients without large rent incentives, and not all cities have the institutional capacity to design and organize Housing First programs (p. 26-27). Even if these barriers can be managed, Housing First does not replace the need for a national housing strategy and related supports (p. 28). The Homelessness Partnership Initiative needs to be made permanent and far more provincial support needs to be provided for municipalities with large homeless populations (Flavo, 2010, p. 28).

Conclusion

Homelessness is a problem in Canada with significant costs for society and for homeless people themselves. The Housing First approach to homelessness, where people are assisted to find permanent homes and then given optional supports, has proven effective in keeping people off the streets. This paper has examined the history, causes, and impact of homelessness, the rise in popularity of Housing First, and two case studies of municipalities using the program. By providing best practices for Canadian municipalities, this paper contributes to the literature by providing a summary of Housing First to date and best practices for communities wishing to proceed with the program.

By using Housing First, the end of homelessness may be within sight. As New York City's Pathways to Housing founder Sam Tsemneris asserts, "homelessness is not like cancer or Alzheimer's disease. We have a cure for homelessness. It's quite simple. The thing that's lacking is the political will and the advocacy" (Tsemneris, 2012, 10:44-11:00). Housing First, used in conjunction with affordable housing, has the potential to end homelessness as a way of

life. Although impossible to avoid emergency situations that may leave people temporarily homeless, Housing First provides a feasible, affordable, and humane way to end long-term homelessness in Canada.

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Appendices

Appendix 1 – Homelessness Typology

OPERATIONAL CATEGORY	LIVING SITUATION	GENERIC DEFINITION
1 UNSHELTERED This includes people who lack housing and are not accessing emergency shelters or accommodation, except during extreme weather conditions. In most cases, people are staying in places that are not designed for or fit for human habitation.	1.1 People living in public or private spaces without consent or contract	<ul style="list-style-type: none"> Public space, such as sidewalks, squares, parks, forests, etc. Private space and vacant buildings (squatting)
	1.2 People living in places not intended for permanent human habitation	<ul style="list-style-type: none"> Living in cars or other vehicles Living in garages, attics, closets or buildings not designed for habitation People in makeshift shelters, shacks or tents
2 EMERGENCY SHELTERED This refers to people who, because they cannot secure permanent housing, are accessing emergency shelter and system supports, generally provided at no cost or minimal cost to the user. Such accommodation represents an institutional response to homelessness provided by government, non-profit, faith based organizations and / or volunteers.	2.1 Emergency overnight shelters for people who are homeless	These facilities are designed to meet the immediate needs of people who are homeless. Such short-term emergency shelters may target specific sub-populations, including women, families, youth or Aboriginal persons, for instance. These shelters typically have minimal eligibility criteria, offer shared sleeping facilities and amenities, and often expect clients to leave in the morning. They may or may not offer food, clothing or other services. Some emergency shelters allow people to stay on an ongoing basis while others are short term and are set up to respond to special circumstances, such as extreme weather.
	2.2 Shelters for individuals/families impacted by family violence	
	2.3 Emergency shelter for people fleeing a natural disaster or destruction of accommodation due to fires, floods, etc.	
3 PROVISIONALLY ACCOMMODATED This describes situations in which people, who are technically homeless and without permanent shelter, access accommodation that offers no prospect of permanence. Those who are provisionally accommodated may be accessing temporary housing provided by government or the non-profit sector, or may have independently made arrangements for short-term accommodation.	3.1 Interim Housing for people who are homeless	Interim housing is a systems-supported form of housing that is meant to bridge the gap between unsheltered homelessness or emergency accommodation and permanent housing.
	3.2 People living temporarily with others, but without guarantee of continued residency or immediate prospects for accessing permanent housing	Often referred to as 'couch surfers' or the 'hidden homeless', this describes people who stay with friends, family, or even strangers.
	3.3 People accessing short term, temporary rental accommodations without security of tenure	In some cases people who are homeless make temporary rental arrangements, such as staying in motels, hostels, rooming houses, etc.
	3.4 People in institutional care who lack permanent housing arrangements	People who may transition into homelessness upon release from: Penal institutions; Medical / mental health institutions; Residential treatment programs or withdrawal management centers; Children's institutions / group homes.
	3.5 Accommodation / reception centers for recently arrived immigrants and refugees	Prior to securing their own housing, recently arrived immigrants and refugees may be temporarily housed while receiving settlement support and orientation to life in Canada.
4 AT-RISK OF HOMELESSNESS Although not technically homeless, this includes individuals or families whose current housing situations are dangerously lacking security or stability, and so are considered to be at-risk of homelessness . They are living in housing that is intended for permanent human habitation, and could potentially be permanent (as opposed to those who are provisionally accommodated). However, as a result of external hardship, poverty, personal crisis, discrimination, a lack of other available and affordable housing, and / or the inappropriateness of their current housing (which may be overcrowded or does not meet public health and safety standards) residents may be "at risk" of homelessness.	4.1 People at imminent risk of homelessness	<ul style="list-style-type: none"> Those whose employment is precarious Those experiencing sudden unemployment Households facing eviction Housing with transitional supports about to be discontinued People with severe and persistent mental illness, active addictions, substance use, and / or behavioural issues Breakdown in family relations People facing, or living in direct fear, of violence / abuse
	4.2 Individuals and families who are precariously housed	Those who face challenges that may or may not leave them homeless in the immediate or near future. CMHC defines a household as being in core housing need if its housing: "falls below at least one of the adequacy, affordability or suitability standards and would have to spend 30% or more of its total before-tax income to pay the median rent of alternative local housing that is acceptable (meets all three housing standards)."

Canadian Observatory on Homelessness. (ND, p. 2). Canadian Definition of Homelessness. Homeless Hub.

Appendix 2 – Homelessness Strategy Designated Communities

The following are the designated communities in Ontario:

- ▶ Belleville
- ▶ Brantford
- ▶ Dufferin County
- ▶ Durham
- ▶ Guelph-Wellington
- ▶ Halton
- ▶ Hamilton
- ▶ Kingston
- ▶ London
- ▶ Niagara
- ▶ North Bay
- ▶ Ottawa
- ▶ Peel
- ▶ Peterborough
- ▶ Sault Ste. Marie
- ▶ Simcoe-Barrie
- ▶ Sudbury
- ▶ Thunder Bay
- ▶ Toronto
- ▶ Waterloo
- ▶ Windsor
- ▶ York

Retrieved from Employment and Social Development Canada

<http://www.esdc.gc.ca/eng/communities/homelessness/designated/on.shtml>

Appendix 3 – Housing First Team Interventions

Housing First is implemented through the following types of teams:

ASSERTIVE COMMUNITY TREATMENT (ACT) - ACT is an integrated team based approach designed to provide comprehensive community-based supports to help people remain stably housed. It is one of the most studied community programs in all of health care and has a very strong evidence base. Programs that follow the Pathways model typically offer intensive supports through ACT teams to address the needs of clients with mental health and addictions, and may support individuals in accessing psychiatric treatment and rehabilitation. These teams may consist of physicians and other health care providers, social workers and peer support workers. The latter are deemed to be key members of the team, for their experience of homelessness can become an essential resource for support and recovery. They help bridge the knowledge that other team members bring with knowledge of what it is to be homeless. ACT teams are designed for clients with the most acute needs and may provide support on an ongoing basis. In some cases, individuals will need to have access to supports 24 hours a day.

RAPID REHOUSING – Often defined as distinct from Housing First, rapid rehousing operates on many of the same guiding principles. It is an approach that targets clients with lower acuity of mental health and addictions challenges. As such, the level of supports is much lower, and usually for a shorter period of time. Clients may be given short term rent supplements, and help in accessing services and supports.

INTENSIVE CASE MANAGEMENT – This can also be a team-based approach that supports individuals through a case management approach, the goal of which is to help clients maintain their housing and achieving an optimum quality of life through developing plans, enhancing life skills, addressing health and mental health needs, engaging in meaningful activities and building social and community relations. It has a moderately strong evidence base. It is designed for clients with lower acuity, but who are identified as needing intensive support for a shorter and time-delineated period. The *At Home/Chez Soi* project has identified that for many clients, the first three months can be most challenging, and providing appropriate levels of support may be crucial for recovery and retention of housing.