Housing First: A Strategy to Reduce Homelessness and Recidivism

by

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B.Sc., University of Ottawa, 2012

Project Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Arts

in the

School of Criminology

Faculty of Arts and Social Sciences

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SIMON FRASER UNIVERSITY

Summer 2015

Approval

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Abstract

The housing initiative at the Vancouver Aboriginal Transformative Justice Services Society originated from the observation that homelessness is a prominent issue among clientele. Three staff members who address the homelessness issue provide housing supports (e.g., helping clients find affordable housing in a tight rental market), complementary supports (e.g., life skills), and referrals to clinical supports (e.g., alcohol and drug counselling). This paper provides an overview of different approaches to homelessness, including Housing First. Housing First involves the immediate provision of housing, which is subsequently combined with wrap-around supports. Research from the United States and Canada has demonstrated that Housing First not only has a positive impact on housing stability but also reduces criminal justice involvement and creates cost offsets in health and criminal justice services. Importantly, Housing First has been successfully adapted to meet the unique needs of Aboriginal people, a population which is over-represented in homeless counts across Canada.

Keywords: housing; homelessness; housing first; mental illness; aboriginal people; aboriginal homelessness

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Chapter 1.

Introduction

In early 2014, I completed a one-term placement, a requirement for one of two streams in the Master of Arts program in the School of Criminology at Simon Fraser University, at Vancouver Aboriginal Transformative Justice Services Society (VATJSS). VATJSS, which will be discussed in detail later in this paper, became Canada's fourth urban Aboriginal justice program when it went operational in 2000 (Palys, 2014). At VATJSS, homelessness is a prominent issue among clientele; a recent programme evaluation found that 31.8% of all clients were homeless or at risk of homelessness (Palys, 2014). The issue of homelessness is often recognized in community council forums. The forums entail the following:

> Community forums are held when a referral involving crime or some other form of trouble – which may arise from a criminal justice agency or a self- or community-referral – warrants a community-based intervention to assess what led to the event(s) and develop a healing plan that starts to address that situation. (Palys, 2014, p. 20)

If the issue is identified as relevant to a client in a community council forum, one of two Homeless Outreach Workers will work with the individual to address that issue. However, the Aboriginal Homeless Outreach Program at VATJSS also works with walk-ins[1] "before it [potentially] becomes manifest in criminality" (Palys, 2014, p. 23).

Indeed, research has indicated that the relationship between homelessness and incarceration is bi-directional (Gaetz, 2012; Gaetz & O'Grady, 2006; 2009). People who are homeless, especially those sleeping on the streets, in parks, and under bridges, are

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[1] Some individuals come to VATJSS via referrals through the courts, but many individuals self-refer or are referred by family members who see VATJSS as a valuable community resource always willing to help. These self-referrals, or walk-ins, have not been charged with any crime.

more likely to become involved with the criminal justice system than those who are housed (Currie, Moniruzzaman, Patterson, & Somers, 2014; Gaetz, 2012; Gaetz & O'Grady, 2006; Novac, Hermer, Paradis, & Kellen, 2006). The surge in homelessness in Canada, which will be discussed briefly, has resulted in greater surveillance of the homeless by the police and the enactment of laws (e.g., the *Safe Streets Act* in Ontario [1999] and British Columbia [2004]) that criminalize the behaviours of the homeless, such as squeegeeing (Gaetz & O'Grady, 2006). Also, homeless and prison populations generally share risk factors, such as mental health and addictions problems, making the former vulnerable to incarceration (Gaetz & O'Grady, 2006).

In turn, people in prison are at an increased risk of becoming homeless upon release (Gaetz, 2012; Gaetz & O'Grady, 2006; Kellen et al., 2010). Novac et al. (2006) have referred to the homelessness experienced by releasees as a move, "from the can to the curb" (in Gaetz & O'Grady, 2006, p. 90). Some releasees were homeless prior to being incarcerated whereas others experienced a loss of housing as a result of being incarcerated (Somers et al., 2013). For example, a study by Kellen et al. (2010) involved interviews with 363 individuals who had spent at least five consecutive nights incarcerated and were scheduled for release within a week from one of four correctional facilities (Toronto Jail, Toronto East Detention Centre, Toronto West Detention Centre, and Maplehurst Correctional Centre in Milton). Among the 363 prisoners surveyed, 22.9% were homeless prior to being incarcerated. In this particular study, homeless was defined as staying in a shelter or a treatment facility, couch-surfing (staying at the home of a friend or family member temporarily), or living on the street. Almost a third (32.2%) of respondents anticipated being homeless upon their imminent release.

One of the main challenges for releasees in making the transition from prison to the community is obtaining and maintaining housing (Gaetz & O'Grady, 2006). People in prison are at risk of becoming homeless when they are released without adequate discharge planning, such as assistance in accessing housing, employment, and support services for mental health and/or addictions problems (Gaetz, 2012; Gaetz & O'Grady, 2006; 2009; Kellen et al., 2010). It becomes difficult for releasees to reintegrate into the community and move forward with their lives when they lack access to housing, employment, and support services (Gaetz & O'Grady, 2009). According to Gaetz (2012),

"people who are housed when they leave prison are less likely to reoffend, and this results in considerable savings to the criminal justice system" (p. 12).

The bi-directional relationship between homelessness and incarceration results in a "revolving door" – a cycling from homelessness to incarceration, and back again (Gaetz & O'Grady, 2006; 2009; Somers, Rezansoff, Moniruzzaman, Palepu, & Patterson, 2013). For some people in prison, being released with inadequate or no discharge planning results in homelessness as they have difficultly accessing housing, employment, and support services. Homelessness can subsequently result in recidivism as people who are homeless, under greater surveillance by the police, engage in activities to meet basic needs (Gaetz & O'Grady, 2006).

In addition to its relationship to criminality, homelessness, especially chronic homelessness, is a costly issue. The chronically homeless make up a small percentage of the overall homeless population, but consume the majority of resources in the homelessness system, such as shelter services (Gaetz, Scott, & Gulliver, 2013; Gaetz et al., 2013). The chronically homeless represent only 11% of shelter users but are responsible for 50% of shelter stays (Polvere et al., 2014). In Toronto and Ottawa, people who are chronically homeless accounted for over half of shelter stays over a four year period despite representing only a small percentage of shelter users (Gaetz, Scott, & Gulliver, 2013).

The chronically homeless also consume resources outside the homelessness system (Gaetz, Scott, & Gulliver, 2013). For example, the use of health and criminal justice services (e.g., emergency room visits and jail stays) is high among this homeless population as health declines and criminal justice involvement increases the longer one remains chronically homeless. In a Vancouver study, the most common category of crime among participants who were absolutely homeless or precariously housed were property crimes (Currie et al., 2014). This could suggest that people who are homeless most commonly become involved with the criminal justice system for engaging in activities to meet basic needs.

The heavy service use among people who are chronically homeless has resulted in higher expenditures outside the homelessness system. According to Laird (2007),

The $4.5 to $6 billion annual cost of homelessness in Canada, as estimated by this report, is systemic: the expense of warehousing the homeless over the past decade has spilled over into emergency services, community organizations, non-profits, the criminal justice system – all have incurred extra expense in responding to unprecedented growth in homelessness. (p. 86)

Thus, responses to homelessness have the potential to not only alleviate homelessness but also reduce criminal justice involvement and be cost effective if the chronically homeless are prioritized. In this paper, I will look at evidence regarding different approaches to homelessness and specifically what VATJSS is doing to address Aboriginal homelessness in Vancouver.

Chapter 2.

Homelessness in Canada

Homelessness in Canada is "a serious public policy concern" (Goering et al., 2014, p. 6). Annually, up to 200,000 people are homeless across Canada at an estimated cost of $7 billion (Goering et al., 2014; Polvere et al., 2014). Among the homeless population, an estimated 20% are youth under the age of 18 and 47.5% are single adult males between the ages of 25 and 55 (Polvere et al., 2014).

Aboriginal people (First Nations, Métis, and Inuit) are over-represented in homeless counts across the country (Polvere et al., 2014). According to Patrick (2014), "Some sources have suggested that Aboriginal homelessness in major urban areas ranges from 20 to 50 percent of the total homeless population, while others have reported that the range may be much wider – from 11 to 96 percent" (p. 26). As Leach (2010), Chief Executive Officer of the Aboriginal Housing Management Association, amply explains,

> Aboriginal homelessness correlates with the history of colonisation in Canada; residential schools across the country, Aboriginal wardship in the child welfare system, displacement from traditional lands, and marginalisation in Canadian society devastated families and cultural traditions. (p. 12)

Intergenerational trauma has been put forth as a contributing factor of Aboriginal homelessness (Menzies, 2006; Patrick, 2014). Aboriginal people have experienced a number of historical injustices, including attempts to assimilate generations of Aboriginal children (e.g., Indian residential schools, the 60s scoop) into the dominant culture. For over a century, Aboriginal children were forcibly taken from their families and communities and placed in Indian residential schools, which were government-funded

and church-run. At these schools, children were prohibited from speaking their language and engaging in cultural practices:

> Children were taught to obey church leaders without resistance and, consequently, abandon their sense of agency. This process produces adults who are either profoundly disempowered and emotionally detached, or angry and self-destructive (which can result in addiction, self-inflicted abuse and victimization of others). (Patrick, 2014, p. 59)

Many children also experienced physical, sexual, and psychological abuse, which have been associated with mental health and addictions issues (Patrick, 2014). This abuse did not only negatively impact children attending these schools, but also their children when they became parents:

> Young people were often reared by adults who had themselves experienced abuse within residential schools. Since these adults had been taught abuse was a form of love and an appropriate way to discipline children, the next generation of children was subject to abuse or received care from emotionally detached, traumatized family members. (Patrick, 2014, p. 60)

During the 1980s and 1990s, homelessness emerged as a significant problem in Canada (Gaetz, 2010; Gaetz, 2012; Gaetz, Gulliver, & Richter, 2014; Gaetz & O'Grady, 2006). According to Laird (2007), the surge in homelessness since the 1990s is "unprecedented in this nation's post-war history" (p. 12).

The surge in homelessness in Canada during the 1980s and 1990s corresponded with changes in federal funding for social housing and related programs (e.g., mental health residential care). From 1984 to 1993, the federal government made cutbacks to social housing and related programs nearing $2 billion (Nelson, 2010). In 1993, the federal government terminated its national housing strategy, which had created over 650,000 social housing units since 1973 (Laird, 2007). Furthermore, responsibility for social housing and related programs was transferred to the provinces in 1996 (Gaetz et al., 2013; Hulchanski, 2009; Nelson, 2010). Unfortunately, provinces do "not have adequate funding streams for the creation of housing for low-income citizens" (Nelson, 2010, p. 139).

According to Laird (2007), up to 20,000 social housing units were constructed annually in the mid-1980s. However, only 4,450 social housing units were constructed from 1994 to 1998. The lack of a national housing strategy in Canada prompted Miloon Kothari, then United Nations Special Rapporteur on the Right to Adequate Housing, to conclude, "Canada has one of the smallest social housing sectors among developed countries" (in Shapcott, 2007, para. 6). This lack of affordable housing supply is exacerbated by an almost 30% increase in Canada's population over the past 25 years (Gaetz, Gulliver, & Richter, 2014). This increased demand for affordable housing outweighs the supply, evidenced by the long waiting lists for subsidized housing, leaving many Canadians at risk of homelessness.

Since the surge in homelessness during the 1990s, Canada's response "has largely been to create homeless shelters, emergency services and other "front line" services which have managed the homeless crisis and, in some cases, facilitated the rapid growth of homelessness in Canada" (Laird, 2007, p. 6). However, it has been argued that this is an expensive way of responding to the growing problem of homelessness (Gaetz, 2012; Goering et al., 2014), and that funding for emergency services would be better allocated to long-term solutions such as Housing First, an approach to homelessness that will be discussed later in this paper (Polvere et al., 2014). This reallocation of funding would shift the response to homelessness from one that focuses on managing the problem to one that focuses on preventing it (Gaetz, Gulliver, & Richter, 2014).

Chapter 3.

Four Approaches to Addressing Homelessness

3.1. The Residential Continuum Model

Prior to the 1950s, people with serious mental illness were housed in psychiatric hospitals (Nelson, 2010). However, beginning in the 1950s and reaching its peak in the 1970s, a period known as deinstitutionalization saw psychiatric hospital closures across Canada and the United States (Polvere et al., 2014). The move in mental health services from psychiatric hospitals to the community resulted in the homelessness of many former patients due to a lack of government support services upon discharge (Metraux, Byrne, & Culhane, 2010; Nelson, 2010).

In the 1970s, mental health professionals began to develop a solution to homelessness experienced by former psychiatric hospital patients that would move them towards independent living. This is sometimes referred to as the Residential Continuum Model (Tsemberis, 2010). Clients are moved along a continuum of housing, starting with outreach and ending with permanent housing:

> It begins with outreach, includes treatment and transitional housing, and ends with permanent supportive housing. The purpose of outreach and transitional residential programs is to enhance clients' "housing readiness" by encouraging the sobriety and compliance with psychiatric treatment considered essential for successful transition to permanent housing. (Tsemberis, Gulcur, & Nakae, 2004, p. 651)

Importantly, permanent housing is only provided when clients first address their mental health and/or addictions issues.

In the 1980s, the Residential Continuum Model came under criticism based on a number of factors. First, the model lacks client choice in decisions pertaining to the type

of housing and supports clients receive; instead, these are left solely in the hands of mental health professionals (Nelson, 2010). Further, the model: (a) lacks community integration as clients are placed in segregated housing; (b) disrupts social relationships as clients progress along the continuum and move away from settings where they had developed a network of support; (c) assumes clients need to demonstrate housing readiness prior to independent living; and (d) inadequately addresses the needs of people who are chronically homeless (Carling, 1995; Nelson, 2010; Polvere et al., 2014; Ridgway & Zipple, 1990; Tsemberis & Eisenberg, 2000).

3.2. Housing First

Housing First emerged to address the limitations inherent in the Residential Continuum Model (Polvere et al., 2014). Paul Carling, with the support of consumer advocates Priscilla Ridgway and Anthony Zipple, introduced an approach called "supported housing," which gives clients choice in where they would prefer to live (Nelson, 2010; Polvere et al., 2014). Housing is permanent and integrated within the community, which is made financially accessible to clients through the use of rent supplements (Nelson, 2010). Rent supplements ensure that users pay no more than 30% of their income towards rent. Housing is not contingent upon clients first demonstrating readiness such as maintaining sobriety. Rather, clients receive "Housing First." Lastly, housing and support services are separated.

This model was adopted and popularized by Sam Tsemberis, founder and CEO of Pathways to Housing, Inc., in the early 1990s (Gaetz, Scott, & Gulliver, 2013; Polvere et al., 2014). Pathways to Housing, Inc. is a non-profit organization established in New York City in 1992 (Tsemberis, 2010). The Pathways Housing First (PHF) program is a combination of supported housing and Assertive Community Treatment (Polvere et al., 2014). Assertive Community Treatment is defined as "an integrated team based approach designed to provide comprehensive community-based supports to help people remain stably housed" (Gaetz, Scott, & Gulliver, 2013, p. 17). The PHF program is important to discuss as it has "informed many future developments in Housing First" (Gaetz, Scott, & Gulliver, 2013, p. 9) and "has emerged as probably the most well developed and researched Housing First program" (Polvere et al., 2014, p. 12).

3.3. Pathways Housing First

The PHF program serves chronically homeless adults with mental illness and/or problems with substance abuse. "Chronically homeless" is defined as having been homeless for a year or more. The PHF program was borne out of the observation that clients were either unable to gain admission to programs under the Residential Continuum Model or to maintain housing once they were admitted to them (Tsemberis, 2010). Clients are identified through street outreach or by hospital staff planning the discharges of patients with mental health and addictions issues (Waegemakers-Schiff & Rook, 2012). During the initial intake process, the client's housing preferences (type and location) are discussed (Tsemberis, 2010). Based on this information and the realities of the rental market, a number of apartments are located and presented to the client who makes the final choice. Furniture and household items are provided and selected by the client. The PHF program partners with private landlords to rent apartments that are affordable, suitable, and adequate using a scattered-site approach to ensure community integration. No more than 20% of apartments are rented in any one building. Clients are provided with rent supplements to ensure that they do not pay more than 30% of their income towards rent.

In addition to an apartment, clients are provided with off-site treatment and support services by the program's Assertive Community Treatment (ACT) team and/or Intensive Case Management (ICM) team (Tsemberis, 2010). Housing and services are provided independently, by the ACT and/or ICM teams, to ensure services are kept constant during a housing crisis and similarly, that housing remains constant during a clinical crisis. The ACT team provides services directly and members typically work as a team with clients. The team serves clients with high needs and includes a nurse, psychiatrist, social worker, housing specialist, peer specialist, and addiction specialist. Conversely, the ICM team brokers services from other community agencies and members work one-on-one with clients. The team serves clients with moderate needs. Treatment and support services are client-driven, individualized, and most importantly, voluntary.

The PHF program does not require housing readiness, and housing is not contingent upon psychiatric treatment and/or sobriety (Tsemberis, 2010). However, the program does have two requirements. First, clients must agree to a weekly apartment visit by a team member. The visit serves housing-related purposes such as ensuring the apartment is well-maintained. The visit also can serve clinical or personal purposes such as helping clients address their mental health or employment problems. Second, clients must adhere to a standard lease which includes paying 30% of their income, usually from disability benefits, toward rent.

In summary, the PHF program first provides immediate housing that is independent and permanent. Housing is then combined with off-site treatment and support services, which are client driven, individualized, and voluntary. As Sam Tsemberis (2010), founder and CEO of Pathways to Housing, Inc., states,

> Some people think when you offer housing right away that you're actually enabling people as opposed to helping them get better. Our experience has been that providing housing first, and then treatment, actually has more effective results in reducing addiction and mental health symptoms than trying to do it the other way. The other way works for some people, but it hasn't worked for the people who are chronically homeless. (p. 23)

3.4. A Housing First/PHF Hybrid

Housing First (HF) continues to grow in popularity as a key approach to reducing homelessness (Gaetz, Scott, & Gulliver, 2013). While HF was initially developed to address the needs of homeless individuals with mental health and/or addictions issues, its principles have since been applied to address other forms of homelessness (Polvere et al., 2014). HF has extended beyond the United States and has been implemented in communities across Canada, such as Calgary, Edmonton, Toronto, and Fredericton.

It is essential that the core principles of HF, heavily informed by the PHF program, be clearly defined in order to facilitate the planning and implementation of programs (Gaetz, Scott, & Gulliver, 2013). Adhering to the core principles of HF ensures fidelity to the model. A lack of fidelity to the core principles as the popularity of HF increases is a cause for concern as Pleace and Bretherton (2012) argue that:

As 'Housing First' has permeated the thinking of policymakers and service providers across the US and the wider world, the core ideas of PHF have been simplified, diluted and in many instances, subjected to change. The PHF paradigm often only has a partial relationship with the wide range of new and remodeled homelessness services that have been given the 'Housing First' label. (p. 5)

However, strict adherence to the model is impractical given differences in local context (e.g., city size, cultural composition, access to affordable housing). What works in Toronto may not translate as well in Moncton, for example, as the latter has substantially fewer mental health services available. Fortunately, it is possible to adapt the model to suit the needs of different communities and sub-populations without compromising the model's core principles, which will be demonstrated later in this paper.

A first core principle of HF is the belief that housing is a basic human right, not something that is to be earned (Tsemberis, 2010). In addition, housing is considered a precondition for recovery (Ridgway & Zipple, 1990; Tsemberis & Eisenberg, 2000). In the process of recovery, the starting point is providing clients with immediate, permanent housing which fulfills their basic needs of safety and security (Tsemberis, 2010). Once these more basic needs have been met, wrap-around supports, which are individualized and client-driven, are subsequently provided (Polvere et al., 2014). This sequence is more conducive for recovery as it allows clients to shift their focus and energy from basic survival to other areas of their lives that warrant attention (Tsemberis, 2010). Until more basic needs have been met, it is very difficult for other needs, such as finding employment, to come into focus. According to Tsemberis and Eisenberg (2000), clients are more likely to seek mental health and/or substance abuse treatment voluntarily after they are housed. One reason behind this may be that housing itself acts as a motivator for clients to reclaim their lives (Goering et al., 2014). Housing is the first step in the process of recovery, initiating a sense of enthusiasm and optimism for the remainder of the recovery process.

A second core principle of HF is that the skills a client requires for independent living are most effectively learned through independent living (Ridgway & Zipple, 1990). This is in line with research in psychiatric rehabilitation which finds that the most effective place to teach a person the skills needed for a particular environment is within

that actual environment (Tsemberis, Gulcur, & Nakae, 2004). This finding undermines the effectiveness of the Residential Continuum Model as it assumes clients can learn the skills required for independent living in transitional housing.

Consequently, a third core principle of HF is that permanent, independent housing should be available immediately without requiring any demonstration of housing readiness (Gaetz, Scott, & Gulliver, 2013; Goering et al., 2014; Polvere et al., 2014). Clients are not required to address their mental health and/or addictions issues before they are deemed housing ready (Gaetz, Scott, & Gulliver, 2013). In a study conducted by Tsemberis, Gulcur, and Nakae (2004), the provision of housing without preconditions for treatment and sobriety did not increase alcohol or drug use among the experimental group (housing not contingent on treatment and sobriety) compared with the control group (housing contingent on treatment and sobriety).

A fourth core principle of HF affirms that clients are capable of setting their own recovery goals (Tsemberis, 2010). Accordingly, HF emphasizes client choice and self-determination (Gaetz, Scott, & Gulliver, 2013; Goering et al., 2014; Polvere et al., 2014; Tsemberis, 2010). Clients have choice regarding the type and location of housing they receive (Polvere et al., 2014). Unfortunately, this can be constrained by the realities of the rental market. In addition to housing, treatment and support services also are guided by client choice (Tsemberis, 2010). Clients choose the type, intensity, duration, and sequence of services. Similarly, HF emphasizes individualized and client-driven supports (Gaetz, Scott, & Gulliver, 2013; Goering et al., 2014; Polvere et al., 2014). Clients' needs vary, with some requiring minimal supports and others more intensive ones (Polvere et al., 2014). Supports should reflect the unique circumstances and needs of each client.

Aboriginal people, in particular, have unique circumstances and needs. The effects of historical injustices imposed on Aboriginal people should be taken into consideration when providing homelessness services to this group:

> Many of the personal issues (including familial dysfunction, substance use, addictions, health issues, community violence) faced by Aboriginal Peoples and that act as contributors to homelessness can be directly linked to various types of historical trauma. (Homeless Hub, 2015, para. 5)

As mentioned in a previous chapter, intergenerational trauma has been cited as an explanation for the over-representation of Aboriginal people in homeless counts across Canada. According to Menzies (2010), people who have experienced intergenerational trauma may:

- Lack of a sense of belonging within a family, community, culture, or nation.
- Be unable to sustain personal or intimate relationships.
- Have low self-esteem, depression, or tendencies toward self-harm or suicidality.
- Develop dysfunctional coping mechanisms such as substance abuse, hyper-sexuality, hyperactivity, aggression, sensation seeking or isolation.
- Be involved with the mental health or criminal justice system.
- Have a limited education and employment history.
- Experience an absence of meaning and hope. (cited by Patrick, 2014, p. 61)

Therefore, supports should reflect the above needs of Aboriginal people who are homeless and have undoubtedly experienced intergenerational trauma (e.g., helping them reconnect with family).

A fifth core principle is HF`s emphasis on the importance of social and community integration (Gaetz, Scott, & Gulliver, 2013; Goering et al., 2014; Polvere et al., 2014). This is essential as social isolation can compromise housing stability (Gaetz, Scott, & Gulliver, 2013; Polvere et al., 2014). Community integration is supported through the separation of housing and services, meaning services are not provided in the same building where clients reside (Polvere et al., 2014). Housing is not confined to specific buildings and neighbourhoods. Instead, housing is integrated into the community using a scattered-site approach (Tsemberis, 2010). Supports also may promote social integration by helping clients reconnect with family, for example. Another core principle involves a recovery orientation, which emphasizes individual well-being by ensuring that a range of supports (e.g., social, recreational, and educational) are made accessible to clients by the ACT and/or ICM teams (Gaetz, Scott, & Gulliver, 2013; Goering et al., 2014; Tsemberis, 2010).

A final core principle involves commitment to using a harm reduction approach, which aims "to reduce both the risk and effects associated with substance abuse and addiction at the level of the individual, community and society without requiring abstinence" (Polvere et al., 2014, p. 15).

Chapter 4.

Program Effectiveness

4.1. Research from the United States

To date, most of the evidence on Housing First (including Pathways Housing First) has been based on programs in large cities in the United States, such as New York City (Goering et al., 2014). Research has demonstrated that HF has a positive impact on housing stability, reduces involvement with the criminal justice system, and is cost effective (Gaetz, 2012; Gaetz, Scott, & Gulliver, 2013; Nelson, Aubry, & Lafrance, 2007; Polvere et al., 2014; Somers et al., 2013).

4.1.1. Housing stability

Research has found that people who participate in HF maintain housing at a higher rate than people who participate in programs, which require sobriety and treatment (Tsemberis, 2010).

Nelson, Aubry, and Lafrance (2007) conducted a review of sixteen empirical evaluations of the effectiveness of housing and supports combined, Assertive Community Treatment (ACT) alone, and Intensive Case Management (ICM) alone for people who are homeless and mentally ill. All three resulted in significant reductions in homelessness among people who were both homeless and mentally ill. However, a combination of housing and supports was found to be the most successful in reducing homelessness:

> In terms of the most effective approach in reducing homelessness, it appears that providing permanent housing and support is the most successful approach. This conclusion is based on the findings that the *ES* [effect size] for housing and support interventions (average *ES* = .67) are

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higher than those for ACT (average *ES* = .47) and the findings from direct comparisons of housing and support with ACT or ICM alone showing the superiority of housing plus support. (Nelson, Aubry, & Lafrance, 2007, p. 358)

Aubry, Ecker, and Jette (2013) conducted a review of nine randomized controlled trials (RCTs) in the United States. These studies were selected based on the following criteria:

(1) the study needed to be published in a refereed journal, (2) the study involved a comparison of at least two groups, of which one of the groups comprised individuals living in supported housing and (3) the study examined effectiveness using at least some quantitative measures. (p. 167)

Of the nine trials, five demonstrated that supported housing was more effective at increasing housing stability when compared to residential continuum housing, case management without housing, supportive housing ("congregate housing with on-site case management"), and "treatment as usual" (TAU) control groups (Aubry, Ecker, & Jette, 2013, p. 167). For example, a RCT of chronic shelter users with mental illness found that participants assigned to the experimental group (one of two HF programs) obtained permanent, independent housing at higher rates than participants assigned to the control group (TAU) (Stefancic & Tsemberis, 2007). Furthermore, 78.3% of participants in the PHF program maintained housing over a four-year period.

Tsemberis and Eisenberg (2000) compared housing stability rates between people in the PHF program with people in residential continuum housing in New York City. After five years, 88% of people in the PHF program remained housed versus only 47% of people in residential continuum housing. In another study conducted by Tsemberis, Gulcur, and Nakae (2004), 225 participants were randomly assigned to either a control group (TAU) or experimental group (PHF). After one year, participants in the experimental group spent 85% of their time in stable housing compared to participants in the control group who spent less than 25% of their time in stable housing (in Tsemberis, 2010). This strongly undermines the assumption that clients need to address their mental health and/or addictions issues before housing is provided. After

two years, participants in the experimental group spent approximately 80% of their time in stable housing whereas participants in the control group spent only 30%.

4.1.2.   Criminal justice involvement

Tsemberis (2010) reported the results of several studies that investigated the impact of PHF programs in different U.S. cities. A study in Denver found a 76% reduction in incarceration rates among PHF clients (Perlman & Parvensky, 2006, cited by Tsemberis, 2010, p. 186). A second study in Rhode Island observed a reduction in jail stays among a cohort of PHF clients from a combined total of 919 jail stays in the year prior to enrollment to only 149 in the first year of enrollment (Hirsch & Glasser, 2008, cited by Tsemberis, 2010, p. 186). A third study in Seattle found declines in jail bookings and jail days among clients in one of two PHF programs. In one program, clients reduced their jail bookings in the year prior to enrollment by 52% and jail days by 45% (HUD, 2007, cited by Tsemberis, 2010, p. 187). The second program showed an 18% reduction in jail days (Srebnik, 2007, cited by Tsemberis, 2010, p. 187). Another in New York City examined service use by homeless people with mental illness before and after being placed in supportive housing (Culhane, Metraux, & Hadley, 2002). The study found significant declines in the number of persons and days incarcerated.

4.1.3.   Cost effectiveness

In a review of the empirical literature on the effectiveness of housing interventions for people who are both homeless and mentally ill, Nelson, Aubry, and Lafrance (2007) examined three studies that looked at the costs of these interventions. One of the studies, conducted by Gulcur et al. (2003), compared supported housing with residential continuum housing, and found the latter to be more expensive (in Nelson, Aubry, & Lafrance, 2007).

4.2. Research from Canada

As previously mentioned, most of the evidence on HF to date has been American-based. However, it is important that evidence for the effectiveness of HF be

grounded in the Canadian context as the two countries differ in health care and social policies (Goering et al., 2014). The success of the PHF program in New York City has sparked interest in the model among policy makers and service providers in Canada (Gaetz, Scott, & Gulliver, 2013).

A growing number of Canadian cities have implemented HF with positive results (Goering et al., 2014). Toronto and Calgary are probably the Canadian cities best known for implementing HF (Waegemakers-Schiff & Rook, 2012). Toronto's Streets to Homes program is well-established as it was "the first large scale application of a program using a Housing First philosophy in Canada" (Gaetz, Scott, & Gulliver, 2013, p. 10). HF is also the guiding philosophy of Calgary's *10 Year Plan to End Homelessness* (Gaetz, Scott, & Gulliver, 2013). Calgary was the first Canadian city to implement a 10 Year Plan, doing so in 2008 (Gaetz et al., 2013). The Plan is implemented by the Calgary Homeless Foundation (CHF) (Gaetz, Scott, & Gulliver, 2013). Between 2008 and 2012, the CHF successfully housed 4,096 people, with an 11.4% reduction in its homeless population (Gaetz, Scott, & Gulliver, 2013; Gaetz et al., 2013).

Background of *At Home/Chez Soi*

In 2008, the Government of Canada provided $110 million for a research demonstration project intended to enhance understanding on how to effectively address homelessness among Canadians with serious mental illness (Goering et al., 2014). Serious mental illness here entails the following:

> Serious mental disorders are defined by diagnosis, duration, and disability using observations from referring sources, indicators of functional impairment, history of recent psychiatric treatment, and current presence of eligible diagnosis as identified by the Mini International Neuropsychiatric Interview (major depressive, manic or hypomanic episode, post-traumatic stress disorder, mood disorder with psychotic features, psychotic disorder). (Goering et al., 2014, p. 43)

Subsequently, the Mental Health Commission of Canada (MHCC) and stakeholders in five selected cities (Moncton, Montreal, Toronto, Vancouver, and Winnipeg) implemented *At Home/Chez Soi*, a randomized controlled trial of HF. *At Home/Chez Soi*

has emerged as the world's largest trial of HF (Gaetz, Scott, & Gulliver, 2013; Goering et al., 2014).

A phone call between Paula Goering, lead researcher of *At Home/Chez Soi* and Sam Tsemberis, founder and CEO of Pathways to Housing, Inc., proved fruitful when choosing a program to implement in Canada for those who are homeless and mentally ill. As Goering recalled,

> That conversation and the quick e-mail messages that followed convinced me that there was something special about this approach – one that combined a radical recovery orientation with a sensible, evidence-informed housing-plus-service model. So we chose it as the intervention to be implemented in a five-city trial across Canada, and as we have explained, defended, and put it into practice, I can say I am pleased with our decision. (in Tsemberis, 2010, p. 227)

The project, which took place from 2009-2013, sought to understand if HF could be implemented in Canadian communities and if it could be adapted to local contexts (Goering et al., 2014). In each of the five sites, HF was compared with existing housing and support services. The project used a randomized trial design in which 1,158 individuals were randomly assigned to the HF option and 990 were assigned to the treatment as usual (TAU) option. A total of 2,148 participants across all five sites, most of whom were recruited from shelters or the streets, were followed for two years. HF participants received their own apartment, a rent supplement, and one of two types of support services. Those with high needs received support from Assertive Community Treatment (ACT) teams and those with moderate needs received support from Intensive Case Management (ICM) teams. Conversely, TAU participants received other housing and support services available in their communities.

In its 2013 budget, the federal government recognized HF as an effective approach to homelessness in Canada (Polvere et al., 2014). Based on the evidence produced by *At Home/Chez Soi*, the federal government announced a five-year renewal, beginning in 2014, of the Homelessness Partnering Strategy (HPS) which included a new focus on HF (Gaetz, Scott, & Gulliver, 2013). Over five years, an investment of $600 million will support communities across Canada funded by the HPS to integrate HF into the homelessness services that they provide (Goering et al., 2014). However, I am

apprehensive as the HPS funds over 60 communities across the country. Is $600 million over five years sufficient? Support workers will need to be trained on HF, which requires a great deal of time and resources.

4.2.1. Housing stability

In all five *At Home/Chez Soi* sites, HF participants obtained and maintained housing at a significantly higher rate than treatment as usual (TAU) participants (Goering et al., 2014; Polvere et al., 2014). Over the course of the study, HF participants spent 73% of their time in stable housing whereas TAU participants spent only 32% of their time in stable housing (Goering et al., 2014). Not surprisingly, TAU participants spent more time in shelters, temporary housing, and on the streets than HF participants. Among HF participants, 62% were housed all of the time, 22% were housed some of the time, and 16% were housed none of the time in the last six months of the study. Among TAU participants, 31% were housed all of the time, 23% were housed some of the time, and 46% were housed none of the time in the last six months of the study.

4.2.2. Criminal justice involvement

Toronto's *Street Needs Assessment* survey indicated that there were over 5,000 homeless people on the night of April 19, 2006, excluding the hidden homeless (in Gaetz & O'Grady, 2006). People who are hidden homeless are "undocumented in homeless count statistics; they are couch surfing, staying with friends or remaining out of sight while sleeping outdoors" (Gaetz, Scott, & Gulliver, 2013, p. 62). Among the over 5,000 survey respondents, 18% reported "an interaction with corrections" and 17% reported "an interaction with probation or parole" in the previous six months (City of Toronto, 2006, p. 23). Novac et al. (2006) further explored the relationship between homelessness and incarceration. They found that, from 2001 to 2004, the number of individuals admitted to five correctional facilities (Toronto Jail, Toronto East Detention Centre, Toronto West Detention Centre, Maplehurst Correctional Centre in Milton, and Vanier Centre for Women in Milton) with no fixed address increased by 64%. Furthermore, 286 individuals with no fixed address were admitted to the above

correctional facilities 496 times from 2004 to 2005. Novac et al. (2007) concluded this indicated a cycling of homeless people through the justice system.

Among the over 2,000 *At Home/Chez Soi* participants, 36% reported criminal justice involvement in the six months prior to the study (Goering et al., 2014). Regarding the type of criminal justice involvement;

> 24 per cent of participants reported being detained or moved along by police, 22 per cent reported being held by police for less than 24 hours, 27 per cent reported being arrested, 30 per cent reported having had a court appearance, and 11 per cent reported participation in a justice service program in the prior six months. (Goering et al., 2014, p. 16)

Criminal justice involvement was higher in the high needs group (43%) compared to the moderate needs group (30%). Accordingly, Somers et al. (2013) argue that people who are homeless and mentally ill should be directly referred from the justice system to HF given their frequent involvement with the former.

Not surprisingly, people who are homeless, especially those sleeping on the streets, in parks, and under bridges, are more likely to become involved with the criminal justice system than those who are housed. By providing stable housing, the likelihood of interactions on the street between police and people who are homeless is reduced (Gaetz, Scott, & Gulliver, 2013). The likelihood of arrest for engaging in activities to meet basic needs of food and shelter, such as sleeping in public areas, is also reduced (Goering et al., 2014).

In Toronto, a review of the Streets to Homes program showed a decline in the use of criminal justice services (City of Toronto, 2007). A total of 88 formerly homeless people housed through the program were surveyed. Findings from the survey showed reductions in the number of persons arrested (56%), incarcerated (68%), and detained in the 'drunk tank' (75%) as compared to the year prior to enrollment in the Streets to Homes program. In 2013, a report entitled *A Plan for Alberta: Ending Homelessness in 10 Years – 3 Year Progress Report* was published (in Gaetz, Scott, & Gulliver, 2013). The Plan for Alberta is based on HF: "All services and program elements within the homelessness sector – including many mainstream services – are guided by the principles of the model" (Gaetz, Scott, & Gulliver, 2013, p. 15). The report found a 66%

reduction in police contacts, an 88% reduction in jail stays, and a 69% reduction in court appearances across Alberta.

In Vancouver, an *At Home/Chez Soi* site, participants were assigned randomly to one of three conditions: (1) Treatment as usual (TAU); (2) scattered-site (SS) HF (no more than 20% of apartments in any one building are rented to participants); and (3) congregate (CONG) HF (all participants housed in one building) (Currie et al., 2014; Somers et al., 2013). Participants assigned to the CONG condition were housed in the Bosman Hotel downtown. The study found a significant reduction in criminal convictions among SS participants after at least one year of HF compared to TAU participants. The study also found a marginally significant reduction in criminal convictions among CONG participants compared to TAU participants. Across all *At Home/Chez Soi* sites, substantial reductions in the use of criminal justice services were found for both HF and TAU participants, with no significant difference between the two (Goering et al., 2014). However, there were fewer reported arrests for offences relating to drugs and public nuisance among HF participants over two years. Reasons for the small effect of HF on participants' criminal justice involvement include:

> First, justice-involved individuals with mental illness are not a homogeneous group. In fact, there are distinct subgroups. HF, as implemented, did not specifically target criminal justice involvement; there may be benefit in further adaptations to suit the specific needs of legally-involved participants. Second, criminal justice involvement is complex and a proportion of service events (e.g., court appearances) may be attributable to criminal behavior that occurred several months or even years before the study began. (Goering et al., 2014, p. 22)

4.2.3. Cost effectiveness

Research has demonstrated that Canada's traditional response to homelessness – investing in emergency services – is an expensive way of responding to the problem (Gaetz, 2012; Gaetz, Scott, & Gulliver, 2013). Given the research on the cost of homelessness in this country, a shift away from a response that focuses on delivering emergency services to one that focuses on prevention, such as HF, has the potential to save money (Gaetz, 2012). Providing housing and supports to people who are chronically homeless is cost effective as this vulnerable population has been found to be

high users of health and criminal justice services (Gaetz, 2012; Gaetz, Scott, & Gulliver, 2013; Gaetz et al., 2013; Kellen et al., 2010; Polvere et al., 2014). Accordingly, Gaetz (2012) concludes, "Given that the annual cost of leaving someone out on the street is clearly much greater than providing them with housing, it is unthinkable that any Canadian would be without a home" (p. 15).

The *At Home/Chez Soi* project concluded HF to be a sound investment (Goering et al., 2014; Polvere et al., 2014). On average, the annual cost of HF per person was $22,257 for ACT participants and $14,177 for ICM participants. Over the two-year study period, a $10 investment in HF services produced an average savings of $9.60 for ACT participants and $3.42 for ICM participants. Even greater savings were found for the following participants:

> For the 10 per cent of participants with the highest service use costs at the start of the study, HF cost $19,582 per person per year on average. Receipt of HF services resulted in average reductions of $42,536 in the cost of services compared to usual care participants. Thus every $10 invested in HF services resulted in an average savings of $21.72. (Goering et al., 2014, p. 7)

The significant savings realized for this group arose from a combination of cost offsets and, to a smaller extent, increased service use costs:

> The main cost offsets were psychiatric hospital stays, general hospital stays (medical units), home and office visits with community-based providers, jail/prison incarcerations, police contacts, emergency room visits, and stays in crisis housing settings and in single room accommodations with support services. For this group, two costs increased: hospitalization in psychiatric units in general hospitals and stays in psychiatric rehabilitation residential programs. (Goering et al., 2014, p. 7)

4.2.4.   Adaptability to different local contexts

The *At Home/Chez Soi* project effectively adapted HF in five Canadian cities (Moncton, Montreal, Toronto, Vancouver, and Winnipeg) while still remaining faithful to the model (Goering et al., 2014). The cities vary in cultural composition, size, and access to affordable housing. In regards to cultural composition, HF was successfully adapted to meet the unique needs of the large Aboriginal population in Winnipeg, which will be

discussed in detail shortly. Pertaining to city size, HF was adapted successfully even in Moncton, the smallest of the five *At Home/Chez Soi* sites, despite the limited mental health services available (Aubry et al., 2014). This was attributed to establishing partnerships in the community:

> [B]y partnering with rural pharmacies, the team could ensure medication was delivered to participants without access to transportation. Another key collaborator was the United Way of Greater Moncton and Southeastern New Brunswick, which provided assistance with the program's finances, liaised with private-market landlords, supported the Assertive Community Treatment Teams from Horizon Health Network and Réseau de Santé Vitalité and even facilitated the purchase of an apartment building to house participants with complex needs. (MHCC, 2015a, para. 5)

HF also has been successfully implemented in other small Canadian cities such as Lethbridge, Victoria, and Fredericton (Gaetz, Scott, & Gulliver, 2013).

HF also has been successfully applied in larger communities with little affordable housing such as Vancouver, Calgary, Toronto, and Edmonton (Gaetz, Scott, & Gulliver, 2013). These cities have some of the tightest rental housing markets in the country. In Vancouver, the vacancy rate for bachelor suites is 0.5%, and the average rent for a one-bedroom apartment in 2011 was $934 (Currie et al., 2014). However, the Vancouver site reported success with housing HF participants despite the city's low vacancy rates and lack of affordable housing. This was attributed to, "(1) creatively matching participants with housing units and (2) forming collaborative relationships with landlords and property management companies" (Nelson et al., 2013, p. 14).

It is essential that the issue of housing affordability be addressed as it can become a barrier to successful implementation of HF. Unfortunately, access to affordable housing is lacking in communities across Canada (Goering et al., 2014). This situation needs to be improved to ensure the successful expansion of HF across the country.

A lack of affordable housing can be addressed in a number of ways. One option is to provide rent supplements so clients do not pay more than 30% of their income toward rent (Gaetz, Scott, & Gulliver, 2013). However, the demand for rent supplements

may eventually outweigh the supply as more individuals become housed through HF. A second option is to increase the supply of affordable housing "through a combination of direct investment (building new stock), [and] zoning (inclusionary zoning, legalizing and regulating secondary suites)…" (Gaetz, Scott, & Gulliver, 2013, p. 190) A third option is to establish partnerships with landlords. There are a number of incentives for landlords to be partners in HF. Some landlords may be persuaded because they want to contribute to ending homelessness (Gaetz, Scott, & Gulliver, 2013; Tsemberis, 2010). Other landlords may participate because rent is guaranteed and/or they are provided with support (Nelson et al., 2013). Such support can include prompt responses to concerns about clients and repairing or paying for damages caused by clients (Nelson et al., 2013; Tsemberis, 2010).

Chapter 5.

Aboriginal homelessness in Canada

As previously mentioned, Aboriginal people are vastly over-represented in Canada's homeless population (Gaetz & O'Grady, 2006; Gaetz, Scott, & Gulliver, 2013; Goering et al., 2014; Laird, 2007). Moreover, this representation of Aboriginal homelessness is likely an underestimate as homeless counts "do not take into account the propensity of Aboriginal people to take family in on a 'temporary' basis, thus making them unlikely to be found on the street when the homeless count occurs while homeless nonetheless..." (Palys, 2014, p. 23)

In Edmonton's 2012 homeless count, Aboriginal people accounted for 46% of the homeless population despite comprising only 5% of the city's population (Gaetz, Scott, & Gulliver, 2013). In Winnipeg, Aboriginal people account for more than 10% of the city's population but approximately 70% of the homeless population (Distasio, Sareen, & Isaak, 2014). The over-representation of Aboriginal people in homeless counts across Canada demonstrates the need for a new strategy to address homelessness among Aboriginal people (Gaetz, Scott, & Gulliver, 2013). Aboriginal people require tailored solutions as they have unique needs (Goering et al., 2014).

For example, when addressing homelessness among Aboriginal people, it is essential that the broader Aboriginal community be actively involved in the development and delivery of services (Gaetz, Scott, & Gulliver, 2013; Gaetz et al., 2013). It is also necessary to incorporate cultural sensitivity and awareness into the development and delivery of services (Gaetz, Scott, & Gulliver, 2013). This includes recognizing the legacy of colonialism such as Indian residential schools and the 60s scoop (Distasio, Sareen, & Isaak, 2014; Gaetz et al., 2013). Lastly, it is important to address trauma, including intergenerational trauma, ignited by issues of racism, systemic barriers, discrimination,

attendance at Indian Residential Schools, and child welfare involvement (Distasio, Sareen, & Isaak, 2014).

Housing First is adaptable to the unique needs of Aboriginal people who are homeless (Gaetz, Scott, & Gulliver, 2013). However, the propensity of Aboriginal people to open their homes to their extended families poses a problem, evidenced by a Housing First staff member:

> I know there are certain things with Aboriginal people like one thing that just popped into my head was, I think culturally, they're a lot more family oriented and so one of the barriers they have to our type of program is we house them independently, individually. And so a lot of the issues that sometimes creep up is they have a really hard time saying no to family or saying no to friends that they've made on the streets, coming into their homes and so that's a challenge for…I don't know if it's more than other cultures but I think that it might be just because of their cultural values. (Bodor, Chewka, Smith-Windsor, Conley, & Pereira, 2011, p. 57)

Aboriginal clients risk eviction when visitors become tenants as Housing First requires clients to adhere to a standard lease, which includes the number of tenants stipulated. For example, "the presence of visitors was among the primary stated reasons for evictions" at the Winnipeg site where 71% of participants were Aboriginal (McCullough et al., 2012, p. 19). The 2011 Implementation Report on the Winnipeg site found the following:

> [M]any Aboriginal participants preferred a more collective living arrangement, and the scattered site model of Housing First can cause feelings of isolation and stress for these participants…Many stakeholders strongly suggested the need for more flexible or communal housing options in such a project, especially options that take into account Aboriginal social norms. Remarked on was the need for housing that accommodated extended family, and the need for congregate options outside of the core to minimize isolation and provide community. (McCullough et al., 2012, p. 19)

Nevertheless, the HF model was successfully implemented in Edmonton and Winnipeg, two cities with the largest urban Aboriginal populations in Canada. The programs adhere to the core principles of the model but support services are tailored to meet the unique needs of Aboriginal people who are homeless.

In Edmonton, Homeward Trust is the organization responsible for implementing the city's *10 Year Plan to End Homelessness*, which is based on HF (Gaetz, Scott, & Gulliver, 2013). Homeward Trust is directed by its Board and an Aboriginal Advisory Committee (AAC). The Homeward Trust Board includes nine Directors, four of whom are Aboriginal community members. The AAC is comprised of Aboriginal community leaders who advise Homeward Trust on matters regarding Aboriginal issues and projects. This includes:

> Providing knowledge, cultural perspectives and awareness of the urban Aboriginal experience to the advisory process; Ensuring Aboriginal focused projects benefit predominately disadvantaged, urban Aboriginal people; Encouraging innovative solutions to promote building organizational capacity within Aboriginal organizations, groups, and communities. (Homeward Trust Edmonton, 2015, para. 1)

This active involvement of the Aboriginal community was essential in developing a strategy to address homelessness among Aboriginal people that focused on the contributing social, cultural, and systemic factors (Gaetz, Scott, & Gulliver, 2013). To address the over-representation of Aboriginal people within the homeless population in Edmonton, every HF team funded by Homeward Trust is required to have a minimum of 40% Aboriginal clients on its caseload. Team members are also required to participate in training on Aboriginal issues. Training is delivered on a variety of topics including Colonization and Decolonization, the 60s Scoop, and Aboriginal Diversity. This is essential as it ensures cultural sensitivity and awareness to Aboriginal issues are incorporated into the delivery of services.

One of the HF teams funded by Homeward Trust is *Nikihk* (meaning home) which is provided by Bent Arrow Traditional Healing Society, an organization that provides programming for Aboriginal children and families based on traditional teachings (Gaetz, Scott, & Gulliver, 2013). The Nikihk team provides culturally-informed support services to Aboriginal people who are chronically homeless in Edmonton. The team's program was designed to connect or reconnect clients with their culture. A Trauma Support Worker and an Aboriginal Cultural and Spiritual Educator are among the staff at Bent Arrow Nikihk. The Aboriginal Cultural and Spiritual Educator helps clients reconnect with their culture through cultural activities, events, ceremonies, and resources such as

relevant advice from elders. Clients are also able to access support services from cultural leaders, pipe carriers, and traditional healers not offered by the Nikihk team. Clients can, under appropriate guidance, participate in traditional teachings, sweat lodges, drumming circles, and pipe ceremonies.

Winnipeg has the largest urban Aboriginal population in Canada. In 2011, Aboriginal people accounted for more than 10% of the city's population. Originally, Winnipeg was chosen as one of the five *At Home/Chez Soi* sites because of the large number of Aboriginal people who are homeless and living with mental illness in the city (Distasio, Sareen, & Isaak, 2014). Similar to Edmonton, the Winnipeg site engaged the Aboriginal community in the development and delivery of services. During the planning process, stakeholders established the Aboriginal Cultural Lens Committee comprised of traditional teachers and elders (Polvere et al., 2014). The committee ensured that support services were consistent with Aboriginal values based on the Seven Teachings outlined by the Grand Council Treaty #3, the government of the Anishinaabe Nation in Treaty #3:

> HONESTY: to achieve honesty within yourself; to recognize who and what you are; do this and you can be honest with all others.
>
> HUMILITY: humble yourself and recognize that no matter how much you think you know, you know very little of all the universe.
>
> TRUTH: to learn truth, to live with truth and to walk with truth, to speak truth.
>
> WISDOM: to have wisdom is to know the difference between good and bad and to know the result of your actions.
>
> LOVE: unconditional love to know that when people are weak they need your love the most, that your love is given freely and you cannot put conditions on it or your love is not true.
>
> RESPECT: respect others, their beliefs and respect yourself. If you cannot show respect you cannot expect respect to be given.
>
> BRAVERY: to be brave is to do something right even if you know it's going to hurt you. (Dudley, Distasio, Sareen, & Isaak, 2010, p. 37)

Two Aboriginal organizations, the *Ma Mawi Wi Chi Itata Centre* and the Aboriginal Health and Wellness Centre, were responsible for delivering Intensive Case

Management (ICM) services to participants with moderate needs at the Winnipeg site (MHCC, 2015b). Due to its experience serving Aboriginal people, Mount Carmel Clinic was responsible for delivering Assertive Community Treatment (ACT) services to clients with high needs. Lastly, traditional teachers and elders from the Aboriginal Cultural Lens Committee were included as part of the support services (Distasio, Sareen, & Isaak, 2014). In addition to participants, traditional teachers and elders were made accessible to ICM and ACT team members. During sharing and teaching circles, they would convey knowledge in Aboriginal values and world views to team members.

Similar to Edmonton, Winnipeg incorporated cultural sensitivity and awareness into the development and delivery of services by "using a broader social and historical lens that was integrated into the recovery work" (Distasio, Sareen, & Isaak, 2014, p. 10). This included knowing the legacy of colonialism experienced by Aboriginal people. Indian Residential Schools and the 60s scoop, both a legacy of colonialism, have resulted in intergenerational trauma.

Indian residential schools and the 60s scoop both involved the forcible removal of Aboriginal children from their families and communities, the former to government-funded schools and the latter to non-Aboriginal homes. The result: "Forced to assume the values of another culture that derided their own belief system, Aboriginal children were left in a cultural vacuum, relating neither to mainstream culture nor to their own community" (Menzies, 2006, p. 4). Understandably, many Aboriginal children became angry and confused as adults, resorting to alcohol and/or drugs as a means to cope. This coupled with a lack of effective parental models as children created insurmountable difficulties when they became parents. As one Winnipeg participant who attended Indian residential school stated,

> Being able to, being able to say 'I love you' and 'I'm sorry' to my kids…I've never said that to them you know, those types of things come out; that's what I mean, those types of fatherly qualities, manly qualities I should have had were always blocked by this anger in me. (Distasio, Sareen, & Isaak, 2014, p. 24)

The legacy of colonialism has important implications for the recovery process among Aboriginal participants. According to Gagne, "Colonialism is at the root of trauma

because it has led to the dependency of Aboriginal peoples to settlers and then to cultural genocide, racism, and alcoholism" (in Quinn, 2007, p. 73). Many Aboriginal participants reported living with pent-up anger stemming from attendance at Indian residential schools or child welfare involvement (Distasio, Sareen, & Isaak, 2014). Furthermore, many Aboriginal participants reported alcohol and substance use as reasons for becoming homeless, perhaps coping mechanisms for trauma as many also reported having lived in foster care, having a parent or grandparent who attended Indian residential school, and having attended Indian residential school themselves (Isaak, 2012). Thus, it is important that services be trauma-informed to support recovery and healing (Distasio, Sareen, & Isaak, 2014).

Chapter 6.

Vancouver Aboriginal Transformative Justice Services Society

In addition to Canada's homeless population, Aboriginal people are over-represented in the country's prison population (Kellen et al., 2010; Novac et al., 2006; 2007). Many Aboriginal people, particularly young males, moved to urban centers "once the most repressive elements of the *Indian Act* revisions of 1920 were rescinded after World War II" (Palys, Isaak, & Nuszdorfer, 2012, p. 1). Incarceration rates for this group rose soon thereafter.

The resulting "over-representation" of Indigenous people in Canada`s prisons was recognized as a problem at least as early as 1967 (Solicitor General Canada, 1967). Successive efforts at "indigenization" of the system in the 1960s and 70s was followed by an "accommodation" strategy in the 1980s and 90s and subsequently by formulation of an "Aboriginal Justice Strategy" that would see limited referral of Aboriginal offenders to community-based programs based on notions of healing (see Palys, Isaak, & Nuszdorfer, 2012). It was under this program that, in 2000, Vancouver Aboriginal Transformative Justice Services Society (VATJSS) became Canada's fourth urban Aboriginal justice program (following in the footsteps of Toronto, Winnipeg, and Thunder Bay) after nearly two years of extensive community consultations (Dorward, 2005; Palys, 2014). VATJSS is categorized as an alternative measures program. Aboriginal offenders are selected by the Crown for referral to the program (Palys, 1999). However, formal referral is limited to a range of offences (Category 3 and 4 accepted, i.e., minor offences).

VATJSS originated from the need to address the over-representation of Aboriginal people in the criminal justice system and the inability of the mainstream

justice system to adequately serve Aboriginal people in conflict with the law (VATJSS, 2012e). Indeed, several commissions, reports, and inquiries have found the latter to be true (Palys, 1999). As the federal Department of Justice (2005) explains,

> The relationship between Canada's Aboriginal people and the Canadian justice system has been an enduring and comprehensively documented problem, the complex product of disadvantaged socio-economic conditions, culturally insensitive approaches to justice, and systemic racism…Aboriginal people have expressed a deep alienation from a system of justice that appears to them foreign and inaccessible. The results are reflected in a growing body of statistics indicating that Aboriginal people experience disproportionately high rates of arrest, conviction, and incarceration. The human and economic costs to aboriginal communities and to Canada are immeasurable. (p. 4)

Instead, the unique needs of Aboriginal people call for justice services which are culturally appropriate and designed and driven by the Aboriginal community (Palys, 1999). If for no other reason, in comparison to the mainstream justice system, "Aboriginal people providing justice services to Aboriginal people can surely do no worse" (Palys, 2014, p. 43). Not only would Aboriginal people be better served but also the broader Canadian public.

To be eligible for the alternative measures program, offenders must be of Aboriginal descent, accept responsibility for the offence(s) committed, be willing to participate in a community council forum (CCF), and fulfill their healing plan requirements within a specified time frame (Palys, 2014; VATJSS, 2012b). A justice coordinator from VATJSS facilitates the CCF, which includes the offender, the victim (if they so choose), their family members, two or three volunteers, and an Elder (Palys, Isaak, & Nuszdorfer, 2012). The primary purpose of the CCF is to identify and discuss the factors that led to the offence(s) (Palys, 2014). During the CCF, a healing plan is developed for the offender "with the goal of making amends and positively reintegrating the offender into the community" (VATJSS, 2012b, para. 3). Importantly, the healing plan is agreed upon by consensus of those present. Healing plan options include, but are not limited to, alcohol and drug counselling, an apology to the victim, employment training, sweat lodges, and traditional teaching and counselling (VATJSS, 2012d). When a client successfully completes the program, a stay of proceedings is granted. When a client is non-compliant, however, their file is returned to the Crown.

6.1. Aboriginal Homeless Outreach Program

The work of VATJSS extends beyond administering community council forums (Palys, Isaak, & Nuszdorfer, 2012). VATJSS also provides the Aboriginal Homeless Outreach Program (AHOP) which "aims to reduce the number of Aboriginals who are homeless by providing direct access to immediate housing with linkages to the necessary support services to address the individual's housing, health, and cultural needs" (VATJSS, 2012a, para. 1). The housing initiative stemmed from the realization that homelessness was a recurring issue arising in the forums (Palys, 2014). The acuity of the homelessness issue and consequent significance of addressing it became clear once AHOP was established as the number of walk-ins seeking these services began to increase. In a recent programme evaluation of VATJSS, "one staff member suggested that 90% of the walk-ins at VATJSS involve housing and homelessness issues" (Palys, 2014, p. 22).

The homeless population in Vancouver is distinct in terms of its geographic concentration (Currie et al., 2014). Of approximately 16,000 people living in Vancouver's Downtown Eastside (DTES), an estimated 40% are Aboriginal (Currie et al., 2014). The DTES has often been called "the poorest postal code in Canada" and is characterized by its high rates of homelessness, crime, mental health and addictions problems (Currie et al., 2014; Gaetz, Scott, & Gulliver, 2013; Goering et al., 2014; Palys, Isaak, & Nuszdorfer, 2012).

VATJSS receives funding, in part, from the Homelessness Partnering Strategy (HPS). Five sectors of activities are eligible under the Aboriginal Homelessness funding stream (Employment and Social Development Canada [ESDC], n.d.) These eligible sectors include:

A. Reducing Homelessness Using a Housing Stability with Support (HSS) or Housing First Approach
B. Support Services
C. Capital Investments
D. Activities to Ensure Coordination of Resources and Leveraging
E. Activities to Improve Data Collection and Use. (ESDC, n.d., p. 4)

Recall that the federal government announced a five-year renewal, beginning in 2014, of the HPS with an investment of $600 million. This renewal included "a refocusing of the HPS toward an approach based on research into effective methods of reducing homelessness – a Housing First approach – designated in Quebec as Housing Stability and Support (HSS)" (ESDC, n.d., p. 3). However, VATJSS opted to apply and was subsequently approved for funding under Sector B, Support Services. In this sector, activities include:

- Placement of individuals in housing outside the HSS framework (Sector A)
- Referral of individuals to income support measures
- Providing individuals with support for employability training and making a transition to the labour market
- Helping individuals to acquire day-to-day life skills (e.g., personal budget, cooking skills)
- Connecting individuals to education and supporting their success
- Implementing measures to help individuals integrate into society
- Using a culturally appropriate method to help Aboriginal people stay in their homes
- Liaising with appropriate resources and referring individuals to those resources
- Prevention of loss of housing (only in the case of individuals and families at imminent risk of homelessness)
- Services to meet emergency or basic needs. (ESDC, n.d., p. 7)

VATJSS chose not to apply for funding under Sector A as staff supports the concept of HF but opposes how the federal government has gone about implementing it. According to staff, there is not enough money and support workers to successfully implement HF in the many communities funded by the HPS.

In the renewal of the HPS, an emphasis was placed on HF based on the evidence produced by the *At Home/Chez Soi* project. It is important to note that only 2,148 individuals across all five sites participated in the four-year project with an investment of $110 million. Thus, *At Home/Chez Soi* was implemented with a substantial investment and relatively few people. Conversely, HPS-funded communities serve many

Canadians, which warrants a larger investment and more support workers to ensure the successful expansion of HF across the country.

Currently, VATJSS has three staff members who address various aspects of the homelessness issue. The Homelessness Liaison provides clients with basic housing information and advice. She gathers affordable housing listings weekly and posts them on the VATJSS website[2] and its Facebook page. More intense cases are addressed by one of two Homeless Outreach Workers. Some of these cases emerge from community council forums when homelessness arises as an issue. Addressing one's homelessness can be a healing plan option. Other cases are self-referrals and referrals from outside organizations.

The Homeless Outreach Workers fill out applications for subsidized housing, however, the waiting list is long. Nonetheless, clients' names are placed on the list in the hopes that the government will recognize the extent of the problem. Clients, therefore, are encouraged to be creative when looking for affordable housing in the rental market, such as room to rent (in a house), or can use the Homelessness Liaison as a resource.

Staff members provide a wide range of support services depending on the barrier(s) preventing each individual client from obtaining and maintaining housing. They offer life skills training such as budgeting and communication (e.g., how to speak to landlords). They assist clients looking to enroll in education or find employment by referring them to appropriate resources such as Native Education College and Aboriginal Community Career Employment Services Society. They also help create resumes and conduct mock job interviews with clients. They connect clients who are eligible with income supports, e.g., by helping to complete Employment Insurance applications. Staff may also facilitate access to treatment services such as alcohol and drug counselling.

As of May 2015, VATJSS has begun administering a new initiative: housing circles. The purpose of housing circles is similar to community council forums in that those present identify and discuss factors that contribute to the individual client's

[2] See http://www.vatjss.com/

homelessness. Another initiative VATJSS offers is the Ready to Rent BC course, which is based in Victoria, British Columbia. The Homeless Outreach Workers travelled to Victoria and were trained to run the six-week course in Vancouver. Six sessions are delivered on a variety of topics aimed at helping participants become suitable tenants (Ready to Rent BC, 2015). Topics include, but are not limited to, budgeting, fire and safety, rights and responsibilities as a tenant, and communication.

Chapter 7.

Conclusion

The homelessness problem in Canada calls for solutions aimed at preventing the problem as opposed to simply managing it. Until recently, Canada's response has overwhelmingly relied upon emergency services, which is an expensive strategy compared to Housing First (HF). Recently, however, the federal government indicated its support for HF when it announced the five-year renewal of the Homelessness Partnering Strategy.

HF has been shown to produce benefits beyond the homelessness system. In addition to increasing housing stability, HF reduces criminal justice involvement. Providing housing to people who are homeless reduces the likelihood of street-based interactions with police. Moreover, the likelihood of arrest for engaging in activities in order to meet basic human needs is reduced. Secondly, HF is cost effective as people who are homeless are high users of health and criminal justice services.

The success of the PHF program in New York City ignited interest in the model here in Canada. The United States and Canada differ in health care and social policies so it was essential that evidence on HF be grounded in the Canadian context. The *At Home/Chez Soi* project, funded by the federal government, effectively implemented HF in Moncton, Montreal, Toronto, Vancouver, and Winnipeg. Importantly, these cities differ in cultural composition, size, and access to affordable housing. In relation to cultural composition, HF was successfully adapted to meet the unique needs of Aboriginal people in Winnipeg, the city with the largest urban Aboriginal population in the country.

Aboriginal homelessness is of particular concern as Aboriginal people are over-represented within Canada's homeless population. Aboriginal people who are homeless have unique needs which require tailored solutions. Given the legacy of colonialism,

wrap-around supports should be culturally appropriate. The development and delivery of supports targeting this vulnerable population demand the incorporation of cultural sensitivity and awareness and the involvement of the Aboriginal community.

References

Aubry, T., Bourque, J., Volk, J., Leblanc, S., Nolin, D., & Jette, J. (2014). *At Home/Chez Soi Project: Moncton Site Final Report.* Calgary, AB: Mental Health Commission of Canada. Retrieved from http://www.mentalhealthcommission.ca/

Aubry, T., Ecker, J., & Jette, J. (2013). Supported Housing as a Promising Housing First Approach for People with Severe and Persistent Mental Illness. In M. Guirguis-Younger, R. McNeil, & S.W. Hwang (Eds.), *Homelessness & Health in Canada* (pp. 155-188). Ottawa: University of Ottawa Press.

Bodor, R., Chewka, D., Smith-Windsor, M., Conley, S., & Pereira, N. (2011). *Perspectives on the Housing First Program with Indigenous Participants.* Blue Quills First Nations College Research and Program Evaluation Partnership. Retrieved from http://homewardtrust.ca/images/resources/2012-07-05-10-26BlueQuillsWEB3.pdf

Carling, P.J. (1995). *Return to community: building support systems for people with psychiatric disabilities.* NY: Guilford Press.

City of Toronto. (2006). *2006 Street Needs Assessment: Results and Key Findings.* Retrieved from http://www.toronto.ca/legdocs/2006/agendas/committees/cms/cms060705/it023.pdf

City of Toronto. (2007). *What Housing First Means for People – Results of Streets to Homes 2007 Post-Occupancy Research.* Toronto: Toronto Shelter, Support & Housing Administration.

Culhane, D.P., Metraux, S., & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate, 13*(1), 107-163.

Currie, L.B., Moniruzzaman, A., Patterson, M.L., & Somers, J.M. (2014). *At Home/Chez Soi Project: Vancouver Site Final Report.* Calgary, AB: Mental Health Commission of Canada. Retrieved from http://www.mentalhealthcommission.ca/

Department of Justice Canada. (2005). *Aboriginal Justice Strategy Annual Activities Report: 2002-2005.* Retrieved from http://www.justice.gc.ca/eng/rp-pr/aj-ja/0205/rep-rap.pdf

Distasio, J., Sareen, J., & Isaak, C. (2014). *At Home/Chez Soi Project: Winnipeg Site Final Report*. Calgary, AB: Mental Health Commission of Canada. Retrieved from http://www.mentalhealthcommission.ca/

Dorward, T. (T'at'usayalthim) (2005). *The Role of 'Community' In the Design and Development of Vancouver Aboriginal Transformative Justice Services*. Unpublished MA thesis. SFU School of Criminology. Retrieved from http://ir.lib.sfu.ca/handle/1892/724

Dudley, M., Distasio, J., Sareen, J., & Isaak, C. (2010). *At Home/Chez Soi Project: Report on Proposal Development at the Winnipeg Site*. Winnipeg, MB: Institute of Urban Studies. Retrieved from http://www.mentalhealthcommission.ca/

Employment and Social Development Canada (n.d.) *Applicant Guide – Homelessness Partnering Strategy (HPS) – Funding Stream: Aboriginal Homelessness*. Retrieved from http://www.esdc.gc.ca/eng/communities/homelessness/funding/pdf/aboriginal_applicant_guide.pdf

Gaetz, S. (2010). The Struggle to End Homelessness in Canada: How we Created the Crisis, and How We Can End it. *The Open Health Services and Policy Journal*, *3*, 21-26.

Gaetz, S. (2012). *The Real Cost of Homelessness: Can We Save Money by Doing the Right Thing?* Toronto: Canadian Homelessness Research Network Press. Retrieved from http://www.homelesshub.ca/

Gaetz, S., Donaldson, J., Richter, T., & Gulliver, T. (2013). *The State of Homelessness in Canada: 2013*. Toronto: Canadian Homelessness Research Network Press. Retrieved from http://www.homelesshub.ca/

Gaetz, S., Gulliver, T., & Richter, T. (2014). *The State of Homelessness in Canada: 2014*. Toronto: The Homeless Hub Press. Retrieved from http://www.homelesshub.ca/

Gaetz, S., & O'Grady, B. (2006). *The Missing Link: Discharge planning, Incarceration and Homelessness*. Toronto: The John Howard Society of Ontario.

Gaetz, S., & O'Grady, B. (2009). Homelessness, Incarceration, and the Challenge of Effective Discharge Planning: A Canadian Case. In J.D. Hulchanski, P. Campsie, S.B.Y. Chau, S.W. Hwang, & E. Paradis (Eds.), *Finding Home: Policy Options for Addressing Homelessness in Canada* (pp. 672-693). Toronto: Cities Centre, University of Toronto. Retrieved from http://www.homelesshub.ca/FindingHome

Gaetz, S., Scott, F., & Gulliver, T. (2013). *Housing First in Canada: Supporting Communities to End Homelessness*. Toronto: Canadian Homelessness Research Network Press.

Goering, P., Veldhuizen, S., Watson, A., Adair, C., Kopp, B., Latimer, E., & Ly, A. (2012). *At Home/Chez Soi Interim Report*. Mental Health Commission of Canada. Retrieved from http://www.mentalhealthcommission.ca/

Goering, P., Veldhuizen, S., Watson, A., Adair, C., Kopp, B., Latimer, E., Nelson, G., MacNaughton, E., Streiner, D., & Aubry, T. (2014). *National At Home/Chez Soi Final Report*. Calgary, AB: Mental Health Commission of Canada. Retrieved from http://www.mentalhealthcommission.ca/

Homeless Hub. (2015). *Aboriginal Peoples*. Retrieved from http://www.homelesshub.ca/about-homelessness/population-specific/aboriginal-peoples

Homeward Trust Edmonton. (2015). *Aboriginal Advisory Council (AAC)*. Retrieved from http://www.homewardtrust.ca/about/aboriginal-advisory-council.php

Hulchanski, J.D. (2009, February). *Homelessness in Canada: Past, Present, Future.* Paper presented at University of Calgary: Growing Home: Housing and Homelessness in Canada, Calgary. Retrieved from http://www.cprn.org/documents/51110_EN.pdf

Isaak, C. (2012). *At Home/Chez Soi Research Demonstration Project: Winnipeg Baseline Consumer Narratives Report*. Mental Health Commission of Canada. Retrieved from http://www.mentalhealthcommission.ca/

Kellen, A., Freedman, J., Novac, S., Lapointe, L., Maaranen, R., & Wong, A. (2010). *Homeless and Jailed: Jailed and Homeless*. Toronto: The John Howard Society of Toronto.

Laird, G. (2007). *Shelter. Homelessness in a growth economy: Canada's 21st century paradox.* Calgary, AB: Sheldon Chumir Foundation for Ethics in Leadership.

Leach, A. (2010). The Roots of Aboriginal Homelessness in Canada. *Homelessness and Dispossession, 23*(4), 12-13. Retrieved from http://www.homelesshub.ca/ResourceFiles/Parity_Vol23-09.pdf#page=12

McCullough, S., Havens, M., Distasio, J., Isaak, C., Deboer, T., & Sareen, J. (2012). *At Home/Chez Soi Winnipeg Site: Later Implementation Evaluation Report*. Winnipeg, MB: Institute of Urban Studies. Retrieved from http://www.mentalhealthcommission.ca/

Mental Health Commission of Canada. (2015a). *Initiatives: Moncton.* Retrieved from http://www.mentalhealthcommission.ca/English/initiatives-and-projects/home/moncton

Mental Health Commission of Canada. (2015b). *Initiatives: Winnipeg*. Retrieved from
http://www.mentalhealthcommission.ca/English/initiatives-and-
projects/home/winnipeg

Menzies, P. (2006). Intergenerational Trauma and Homeless Aboriginal Men. *Canadian Review of Social Policy*, *58*, 1-24.

Metraux, S., Byrne, T., & Culhane, D.P. (2010). Institutional Discharges and Subsequent Shelter Use among Unaccompanied Adults in New York City. *Journal of Community Psychology, 38*(1), 28-38.

Nelson, G. (2010). Housing for People with Serious Mental Illness: Approaches, Evidence, and Transformative Change. *Journal of Sociology & Social Welfare, 37*(4), 123-146.

Nelson, G., Aubry, T., & Lafrance, A. (2007). A Review of the Literature on the Effectiveness of Housing and Support, Assertive Community Treatment, and Intensive Case Management Interventions for Persons with Mental Illness Who Have Been Homeless. *American Journal of Orthopsychiatry, 77*(3), 350-361.

Nelson, G., MacNaughton, E., Caplan, R., Macleod, T., Townley, G., Piat, M., Stefancic, A., Tsemberis, S., & Goering, P. (2013). *Follow-up Implementation and Fidelity Evaluation of the Mental Health Commission of Canada's At Home/Chez Soi Project: Cross-Site Report*. Mental Health Commission of Canada. Retrieved from http://www.mentalhealthcommission.ca/

Novac, S., Hermer, J., Paradis, E., & Kellen, A. (2006). *Justice and Injustice: Homelessness, Crime, Victimization, and the Criminal Justice System*. Toronto: Centre for Urban and Community Studies.

Novac, S., Hermer, J., Paradis, E., & Kellen, A. (2007). A Revolving Door? Homeless People and the Justice System in Toronto. *Centre for Urban and Community Studies Research Bulletin, 36*, 1-7.

Palys, T. (1999). Vancouver's Aboriginal Restorative Justice Program: The Challenges Ahead. *Aboriginal Justice Bulletin, 3*(1), 2-3. Retrieved from http://www.sfu.ca/~palys/VATJS1999.pdf

Palys, T. (2014). A Programme Evaluation of Vancouver Aboriginal Transformative Justice Services Society (VATJSS). Report prepared for VATJSS with funding from the Department of Justice Aboriginal Justice Strategy Capacity Building Fund. Retrieved from http://www.sfu.ca/~palys/VATJSEvaluation-2014.pdf

Palys, T., Isaak, R., & Nuszdorfer, J. (2012). Taking Indigenous Justice Seriously: Fostering a Mutually Respectful Coexistence of Aboriginal and Canadian Justice. Research report prepared for Vancouver's Downtown Community Court and Vancouver Aboriginal Transformative Justice Services Society. Retrieved from http://www.sfu.ca/~palys/PalysEtAl-2012-Aboriginal&CanadianJustice-final.pdf

Patrick, C. (2014). *Aboriginal Homelessness in Canada: A Literature Review*. Toronto: Canadian Homelessness Research Network Press. Retrieved from http://www.homelesshub.ca/sites/default/files/AboriginalLiteratureReview.pdf

Pleace, N., & Bretherton, J. (2012, June). *What do we mean by Housing First? Categorising and Critically Assessing the Housing First Movement from a European Perspective*. Paper presented at European Network of Housing Research Conference: 'Housing: Local Welfare and Local Markets in a Globalised World', Lillehammer. Retrieved from http://www.york.ac.uk/media/chp/documents/2012/Norway_HF_paper_Nicholas%20&%20Jo.pdf

Polvere, L., MacLeod, T., MacNaughton, E., Caplan, R., Piat, M., Nelson, G., Gaetz, S., & Goering, P. (2014). *Canadian Housing First toolkit: The At Home/Chez Soi experience.* Calgary and Toronto: Mental Health Commission of Canada and the Homeless Hub. Retrieved from http://www.housingfirsttoolkit.ca/

Quinn, A. (2007). Reflections on Intergenerational Trauma: Healing as a Critical Intervention. *First Peoples Child & Family Review*, *3*(4), 72-82.

Ready to Rent BC. (2015). *The R2R Course.* Retrieved from http://www.readytorentbc.net/class-schedule

Ridgway, P., & Zipple, A.M. (1990). The Paradigm Shift in Residential Services: From the Linear Continuum to Supported Housing Approaches. *Psychosocial Rehabilitation Journal, 13*(4), 11-31.

Shapcott, M. (2007, October 22). *UN to Canada: Take action on housing, homelessness!* Retrieved from http://www.wellesleyinstitute.com/housing/un_to_canada__take_action_on_housing__homelessness_/

Solicitor General Canada (1967). *Indians and the Law*. Ottawa: Solicitor General Canada (mimeo).

Somers, J.M., Rezansoff, S.N., Moniruzzaman, A., Palepu, A., & Patterson, M. (2013). Housing First Reduces Re-offending among Formerly Homeless Adults with Mental Disorders: Results of a Randomized Controlled Trial: *PLoS ONE, 8*(9): e72946. doi: 10.1371/journal.pone.0072946

Stefancic, A., & Tsemberis, S. (2007). Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Study of Housing Access and Retention. *The Journal of Primary Prevention, 28*(3-4), 265-279.

Tsemberis, S. (2010). *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction.* Center City, MN: Hazelden Publishing.

Tsemberis, S., & Eisenberg, R.F. (2000). Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities. *Psychiatric Services, 51*(4), 487-493.

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis. *American Journal of Public Health, 94*(4), 651-656.

Vancouver Aboriginal Transformative Justice Services Society (VATJSS). (2012a). *Aboriginal Homeless Outreach Program.* Retrieved from http://www.vatjss.com/ahop.html

VATJSS. (2012b). *Justice Program.* Retrieved from http://www.vatjss.com/justice.html

VATJSS. (2012c). *Our Mission.* Retrieved from http://www.vatjss.com/

VATJSS. (2012d). *Process through Justice Program.* Retrieved from http://www.vatjss.com/vatjss-program.html

VATJSS. (2012e). *VATJS Background.* Retrieved from http://www.vatjss.com/background.html

Waegemakers-Schiff, J., & Rook, J. (2012). *Housing First – Where is the Evidence?* Toronto: Homeless Hub. Retrieved from http://www.homelesshub.ca/