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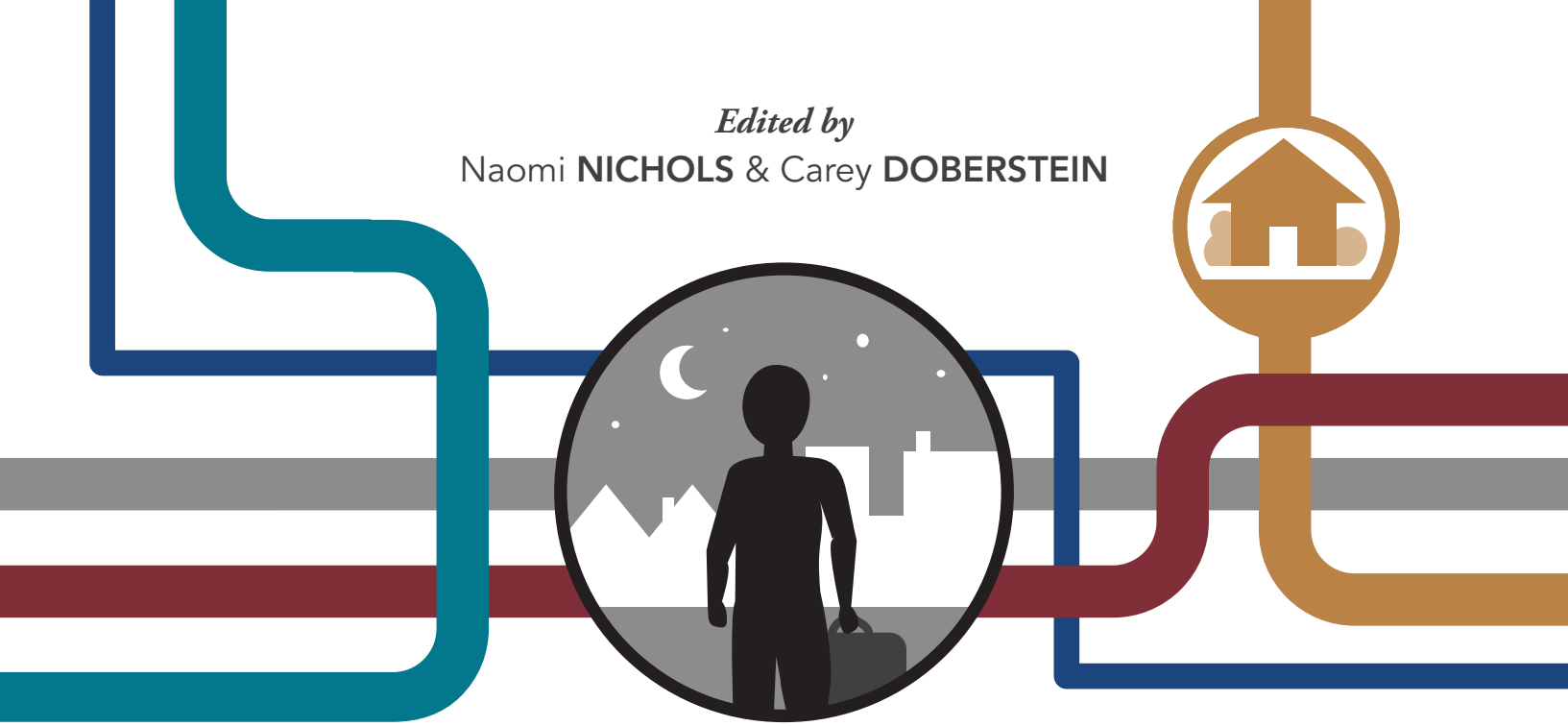
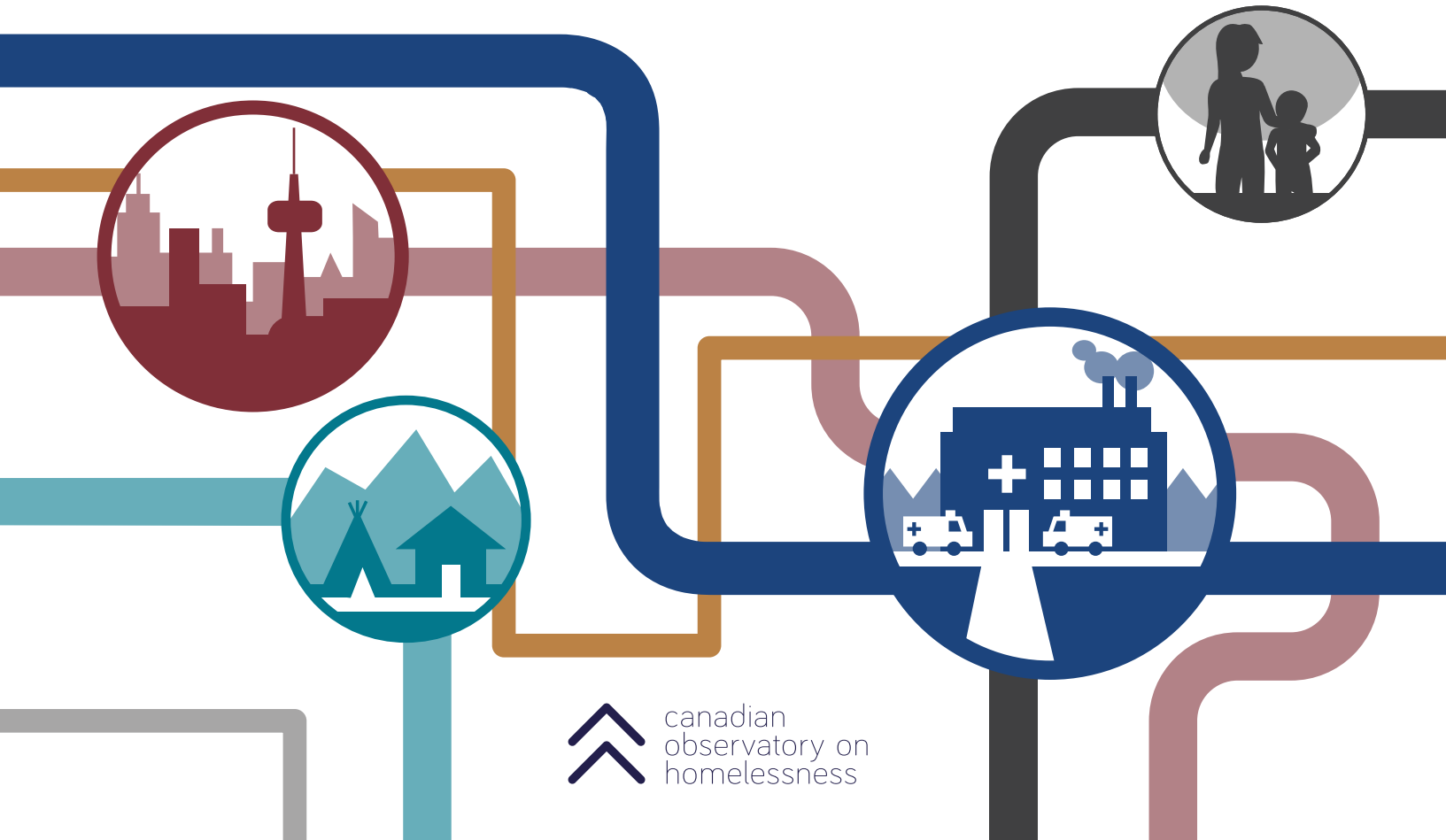


EXPLORING EFFECTIVE SYSTEMS RESPONSES TO HOMELESSNESS



canadian observatory on homelessness

EXPLORING EFFECTIVE SYSTEMS RESPONSES TO HOMELESSNESS

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ACKNOWLEDGMENTS

This book project required considerable effort and time investment by many, but was an absolute pleasure to complete. The peer review process was conducted in a timely and effective way, refining what were already strong contributions. The contributing authors were engaged and responsive to critical comments from the book's reviewers and the editors. As a result, we've pulled together a practical and thoughtful collection of work that will appeal to practitioners and scholars alike. Of course, none of this would have been possible without the gifted and dedicated staff at the Homeless Hub. Because of their managerial and creative efforts, we were able to complete the project in just over a year. Finally, we want to extend a thank you to Stephen Gaetz and all of those associated with the Canadian Observatory on Homelessness. You served as authors, reviewers, and critical colleagues throughout the process of envisioning and producing this book, and we are grateful for your insights and enthusiasm.

CONTENTS

INTRODUCTION

Carey DOBERSTEIN & Naomi NICHOLS

Homelessness is a systemic problem involving numerous sectors, institutions and agencies and, therefore, requires more integrated system responses in terms of governance, policy and programs. The widespread homelessness experienced in our communities indeed reveals deep structural inequities in our economy and society that ought to be addressed, but also represents a systematic governance failure characterized by a lack of ownership of this issue in and across government. The growing scholarly and practitioner movement towards systems integration thus refers to strategies and frameworks to improve collaboration and coordination between people, organizations and sectors that touch upon homelessness, including some that may not conceive of themselves as directly related to the issue.

A key problem is that most services and programs within this realm have been developed incrementally and have evolved in parallel: housing separate from social services which are separate from health services, corrections, mental health or employment and each has a separate funding stream, different set of rules and usually a separate service location. The resulting patchwork of services can be replete with gaps and inefficiencies that undermine efforts to help citizens exit from homelessness, no matter how well each program may function individually. And in some countries, senior-level government coordination incentive programs have been more focused on filling gaps in the system and less particularly focused on generating effective systemic changes in the relationships between agencies and funders (Hambrick & Rog, 2000).

As such, scholars and advocates increasingly point toward collaborative or network governance involving civil society professionals, government officials and researchers as a key governance mechanism toward systems planning and integration (Doberstein, 2016). Yet network governance for cross-sectoral collaboration presents its own challenges, given the diversity of interests and policy legacies that must be thoughtfully reconciled and untangled (Concodora, 2008). There are organizational and individual-level considerations with respect to governance design and management that matter greatly to the success of interagency and intergovernmental collaborative action (Smith & Mogro-Wilson, 2008). This problem is not unique to the public response to homelessness (see for example Allen and Stevens (2007) in relation to health and Wiig and Tuel (2008) in relation to child welfare) but it is especially relevant to this issue given the vast assortment of policy activity and programs across sectors and the multiple causes of and pathways to homelessness. Yet despite these challenges associated with collaborative governance, within the broader public administration literature there is a growing sense that coherence and cohesiveness of

policy ought to be a more important consideration for policymakers, with suggestions that "substantial public value is being lost to insufficient collaboration in the public sector" (Bardach, 1998: 11).

It is important to establish at the onset of this volume that systems planning and integration alone will not end homelessness. Adequate and sustained funding commitments from government in this regard are essential components upon which all of the contributions and findings within this volume hinge. Financial resources for housing and program investments are critical, though they are not the only resources that need to be reconfigured in systems integration efforts. Simply allocating more money toward housing and homelessness alone will not be effective without a strategic orientation and policy framework that ensures that the various sectors and public authorities are working toward the same end goal. Thus human resources, time, knowledge and expertise constitute important resources that must be critically examined in systems integration efforts alongside the issue of securing adequate and sustained financial resources. In this regard, cultivating a culture of collaboration is an essential ingredient to systems integration in terms of high-level governance and policy all the way down to service integration on the ground.

WHAT ARE THE GOALS OF THIS BOOK?

This edited volume finds its origin in our desire to move the discussion forward among those focused on homelessness toward a more intentional and coordinated suite of policies and programs. Consistent with the collaborative approach advocated in this book within the policy realm, we sought to draw on the expertise and experience of service providers, program specialists, government officials and academic researchers in various fields to assemble the first comprehensive examination of systems planning and integration efforts, with a particular focus on systems-level reforms underway in Canada.

One of the primary goals of this volume is to bridge the gap between scholarship on systems integration and the practice of it. Problems of coordination and integration are not unique to homelessness but it is especially relevant to this problem and thus we aim to draw upon scholarly contributions that can structure our analysis and provide the means through which we can evaluate and improve our efforts. Equally important is to marshal stories from the ground to display the emerging and established efforts toward systems integration and coordination across Canada and abroad to reveal common challenges, opportunities and lessons.

Systems integration may appear to be a daunting task given the complexity of the broader homelessness system and the multitude of governments, overlapping authorities and competing interests. Yet we have assembled three dozen case studies written by practitioners on the ground and researchers in the field to demonstrate that systemic change is possible at various levels of activity within the realm of homelessness and associated sectors. We do not need to wait for the perfect conditions to emerge to resolve governance and service inefficiencies – our day-to-day work is always where sustained change is derived and upon which further efforts and refinements are built.

The assemblage of case studies all across Canada, complemented by a few international case studies, at the service, program and governance levels serve to reveal the connectivity between legislative mandates, policy frameworks, resources and sectors. Policy and programs may be created and evolve within a narrow space but their effects are certainly not limited to their own domain. The case studies cut across sectors that touch upon homelessness – including housing, health, child protection and enforcement – each consistently revealing that policies derived from the associated sectors have at times dramatic impacts on their ability to intervene and deliver services or programming effectively.

The final objective of this volume is to leverage the three dozen case studies to distill lessons about what is working as well as the areas most in need of reform, in terms of early systems integration efforts. What are the common difficulties encountered by civil society and government when initiating these types of integration efforts? What are the first steps to take? How are inter-sectoral tensions resolved? What are the concrete strategies that have been employed on the ground to initiate and sustain systems integration and planning? What are common mistakes to be avoided? One thing this book project revealed immediately is that contrary to conventional wisdom, there is a lot of 'systems' style thinking and activity in Canada. We are not at ground zero. Yet as this agenda gathers momentum we need to identify the early lessons and identify the areas in most need of change to achieve sustained and effective systems integration.

MAJOR THEMES IN THE BOOK

Systems planning and integration efforts occur across numerous levels, from the actions of individuals working on the ground, to agencies collaborating and learning, to networks of agencies and governments engaging in deliberative problem solving, to intergovernmental collaborative policymaking. To reflect this diversity and to isolate the unique challenges and opportunities at each level, we have separated out the contributions to this volume along these lines. The following paragraphs outline the broad contours of this volume and preview the superb contributions from practitioners and scholars alike across Canada and abroad.

PROGRAM AND SERVICE-LEVEL COLLABORATION

The first section of this volume is focused on wide-spectrum service collaboration among agencies and government to integrate and coordinate their activities with the most direct and immediate impact on those accessing services.

In the first chapter in this section, Dressler reports on the Calgary Homeless Foundation's Coordinated Access and Assessment system in which housing providers collectively place clients in appropriate Housing First programs, after observing it in real time over eight months. Dressler then reflects on successes and challenges with the approach. Norman and Pauly complement the Dressler chapter on Calgary's system with an evaluation of Victoria's Centralized Access to Supportive Housing, finding similar patterns in terms of early results but also distinct challenges going forward in their context.

Hurtubise and Rose reflect on their six-month period of being embedded with an inter-organizational team composed of health workers, social workers and police officers in Montreal that provides follow-up on the streets and case management on a mid- and long-term basis as an alternative to the criminalization of homelessness. Kline and Shore document a wholly different approach to a systems integration effort in Pinellas County, Florida, centred around a large shelter that involves multiple levels of government, enforcement and faith-based organizations jointly engaging in a cultural shift away from previous practices in a challenging political environment.

In a short vignette, Charette, Kuropatwa, Warkentin and Cloutier document the early outcomes and learnings from Winnipeg's Bell Hotel supportive housing partnership model, demonstrating declining engagement with emergency, health and police services. In another short vignette, Hug zeros in on how a partnership model of housing and supports turned around a once-infamous building in Toronto, identifying the necessary ingredients of the partnership and the key factors that facilitated the collaboration.

SYSTEMS PLANNING FOR TARGETED GROUPS

To reinforce one of our key arguments that systems integration does not imply a single rationality or model to address the complex and distinct needs among those experiencing homelessness, in the next section of the book we present case studies of systems integration efforts with a particular focus on targeted groups, specifically women, Aboriginal peoples and youth. In this section of the volume, our contributors drill down into the specific needs of target populations to reveal the unique context of policy and program development, demonstrating that one rationality or approach will not work across diverse target groups but instead confirming the different pressures on the system that ought to be recognized to build a complex quilt that captures diversity of need.

With respect to systems integration targeting the unique needs of women, Kirkby draws on two different supportive housing models used in Toronto to illustrate that a gendered approach to service provision – one that is flexible and adaptable to take into consideration the context of women's lives – results in improved service to participants and sustained engagement with programs. In another report from Toronto, LeMoine presents Toronto Public Health's Homeless At-Risk Prenatal program for pregnant women, which hinges on informal coordination across various providers in the region and then distills the 10 most important activities that enhance service coordination.

Bopp, Poole and Schmidt illustrate the unique needs of Northern homeless women, focusing on three Communities of Practice in each of the territorial capitals as sites to support relational and programmatic systems change through collaboration and policy learning. In a short vignette, Schiff and Schiff likewise argue that the unique pressures in the North demand tailored, local-level responses and examine collaborative efforts in Happy Valley-Goose Bay that sought to develop innovative housing programs for high-needs Aboriginal women.

With respect to systems integration targeting the unique needs of youth, Puligandla, Gordon and Way from Homeward Trust in Edmonton present the Community Strategy to End Youth Homelessness and identify early successes towards enhanced coordination and collaboration amongst community and government providers, including the establishment of a Youth Systems Committee to co-design a future youth homelessness system based in integrated service delivery. Nichols complements this chapter by contemplating the cross-sectoral thinking, learning, planning and relationship building that must occur to build an integrated systems response to homelessness prevention for youth, suggesting that shared language, values and accountabilities are essential first steps. Nichols, in a subsequent chapter, describes the grassroots collaborative planning and change process spearheaded by the Street Youth Planning Collaborative in Hamilton and teases out the organizational and behavioural components of a change process that supports a fundamental shift in how people work and think in this context.

In a short vignette, Frisina evaluates a youth-focused mental health program in Hamilton, a model of care that reflects partnership, client-centred practices and a shared vision to effectively utilize resources and adapt service responsiveness for hard-to-reach youth. Lethby and Pettes report from rural Niagara Region on a youth program that highlights the concrete and measurable benefits of integrating social services targeting youth homeless populations and illustrates how prevention and systems integration can be successfully implemented.

INTER-SECTORAL COLLABORATIONS

In the third section of the volume, our contributors are focused on inter-sectoral collaborations or what is known as horizontal systems integration, which identifies the need for parallel sectors and agencies within government to strategize, collaborate and work in a coherent fashion toward a common goal.

In the first chapter in this section, Kovacs-Burns and Gordon draw on the concept of 'determinants of homelessness' to reveal the complexity of homelessness, the challenges living with it and the gaps in public policies to support a systems approach to successfully resolve it. The chapter ends with specific recommendations for communities to evaluate and expand their own systems-level responses. Brydon complements this by developing a method through which communities can collect and interpret data regarding inflows and outflows of homelessness as part of a systems effort to evaluate progress toward ending homelessness. Duchesne, Rothwell, Ohana and Grenier document an integrated community-academic partnership model in Montreal as an example of creating an institutionalized feedback loop at the community level that continually evaluates service effectiveness and creates a culture of research and self-reflection.

Schiff and Schiff explore the Community Advisory Board model within the Government of Canada's Homelessness Partnering Strategy, suggesting that there are examples of its structure facilitating systems-level responses in communities, but also that there are untapped opportunities to learn from such boards across Canada. Evans then examines efforts in Hamilton to coordinate local services through the scaffolding of 'soft' (informal) community collaborative arrangements – which he calls community-based managerialism – over top 'hard' managerial arrangements or mandates, which he argues more effectively focused services on the chronically homeless but also reconfigured the local voluntary landscape.

Following that, Bucceri explores the fragmentation of homelessness and public health services in Toronto through the illustrative example of the H1N1 pandemic, identifying barriers to integration and specific strategies to overcome them. Finally, in a short vignette, Forchuck, Richardson and Atyeo assess the performance of a model of connecting housing with supports for veterans piloted in four Canadian cities, whereby housing and veteran-support agencies collaboratively redesigned and adapted their previous service approaches to better serve their target population.

HIGH-LEVEL GOVERNANCE CHALLENGES AND OPPORTUNITIES

The final section of this volume builds up to the highest level of analysis in terms of systems integration: the political and macro-governance realm. Homelessness is a public administration or governance problem as much as it is an economic or social problem. We are dealing with new public policy problems within old governance models. Clearly, governance models must support policy and program coherence from senior governments down to the service level.

Doberstein begins this section by articulating a conceptual framework to understand and guide efforts toward system planning and integration from a governance and policy perspective. His chapter identifies the necessary ingredients as well as the likely barriers to the pursuit of systems integration. Pleace, Knutagård, Culhane and Granfelt then flesh out this conceptual framework with a Finnish example. They describe the Finnish National Homelessness Strategy, the context in which it arose, the successes that have been achieved and the challenges that still face Finland in terms of devising and implementing an integrated strategy. Following that, Belanger reviews a classic macro-governance failure in Canada: Aboriginal housing policy in Canada since Confederation. Belanger identifies federal and provincial feuding and hardened silos as well as historical policy frameworks imposed upon Aboriginal Canadians as historical barriers toward effective policy, despite considerable public investment in Aboriginal housing over the years.

Doberstein and Reimer then explore U.S. Interagency Councils as attempts to build system-level responses to address homelessness within and across governments, setting the context for their evaluation of the Alberta government's recently created Interagency Council to End Homelessness. The final two chapters remain focused on Alberta, where Milaney describes the Calgary Homeless Foundation's System Planning Framework and presents its development and related process features as well as shares learnings and issues that communities considering similar frameworks ought to contemplate. Finally, Turner reports on Medicine Hat, the self-declared 'First City to End Homelessness,' and shares lessons from developing the key features of an integrated system of housing and supports in a small city.

CONCLUSION

The final chapter of this volume attempts to synthesize the diverse conceptual and empirical contributions found within these pages, with the aim of identifying practical next steps and strategies to confront the difficult, but necessary, work ahead. While the findings presented in this volume demand that we confront the complex interplay between sectors and levels of government associated with homelessness, they also provide us with encouragement that dedicated people and organizations remain committed to ending homelessness with greater strategic intention than ever before.

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I am an engaged scholar who studies institutional and policy relations that contribute to processes of social exclusion and marginalization. I am committed to making sure my research contributes to socially just change processes.

1.0

Program and Service-level Collaboration

Program and Service-level Collaboration

1.1

COORDINATED ACCESS AND ASSESSMENT: CALGARY, ALBERTA

Jerilyn DRESSLER

INTRODUCTION

Since its inception in 1998, one of the primary goals of the Calgary Homeless Foundation (CHF) has been to create an umbrella system for relevant programs and services and create a single point of entry for Calgarians experiencing homelessness (Scott, 2012). Building a homeless-serving system was identified as Phase 2 of Calgary's 10 Year Plan to End Homelessness (the Plan), originally launched in January 2008. This phase was scheduled to take place from 2011–2014 following the first phase of the Plan, which was focused on injecting new resources into the homeless-serving sector. Phase 2 was recognized as the most labour-intensive and difficult phase, and included creating a standardized assessment process, coordinating intake for housing programs and services, filling in gaps in service and working with large systems.

The Coordinated Access and Assessment (CAA) program is an intake program for all CHF-funded Housing First programs—a single point of entry for Calgarians experiencing homelessness. It was launched in June 2013, just days before a great flood displaced thousands of Calgarians and several homeless-serving agencies and programs, including the storefront CAA program located at the Safe communities Opportunities and Resource Centre (SORCe). The program was up and running again in the fall of that year, and was in operation for a year when the writing of this report began in 2014.

This report was prepared at a critical time in the history of the CHF. The clock was ticking on the Plan's countdown to ending homelessness—less than four years were left on the countdown to the 10-year anniversary of the Plan being launched. The CHF had undergone significant changes in its senior leadership, and it was increasingly difficult for Calgarians to find housing—affordable or otherwise—due to a strong economy and significant population growth. The flood of 2013 further reduced Calgary's vacancy rate as people were displaced from their inner city homes. Despite these challenges, the CHF managed to keep moving toward its goal of further developing a coordinated intake and assessment program to anchor its system of care and end homelessness.

The observations documented in this report took place over the course of eight months, between May and December of 2014. The purpose was to document

and provide information about the CAA program's formative process, and to inform the ongoing development of the CAA program in Calgary. Data collection included participant observation at CAA's storefront location at SORCe, in relevant internal meetings at CHF and at Placement Committee Meetings (PCMs) where clients who have been assessed are matched to programs. It included an extensive review of internal policy and procedural CHF and CAA documents and of the literature regarding Housing First and coordinated intake programs.

BACKGROUND

There are several contextual factors that have influenced the state of homelessness in Calgary and efforts to end homelessness in this city. Prior to the launch of the CAA, the CHF engaged the community in its 10 Year Plan to End Homelessness, implemented the Homeless Management Information System and consulted the community in regard to the development of a coordinated intake program for Calgarians experiencing homelessness.

Environmental Scan

Alberta's "boom and bust" economy has direct and indirect impacts on the state of homelessness in the province. When booming, the province's resource-based economy creates more jobs than there are people to fill them. Calgary's most recent civic census data indicates that the city experienced a record-breaking population growth of 3.33%, or 38,508 residents, from 2013 to 2014 (Election and Information Services, 2014). Alberta's growth rate was the highest in Canada at 0.34% in the last quarter of 2014 (Ferguson, 2015). The CAA team at SORCe reports that in boom times like these many individuals and families come to Calgary to find work, without a full understanding of the high cost of living or a social network to rely on during difficult times. Almost one-fifth (18%) of Calgarians experiencing homelessness migrated to Calgary in the past year, compared to about 6% of Calgary's population as a whole (CHF, 2015). Safe and affordable housing is difficult to find due to Calgary's exponential population growth—in 2012, Calgary's vacancy rate was the lowest in Canada at 1.3% (Employment and Social Development Canada, 2014). Excessive demand for housing and increasing property values leave few safe and affordable housing options. The flood of 2013 placed further pressure on Calgary's minimal rental unit vacancy rate.

Calgary's 10 Year Plan to End Homelessness

Calgary's Updated Plan to End Homelessness (The Plan, CHF, 2015) is based on Housing First values and principles. It was created in 2008 using a model applied in over 300 American cities but was the first plan of its kind in Canada. The most recent version of the Plan emphasizes a person-centred approach and community ownership and collaboration. The Plan guides CHF in all of its work, and the 2015 update maintained the core principles defined in the original Plan:

- The Plan will aim to help people move to self-reliance and independence.
- All people experiencing homelessness are ready for permanent housing with supports, as necessary.
- The first objective of homeless-serving systems, agencies, programs and funding is to help people experiencing homelessness gain and maintain permanent housing (Housing First).
- The most vulnerable populations experiencing homelessness need to be prioritized.
- The selection of affordable housing and the provision of services should be guided by consumer choices.
- Resources will be concentrated on programs that offer measurable results.
- Affordable housing is safe, decent and readily attainable. Diverse, integrated, scattered site affordable housing, close to services, is preferred.
- Plan funding should be diverse and sustainable.
- The use of markets will be maximized by involving the private sector in the implementation of the Plan.
- The economic cost of homelessness will be reduced.
- A well-educated, well-trained and adequately funded non-profit sector is central to the success of the Plan (CHF, 2015, p. 1).

State of the System of Care

Prior to the implementation of the CAA program in 2013, the numerous homeless-serving agencies and programs in Calgary were operating relatively independently of one another, with little coordination regarding client intake or shared clients. Agencies and programs in the system of care included emergency shelters and programs offering transitional housing, permanent housing, rapid rehousing, prevention, outreach, affordable housing and support services. Combined, they did not resemble a system, but rather a fragmented collection of agencies and programs; historically, the Plan has used a "traffic system" analogy, one with no established traffic flow or clear rules of the road. Homeless individuals were often being served by multiple agencies and sat on multiple waitlists for housing, each of which was accessible only through the program itself.

Not only was this fragmented system difficult for clients to navigate—and potentially re-traumatizing because it required them to tell their story over and over again—but agency and program accountability was also lacking. Agencies had the ability to refuse to serve clients based on their own assessment of programmatic fit, or if the client's needs were too complex. This practice is known in the homeless-serving sector as "cherry-picking" or "cream-skimming," i.e. picking clients who are easier to serve and thus more likely to be successful in agency programs and produce more positive outcomes. Agencies could assume that another agency or program would serve the client, but this left many clients under-served when in fact they were the clients requiring the most support. Furthermore, several

examples emerged of people without a history of homelessness being housed in homeless-serving programs at PCMs—one in a housing program for those with physical health requirements and others in a housing program for clients struggling with substance abuse.

HMIS and System Planning Framework

In 2011, the Homeless Management Information System (HMIS) was implemented as the first system of its kind in Canada. It is a database and case management tool used by CHF-funded programs. If a client agrees to share their information, HMIS allows case workers from different programs to see the client's history, improving their understanding of the client's situation and needs. It is meant to ensure that clients experiencing homelessness do not fall through the cracks. The information within HMIS has also informed and influenced CHF policy and program design and helped identify gaps within the system of care. It has been called "the backbone of the system of care" by CHF's HMIS Manager Chantal Hansen (Fletcher, 2012).The CHF's System Planning Framework is guided by data collected in Calgary's HMIS program.

This practice is known in the homeless-serving sector as "cherry-picking" or "cream-skimming," i.e. picking clients who are easier to serve and thus more likely to be successful in agency programs and produce more positive outcomes.

Key elements of a System Planning Framework include:

- Defining the key program types that are responsive to diverse client populations and their respective needs;
- Ensuring programs have clear, consistent and transparent eligibility and prioritization processes to support right matching of services for clients;
- Using a common assessment tool to determine acuity or need, direct client placement and track client progress;
- Having clear and appropriate performance measurement indicators and quality assurance expectations at the program and system level to monitor and evaluate outcomes;
- Using data to direct strategies and assess program and system impact in real time (i.e. a HMIS); and
- Promoting information sharing across programs (CHF, 2014, p. 2).

The CAA team at SORCe is the primary administrator of the "common assessment tool"—the Service Prioritization Decision Assessment Tool (SPDAT). CAA plays a role in many of the points above by bringing CHF-funded agencies together each week at PCMs. At each PCM, the CAA program and CHF-funded agencies collaboratively match clients to programs and share information across programs. The CAA has been instrumental in not only coordinating access to homeless-serving programs, but in coordinating the entire system of care and increasing the level of accountability in regard to triaging and accepting clients at PCMs. By implementing CAA (along with HMIS) and participating in the collective discussion that takes place at PCMs, homeless-serving organizations are able to more clearly identify the needs of clients and the programs that best meet those needs.

Establishing CAA

The CHF is dedicated to collaboration and community consultation, and has demonstrated this commitment through the creation and subsequent updates of the 10 Year Plan to End Homelessness. Prior to the implementation of CAA, CHF engaged in community consultation including surveying community agencies and community system planning meetings, the creation of Client and Youth Advisory and Request For Proposal Advisory Committees, an agency advisory strategic planning day and individual meetings with every CHF-funded agency. Based on feedback specifying that community agencies wanted input on the clients they were accepting, PCMs were established so that CHF-funded programs taking clients from CAA could collectively match clients to programs. Quarterly Advisory Committee and community information and feedback meetings continue to take place to guide the ongoing development of CAA.

The level of collaboration and coordination among such a large group of community organizations is impressive and unprecedented in the local context. The decision to conduct PCMs to assign clients to programs was an additional step taken to ensure buy-in from homeless-serving agencies and programs in Calgary. Programs would not be told which clients they were assigned by a centralized CAA service, as happens in other cities with coordinated access programs across North America, but would have direct input into the capacity of their programs and whether or not any one particular client was a good fit for their program.

Distress Centre Calgary (DCC) was chosen to deliver service through CAA's storefront location at SORCe. The delivery of information and referral is the business of DCC's 211 program, which connects people in need with government, social and community services. DCC was well equipped to prevent clients from entering homelessness and divert them from the homelessness system of care, which is a key role of the CAA team at SORCe. Several coordinated access programs for shelter and housing in the United States are connected to the local 211 service, including those in King County (Washington), Orange County (California) and the state of Arizona.

COORDINATED ACCESS AND ASSESSMENT

There are key characteristics and activities of the CAA program that help improve service to clients and programs participating in the common intake process. These include a centralized location, the administration of the assessment tool, PCMs, and a flexible, organic decision-making process.

Centralized Location

CAA's storefront location at SORCe is located near Calgary's emergency shelters and steps away from a Calgary Transit Light Rail Transit (LRT) station. SORCe is a Calgary Police Service initiative and is intended to support Calgary's downtown homeless population. It is a multi-service site where 14 homeless-serving agencies provide a variety of services that people experiencing homelessness may require, including prevention and diversion from the system of care through information and referral, income support, addiction and mental health services, and outreach services.

In implementing CAA, it was determined that it would be best to enlist several "door agencies," agencies who have trained staff to conduct an assessment for access into CAA, to provide services in addition to establishing a centrally located storefront operation. This established a "no wrong door" approach for Calgarians experiencing homelessness; they could receive service at an easily accessible location in downtown Calgary or sit down with workers at the emergency shelter or hospital or treatment or correctional facility in which they were staying. This created ease of access for clients as well as a more seamless delivery of services, and enabled a more client-centred approach.

Assessment Tool

SPDAT was chosen by Alberta's 7 Cities on Housing and Homelessness and approved by their largest supporter, the Government of Alberta's Human Services, prior to the implementation of CAA in Calgary. It is a detailed assessment measuring an individual's or family's acuity for the purpose of triaging and prioritizing service delivery. It uses 15 measures to calculate a score out of 60 for individuals experiencing homelessness. The 15 measures include:

- Self-care and Daily Living Skills;
- Social Relationships and Networks;
- Managing Daily Activities;
- Personal Administration and Money Management;
- Managing Tenancy;
- Physical Health and Wellness;
- Mental Health and Wellness and Cognitive Functioning;
- Medication;
- Interaction with Emergency Services;
- Involvement in High Risk and/or Exploitative Situations;
- Substance Use;
- Abuse and Trauma;
- Risk of Personal Harm and Harm to Others;
- Legal; and
- History of Homelessness and Housing.

OrgCode Consulting, the creator of the SPDAT tool, was brought to Calgary to train staff who were going to be conducting the assessments at door agencies and at SORCe, and also to train trainers to continue training new staff on the administration of the SPDAT.

Clients are given a score of 0–4 in each category, with a higher number indicating a higher acuity, or higher risk. It also identifies what services are most appropriate for clients based on their score—Housing First, Rapid Rehousing, or Prevention and Diversion. OrgCode Consulting, the creator of the SPDAT tool, was brought to Calgary to train staff who were going to be conducting the assessments at door agencies and at SORCe, and also to train trainers to continue training new staff on

the administration of the SPDAT. The tool is in use in over 100 communities across North America. Along with the use of the SPDAT tool for all clients entering CHF's system of care, standardized prevention and diversion questions were employed to ensure as many people as possible are diverted from the system of care.

The SPDAT assessment is deficit-focused, which is a concern for program staff as it has the potential to leave vulnerable clients feeling poorly about, or responsible for, their current situation. At PCMs, positive ways in which to reframe the SPDAT assessment and score have been discussed. Examples involved focusing on an individual's strengths at the end of the SPDAT, e.g. asking the client to identify what they see as their biggest strength, and working with clients who are unlikely to get placed due to their score to see their strengths and how they can leverage those strengths to find housing independently.

The SPDAT training emphasizes that as little information as possible should be collected to assess the client in order to prevent re-traumatization.

Consistency or "inter-rater reliability" of the SPDAT assessment was identified as a concern early in the research process. Over several months, measures were taken to improve the consistency among those conducting the SPDAT assessment, including the introduction of a SPDAT-trained staff registry, a shadowing and mentorship process, and spot-checking of SPDAT assessments by senior staff with Distress Centre's CAA team at SORCe. Documentation was also identified as a concern, in particular regarding what should/should not be included in the SPDAT assessment. The SPDAT training emphasizes that as little information as possible should be collected to assess the client in order to prevent re-traumatization. The purpose of the SPDAT is prioritization, not case management; therefore very little information is required to support the score given. Continued emphasis on training and communication will address many of these issues over time.

PLACEMENT COMMITTEE MEETINGS (PCMS)

Four PCMs were created for CHF-funded housing program staff, CAA staff and CHF staff to meet and collectively match clients to programs. The four meetings include those to discuss and place high-acuity singles (clients with a SPDAT score over 44), mid-acuity singles (clients with a SPDAT score under 44), families and youth. PCMs generally take place once a week at a regularly scheduled time and place. The amount of client information shared within CAA and at PCMs is very high. Clients sign a Release of Information granting permission to share information with and gather information from a relatively long list of agencies and programs, with the option for the client to exclude any one of them. If clients do not wish to share their information, they can either choose to be anonymous or, alternatively, there are a handful of non-CAA participating agencies that they can contact independently in their search for housing.

The primary purpose of PCMs is to collectively match clients to programs, but there is much more to PCMs than reviewing the triage list and assigning clients to programs. Some benefits of holding PCMs include constant renewal of the groups' commitment to the Housing First philosophy, a very high level of inter-program collaboration, collective decision making and increased accountability of programs.

HOUSING FIRST

The Housing First philosophy has been adopted by the CHF and commitment to this philosophy is regularly renewed at PCMs. There were times when program staff appeared reluctant to accept clients at the top of the list based on their history of substance abuse. In such instances, the meetings' chairs emphasized that substance use should not be a "screen-out," and that it is possible or even likely that clients' substance use would decrease after being housed; it is common for clients to use substances as a way to cope with being homeless. The group as a whole appeared to struggle with the Housing First philosophy in regard to clients with violent criminal histories. On several occasions program staff were reluctant to take clients due to concerns about their ability to remain safe while working with the client, regardless of whether or not they were at the top of the triage list.

the meetings' chairs emphasized that substance use should not be a "screen-out," and that it is possible or even likely that clients' substance use would decrease after being housed; it is common for clients to use substances as a way to cope with being homeless.

Client Choice

Client choice, when stated, was always respected, including preferences related to housing location, roommates, sober living versus harm reduction, family reunification, etc. At times, client choice may limit the options available and increase the length of time spent waiting for housing; e.g. if the client did not want a roommate but there was only housing with roommates available. However it was recognized that respecting client choice increases the chance that a client will be successful in a program and not end up back on the streets.

Collaboration

There was a very high level of collaboration observed at PCMs, particularly regarding very high-acuity and/or complex clients. Program staff were willing to share their expertise and support and make recommendations in regard to complex clients. On more than one occasion, a client was presented at PCM with the goal of transferring the client to another program. With the support and recommendations provided at the table, the client was able to remain in their current program and avoid being bounced from program to program or, worse, discharged into homelessness. Dual programming was also put in place for some clients; i.e. two programs were enlisted to support a client with complex needs. Furthermore, CHF's policies regarding dual programming were subsequently modified and relaxed in order to accommodate such arrangements for complex clients. CHF's awareness of the resources and programs required to house and support complex clients increased as a result of CAA and PCMs, resulting in policy changes benefitting both clients and program staff.

Mutual Trust and Respect

While it is specified in CAA's operating manual that Shelter Point (a database tracking the number of spaces available in CHF-funded programs) is to be used to identify the number of spaces available in each program, it is common practice at PCMs for programs to self-identify the number of spaces they have available. It is recognized by each PCM chair and the CHF that program capacity is not black and white with regard to how many spaces are available in each program; i.e. the number of spaces available may be impacted by the amount of support required by clients (e.g. complex clients), unfilled case worker positions and the level of skill and experience of the case workers who are available to take clients. This ad-hoc process is empowering to program staff and respectful of their expertise regarding what is happening in their programs, and builds trust between programs and the CHF at the PCM tables.

When a discrepancy between the number of spaces available in Shelter Point and those being identified at PCMs was raised (from a place of respect and open curiosity), program staff identified lack of housing and open case manager positions as the major issues impacting their capacity. Not only is there a lack of appropriate housing, but landlords are often reluctant to work with programs serving homeless clients.

Agency Accountability

The triage model is one that the community has collectively agreed to, and it is useful when working with limited resources. On several occasions at PCMs program staff appeared reluctant to accept particular clients, despite the client being next on the triage list as well as a suggested program match. While everyone at the PCM tables is respectful of programs self-identifying their capacity, there were times when it appeared that program staff accepted particularly challenging clients because they were held accountable by those at the PCM table—not only by a CHF representative, but also by their peers. There was a process in which the client's situation was discussed, including the reasons they were at the top of the triage list, and it was made clear why it was critical that the client be placed. If the program staff remained reluctant to accept the client, they were reminded that they could return the client to the triage list if after meeting with them it was determined that they were not a programmatic fit.

Despite the benefits of the process described above, some CAA program staff appeared to feel pressured to take particular clients. PCM chairs may wish to remind CAA program representatives that they retain the ability to return the client to the triage list after they have met with the client if the client is determined not to be a good fit with their program. There must be a justifiable rationale and CAA members are accountable to all other members of the group, but this encouragement may help program staff feel empowered and less reluctant to give the client an opportunity in their program.

There are many examples of collective decision making at PCM tables. When deciding whether or not to hold a bed for a client, for example, it was stated "it's up to the committee." On another occasion, regarding a transfer, one program staff stated "as long as the committee is okay with it." There is a delicate balance of program autonomy and collective decision making that must be maintained to ensure the active and willing participation and engagement of program staff.

FLEXIBILITY IN PROCESS

There have been many additions and modifications to the common intake process that are specific to the Calgary context, likely because a funder, rather than a service provider, has led the implementation and operation of the program. CHF has the ability to make decisions based on both its observations and the recommendations of community agencies participating in CAA. This has allowed for slight changes to the SPDAT assessment, including the use of baseline scores for SPDATs for clients who have been institutionalized (i.e. scores prior to being in hospital or incarcerated), vulnerability scores (calculated using scores from the Physical Health, Mental Health, Interaction with Emergency Services, Risk of Personal Harm and Harm to Others, and History of Homelessness and Housing fields from the SPDAT assessment), a pregnancy calculator for the family sector, and an FASD (Fetal Alcohol Spectrum Disorder) toolkit to assist program staff in completing SPDAT assessments of clients who have FASD. It has also allowed for changes in processes to improve CHF's understanding of Shelter Point data and create a clearer picture of what is happening within community agencies; such changes include the CHF policy regarding "dual programming" and new procedures regarding how to "ramp up" caseloads for new case managers.

The process for change within CAA could be described as "organic"—that is, change happens as needed, when issues arise and are identified within the programs and at PCM tables. Through the writing of this report, it was identified that processes for change should be outlined more clearly within CHF. A governance structure was suggested, dividing oversight of the program into strategic and operational realms, with the strategic oversight being the responsibility of a steering committee consisting of CHF and community agency leadership, and the operational oversight being the responsibility of CHF's System Planners and CAA-participating agencies and staff, primarily at PCM tables. While clear processes and communication will be helpful for the continued development of CAA, the ability to react quickly and adapt to community and client needs is a strength of not-for-profit and non-governmental organizations, one that has been identified by the Government of Alberta (2013) and should not be lost.

SYSTEM OF CARE

Gaps in the System of Care

Throughout the research process, several gaps in the system of care were observed at PCMs:

Harm Reduction:

On several occasions it was observed that the majority of spots available at both high- and mid-acuity PCMs were available only to clients interested in or already maintaining sobriety from drugs and alcohol. While it is important that clients interested in sobriety have a safe and "dry" home environment, the vast majority of clients on the triage list are in need of harm reduction program placements, i.e. programs that are willing to work with individuals who are actively engaged in their addiction. This imbalance in the amount of sober housing and the relatively low number of clients interested in sobriety meant that much lower acuity clients interested in sobriety received placement above those who were higher in acuity and in greater need of housing according to the triage model. This imbalance was further exacerbated by the introduction of a sober living apartment tower in Calgary's beltline. CAA participating programs had a difficult time filling the units they held in this tower, as it was not easy to match clients to their program who were also clean and sober. The excess of sober housing sends an implicit message to clients that people who are clean and sober are more deserving of housing, in direct opposition to Housing First principles. CAA provides data that should be used to make funding decisions based on the needs of the population being served. From the Waterloo Social Planning, Policy and Program Administration (2013):

> *As part of the... process, communities should establish a feedback loop that involves using the information gained from these assessments to make any necessary adjustments to the system. For example, if families are being referred to the right program, but that program cannot serve them due to capacity issues while other program types have an increasing number of empty beds, it may be time to make system-wide shifts in the types of programs and services offered. Communities with a coordinated entry system tracking all their data have a centralized source of information on who is entering their system, who is on a wait list, what their needs are, and how those needs match with what's currently available. (p. 21)*

Using data to inform CHF-funded programming and services for Calgarians experiencing homelessness is one of the key shifts from the previous Plan identified in the Updated Plan (CHF, 2015). A systemic shift of this significance in the homeless-serving system as a whole, however, requires working with other systems to ensure that all programming and services are informed by data and the needs of the population. Fortunately this is also a clearly identified priority in the Updated Plan.

Couples:

There are very few programs willing to take couples, either because it is not the mandate of their program and/or because of the risk of domestic violence and the subsequent risk to housing stability.

Non-English Speaking Clients:

There appeared to be little capacity for programs to work with clients who have limited English-language skills—any capacity was dependent on the program staff's ability to speak other languages. Subsequently, throughout the research process program staff were instructed to access a language line for tele-interpretation through Distress Centre's 211 service as needed.

Transitional Housing:

There is a lack of housing for transitions from systems like corrections or for those with physical health needs upon being discharged from hospital. Clients are routinely discharged from hospital or corrections into homelessness, despite it being against Alberta Health Services' (AHS') policies to do so.

Clients with a Violent History:

These clients may pose a safety concern to program staff, other residents if in place-based housing and the community in which they are placed. As such, CAA-participating programs were reluctant to take on clients with a violent history within their existing resources.

Complex Clients:

Complex clients are those clients for whom there is no program match, often due to high needs in multiple areas of the SPDAT assessment (e.g. addictions, mental health, risk of harm to self or others, legal, etc.). "Dual programming," i.e. assigning more than one program to the client, can address complex clients' needs only a fraction of the time. A Complex Case Review Committee was created to discuss complex cases and develop potential strategies regarding how to house and support these clients. One recommendation is to assign a case manager to complex clients in homelessness until the client can be housed either by the program with which the client is engaged, or with the program best suited to meet some of the client's needs.

Some clients are deemed complex because there is no program able or willing to serve clients with an extensive history of violence. The CAA program has outlined safety procedures in its operating manual, and it is expected that all housing programs have safety procedures in place. If clients cannot be supported safely within the parameters of any program's safety procedures, the client is deemed complex. Ideally, the resources required to safely support that client are identified at the Complex Case Review Committee meeting and provided to the program willing to support the client, similar to a fee-for-service model. The alternative is to direct these clients back to AHS, where there may be more resources to adequately and safely support such clients (e.g. Assertive Community Treatment Team or locked-down, place-based housing). That being said, it is clear that all such systems are operating at or over capacity. Currently there is no clear process in place to get the needs of complex clients met in a sector that has little to no capacity.

Upon review of the complex clients' SPDAT assessments, what stood out was the extensive history of significant trauma experienced by these clients and the impact it was having on the clients' current life and experience of homelessness. Clients reported witnessing and experiencing physical, financial, emotional and sexual abuse, and violence as children, as adults, and as adults experiencing homelessness. Clients reported being repeatedly institutionalized in foster homes and in correctional facilities. Trauma-informed care within CHF's System of Care is critical for such clients.

OUTSIDE OF CHF'S SYSTEM OF CARE: ENGAGING SYSTEMS AND NON-CHF-FUNDED AGENCIES

The high level of coordination and collaboration within CAA and CHF's system of care is unprecedented within any other system serving particular populations in Calgary. Having a relatively comprehensive list of clients requiring housing made it apparent that many clients waiting for housing were eligible for supports from other systems, most of which have a larger pool of resources than CHF's system of care. CHF's System Planner worked to connect clients on CAA's triage list to supports from other, larger systems, including the Government of Alberta's Persons with Developmental Disabilities, AHS' Regional Housing and Corrections Transition Team and Child Welfare. It was recognized that all systems supporting homeless clients are under-resourced, and in some cases programs from different systems would agree to work together to ensure clients received the support they needed. This level of advocacy created increased communication and coordination between systems, and will benefit shared clients. It also created more positive transitions from systems to housing, particularly for homeless clients transitioning out of correctional facilities or hospitals.

It was recognized that all systems supporting homeless clients are under-resourced, and in some cases programs from different systems would agree to work together to ensure clients received the support they needed.

Recommendations

Lack of Strategic Direction

The process of implementing CAA has been described by CHF staff as "flying the plane as it is being built." The pressure created by the timelines in the 10 Year Plan may have been related to decisions being made without clear vision regarding what CAA should look like, and what CHF's role would be in the future. There was confusion regarding who was primarily responsible for CAA. Was it CHF as the funder leading the implementation? Was it Distress Centre, chosen to operate the storefront location of CAA at SORCe and play a key role in Placement Committees? Was it the community of homeless-serving programs and agencies under the umbrella of CAA? These questions have yet to be answered. As CHF endeavours to engage the community in systems-level decision making and ending homelessness in Calgary, it would be advisable to involve the community in the ongoing development of CAA as much as possible.

Until this research process, a program logic model and the evaluation of the program had not been discussed. CHF was reluctant to create a logic model and evaluation framework for CAA, as it was considered counter-intuitive to their goal of collective ownership of both the 10 Year Plan and of CAA. The first logical step moving forward is to establish a governance model and strategic oversight and goals for the program. A steering committee is currently being established and will ultimately set a strategic direction for CAA, after which a program logic model can be created and a program evaluation framework begun.

Outcome Measures

The introduction of CAA has caused a shift from program-centred to client-centred care. Looking ahead, it will be important to measure the outcomes that are hoped for with the introduction of diversion processes and common intake, as outlined in Social Planning, Policy and Program Administration (2013):

- Outcomes related to common intake (streamlined intake and program matching):
  - » Shorter time from system entry to permanent housing;
  - » Fewer interactions with different agencies;
  - » Reducing length of stay in shelter; and
  - » Reducing repeat episodes of homelessness.
- Outcome related to diversion:
  - » Reducing new entries into homelessness.

Other measures identified in the research process as useful in measuring the success of CAA's coordinated intake and program matching include:

- Program occupancy (although true program capacity is difficult to measure due to the influence of staffing levels and availability of housing);
- Positive destinations at exit from program;
- Fewer clients returning to shelter/ rough sleeping; and
- Less frequent discharge from public institutions into homelessness due to engaging large systems through CAA.

Missing from this report, and from the CAA in general, is client feedback on the common intake process. Feedback should be collected, primarily from clients who are housed as those who are still waiting on the list would have an inherent bias.

Remaining Questions

There are clear indications that CHF and CAA are achieving success in the work being done in Calgary's homelessness sector. Despite Calgary's rapid growth, the city's homeless population has remained stable in recent years. In addition, CHF's system of care is currently at 95% capacity—programs are full and any empty spaces are filled quickly and efficiently. One of the most significant questions begging to be answered is regarding continuing to assess clients, considering the likelihood of them being housed is currently extremely low. Should CAA continue to SPDAT clients? If the program operates on a triage model, should CAA be conducting SPDATs within emergency shelters to reach only the highest acuity clients? Should the system remain a triage model? These are questions that I believe need to be answered by a steering committee, with an eye on the strategic direction of the program.

CONCLUSION

The CHF, along with its funded agencies, has managed to complete the most challenging phase of Calgary's 10 Year Plan to End Homelessness. They have chosen a standardized assessment process (the SPDAT assessment), developed a coordinated intake team and process, and have begun working with large systems to ensure that Calgarians experiencing homelessness are receiving the most appropriate care. Work remains to be done around using the data collected in HMIS to inform resource allocation within the system of care, as demonstrated by the over-abundance of sober housing in a system that requires more programs working with clients who require harm reduction.

Despite the challenges posed by changes in leadership at CHF and Calgary's "boom and bust economy," Calgary has managed to slow the rate of homelessness in Canada's fastest growing city. The CHF has introduced key infrastructure to coordinate and anchor its system of care. Further coordination surrounding the strategic direction, logic model and an evaluation framework is required. With these guiding frameworks in place, the CAA program in Calgary will serve as a pillar in this city's goal to end homelessness.

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Program and Service-level Collaboration

1.2

WHERE'S THE CASH (CENTRALIZED ACCESS TO SUPPORTED HOUSING)?: EVALUATION OF A SINGLE POINT OF ACCESS TO SUPPORTED HOUSING

Trudy NORMAN & Bernie PAULY

Since the 1980s homelessness has been and continues to be a significant concern throughout Canada. The number of people experiencing homelessness in Canada is estimated to be 235,000 (Gaetz, Gulliver & Richter, 2014). Like other cities in Canada, the City of Victoria is grappling with issues of homelessness. There are more than 1,700 people who experience homelessness in one year and more than 1,000 people in need of permanent housing on a single night (Pauly, Cross, Vallance, Winn-Williams & Styles, 2013). Emergency shelter beds are often oversubscribed and capacity in recent years has been at 111% due to the use of additional mats on the floor in emergency shelters.

Addressing homelessness requires a multi-sectorial response with engagement of multiple partners. A key response to homelessness in many jurisdictions is the development of coalitions and 10-year plans to end homelessness. Such efforts were initiated in Victoria following a 2007 City of Victoria mayor's task force on breaking the cycle of homelessness, mental illness and addictions and the formation of the Greater Victoria Coalition to End Homelessness (GVCEH) in 2008. The GVCEH consists of over 50 agencies and corporate partners including municipal and community links with responsibility for the development of a plan to end homelessness by 2018. A key tenet of this and many other plans to end homelessness across Canada is the adoption of the principles of Housing First. These principles are "immediate access to permanent housing with no housing readiness requirements; consumer choice and self-determination; individualized, recovery-oriented and client driven supports; harm reduction and social and community integration" (Homeless Hub, 2015).

Housing First principles provide a philosophical orientation that can be integrated into a wide range of homelessness programs if the aim is to end homelessness. While Housing First programs are often premised on access to market housing, Housing First principles can be incorporated into social and supported housing programs, thus increasing opportunities for permanent housing and providing client choice in type of housing.

Direct access to market housing in Victoria is often challenging. Market units are unaffordable and unavailable for people experiencing homelessness and

those living on low incomes including those working for minimum wages or on social assistance (Pauly et al., 2013). As a result, an essential resource for people who are homeless or at risk of homelessness is access to social[1] and supported housing[2]. As of March 31, 2013 the waiting list for social housing in Victoria was 1,477 (Pauly et al., 2013). The number of people on the waiting list for social housing has remained relatively stable since 2006. Further, in order to access social and supported housing, individuals and families must navigate a complex and fragmented maze of services and resources (Albert, Pauly, Cross & Cooper, 2014; Pauly et al., 2013). For example, supported housing providers may have their own referral process, admission criteria and waiting lists often resulting in confusion and frustration for clients. In addition, clients are often required to access multiple income support services as well as health and other social services. To further complicate the situation when housing resources are limited and overprescribed, individuals may experience extended waiting periods on social housing lists for months or even years and in some cases never receiving housing.

"I had to actually ask what CASH stood for, and that was just a month ago. But when they said 'CASH referral,' I didn't know that it was an acronym, so I'm thinking cash referral, I'm thinking, okay, cool!"
– A client participant

In an attempt to increase access to housing, centralized intake or 'single point access' programs have been developed in the United States and the United Kingdom. The rationale for these programs is that a single point of entry to services provides individuals with easier access to information and needed supports in a timely way while providing more effective use of limited resources (Gaetz et al., 2014). Centralized services may include housing, case coordination, assertive case management or other health care services. In 2012, CASH (Centralized Access to Supported Housing) was established to improve equity in access to supported housing in Victoria.

In this chapter, our purpose is to describe the CASH program and provide an overview of the findings and insights from an initial program evaluation. We begin with some background on centralized programs, a description of the CASH program and our approach to evaluation. We then present the findings and discuss their implications and recommendations for improving such programs.

1. Social housing generally refers to housing whose rents are reduced through government subsidy. Here social housing refers to housing provided through the BC Housing Management Corporation.
2. Supported housing is defined here as a specialized form of social housing that integrates tenancy and onsite support services often seeking to house and support people with mental health and/or substance use concerns.

BACKGROUND

According to the United States Department of Housing and Urban Development (HUD), central intake has numerous potential benefits for service seekers, service agencies and planners (2010). For service seekers, a single point of access may simplify and accelerate access to the most useful services; for agencies it may provide an ongoing source of referrals, a clear picture of client needs, support interagency collaboration and reduce overlapping service functions and provide decision makers and funders with accurate information that will assist them in more effective service planning and provide data to support future service planning (HUD, 2010). A benefit of centralized intake services is the use of a common assessment instrument to collect information that is held in a single location. The Rapid Rehousing for Families Demonstration program in the United States in 2008 used a centralized intake tool because of the potential benefits to individuals and the system (HUD, 2010).

The Rapid Rehousing for Families Demonstration program in the United States in 2008 used a centralized intake tool because of the potential benefits to individuals and the system (HUD, 2010).

Burt and Wilkins (2012) suggest that coordinating access to supported housing for people who have experienced chronic homelessness can improve efficiencies and access to available housing. Further, Burt (2015) suggests that coordinating housing among a suite of care services for people who experience chronic homelessness may improve health outcomes and reduce the cost of care. A 'coordinated entry system' for accessing housing piloted in Los Angeles is emerging on the national level in the Housing for Health program within the Department of Health Services in the United States. Burt cautions that such coordinated efforts among service providers must however offer "an expanded supply of housing options… to find the best fit between homeless people with the greatest needs and the available housing options" (2015: 59). To our knowledge coordinated entry system efforts have not yet been evaluated.

In Canada, the Access Point[3], formerly known as Access 1 and the Coordinated Access to Supported Housing program, is operated by the City of Toronto Mental Health and Addictions services. The Access Point (accesspoint.ca) is a single online site where individuals who may be homeless and experiencing mental health and addictions issues or a professional working with them may apply for supported housing and assertive case management services in the Greater Toronto Area. The Access Point coordinates access to 4,000 housing units ranging from shared rooms in licensed boarding home situations to independent living in scattered site apartments. The Access Point has 20 staff and a budget in excess of $1M annually. Centralized access programs provide access to a range of housing types including access to market housing and programs which may or may not operate in accordance with Housing First principles.

Given the long waiting list in Victoria for social housing, it is clear that availability of this resource is limited for those who require only low cost housing. Further, there is limited availability of supported housing for people experiencing mental health and substance use concerns. Two previous attempts at coordinating access to supported housing in Victoria were abandoned, in part due to lack of access to a supply of social and supported housing. In an effort to improve access and efficient use of an extremely limited resource, supported housing units, service providers developed CASH in 2011 through the Service Integration Working Group (SIWG) of the GVCEH. The Victoria CASH program was launched in May 2012 and is funded and staffed by Island Health, one of seven regional health authorities in BC.

3. Please see theaccesspoint.ca for more information.

In early 2014, the authors were invited to undertake an evaluation of the CASH program in Victoria, BC. The focus of this evaluation was to provide feedback on the extent to which the CASH program objectives were being met and provide recommendations for improvements. Before describing the evaluation approach and findings, we provide an overview of the CASH program.

PROGRAM DESCRIPTION

The primary goal of CASH is to "streamline access to supported housing with a fair and equitable process for all people seeking… supported housing[4] in the Greater Victoria area" (Centralized Access to Supported Housing, 2013). Through a "cross-organizational hub"[5] format CASH staff coordinate referrals and facilitate placement of wait-listed participants in approximately 976 supported housing units in Greater Victoria. The vast majority of supported housing that is part of CASH is provided by six not-for-profit housing/support agencies. CASH includes the Streets to Homes program which provides housing and supports through 120 rent supplements to individuals placed in market housing. Streets to Homes is described as a Housing First program.

The objectives of the CASH program are:

- A fair and equitable process for all people accessing supported housing in the Greater Victoria area;
- A single community supported housing application that can be completed and submitted by any agency. CASH supports the motto – "Any door is the right door";
- Efficient use of community supported housing resources and timely referrals;
- Transparent, clear selection and referral process; and
- Shared best practices amongst housing providers.

The CASH program operates under a memorandum of understanding (MOU) between housing providers and Island Health, the local recipient of provincial health funding. The advisory committee oversees CASH, responding to challenges and changes in the operating environment. The advisory group consists of a senior manager from CASH partners and an Island Health representative responsible for the CASH program. The selection committee is comprised of managers/coordinators from partner agencies. Each provider is encouraged to have a staff person attend selection committee. Generally, three or four housing provider representatives attend selection committee meetings. Thus, the selection committee may have different partner agency representatives at each meeting with the exception of Island Health and CASH coordinating staff who attend all meetings.

The CASH office is co-located with two other Island Health programs near the downtown core of Victoria. The CASH program has three full-time staff members employed by Island Health. The office assistant manages the client database and waiting lists. A social program officer and occupational therapist 'facilitators' receive and ensure completeness of referrals, gather collateral information as required and present individual cases at selection committee meetings.

4. "Supported housing integrates tenancy with on-site support services and is intended for people who are managing multiple barriers including mental health and/or addiction issues; who, due to these issues, are experiencing homelessness or are at risk of homelessness; whose support needs cannot be managed with community supports" (Centralized Access to Supported Housing, 2013).

5. 'Cross organizational hub' means that the CASH program is the centre point through which the wait-listing process for supported housing is provided through the six partner agencies.

Selection and Wait-listing Process

The selection committee meets twice weekly totaling approximately four hours a week. Generally, six to eight referrals are reviewed at each meeting. Facilitators present details of the case. At the end of the case presentation and discussion, a decision is made to wait-list or not wait-list the client. Files of clients not wait-listed may be closed or, if new information comes from the community, amended and re-reviewed. Individuals who are not wait-listed may also be re-referred should their circumstances change. If the client is selected for wait-listing he or she is placed on those waiting lists that, in the opinion of the selection committee, best support the client. Committee members confer and come to an agreed upon score for each application on a scale of zero to 80 representing the level of client need and likelihood the client will benefit from supported housing services. The score determines the individual's place on the waiting list. Occasionally, only one program may be considered appropriate for a specific client based on the match between client needs and a particular housing program's supports. Generally, referrals are dealt with chronologically; however, individuals who are hospitalized at the time of referral[6] are prioritized for selection committee. Thus, the application of an individual who is in hospital will be finalized and reviewed at selection committee ahead of other referrals. If approved these applications enter the waiting list in the same way as other community referrals.

Each application on the waiting list is reviewed every three months to ensure that the client is still in need of supported housing. If the client has found other accommodation, has not been in contact with the referral agent or for other reasons no longer needs supported housing the application is closed and removed from the waiting list. In essence, clients are placed onto a waiting list and prioritized for supported housing when it becomes available.

OBJECTIVES OF THE EVALUATION

The objectives of the evaluation were:

1. To provide insights into the current operations of CASH, including successes, challenges and impacts of the program;
2. To determine the extent to which the CASH program is effective in meeting its intended objectives;
3. To identify the consistency of CASH principles with principles of Housing First;
4. To determine the level of participant, staff and partner agency satisfaction with the CASH program particularly in relation to the referral process in terms of fairness, equity and transparency; and
5. To identify recommendations that would increase the overall effectiveness of and stakeholder satisfaction with the CASH program.

Committee members confer and come to an agreed upon score for each application on a scale of zero to 80 representing the level of client need and likelihood the client will benefit from supported housing services.

6. Individuals may be in in-patient psychiatric care or acute care.

METHODOLOGY

Case study designs are characterized by drawing on multiple sources of data and inclusion of the sociopolitical context to better understand how the program operates and provide a useful framework for findings (Baxter & Jack, 2008).

A descriptive case study design was employed with the unit of analysis being the CASH program. Case studies aim to understand how phenomena operate in the real world (Stake, 1994; 2005) by accounting for the circumstances or context in which they are being implemented. Our interest was in evaluating CASH, a central registry for supported housing, and how such a registry operates within the broader sociopolitical and economic context of Victoria, BC. Case study designs are characterized by drawing on multiple sources of data and inclusion of the sociopolitical context to better understand how the program operates and provide a useful framework for findings (Baxter & Jack, 2008). Pauly, Wallace & Perkin (2014) argue that case study designs are appropriate for evaluating services for people who are homeless as the sociopolitical, historical and economic context that influence program operations may be taken into account rather than simply blaming programs and participants for lack of success. Further, these authors suggest that inclusion of user voices in case study-based evaluation can contribute important understandings of the program's operation and context (Pauly, Janzen & Wallace, 2013).

DATA SOURCES

For the evaluation we drew on multiple data sources including a series of 30 individual interviews, participant observations of CASH meetings and CASH program documents including program statistics. One researcher observed five meetings of the selection committee over a period of six weeks during December 2014 and January 2015. All participant interviews were audiotaped and transcribed verbatim. The data were coded line by line and analyzed inductively (Thorne, 1997) to elicit themes and gain an overall understanding of the current operation and outcomes of the CASH program. Thematic interpretation is enhanced and augmented by observations of selection committee proceedings and program data. The findings are situated within the sociopolitical and economic context of housing in Greater Victoria to further augment understanding of the CASH program and the extent to which it is meeting its objectives.

Participant Recruitment

Client participants were recruited through posters placed at several agencies serving people who experience homelessness. Interview opportunities were scheduled at each agency and clients indicated a willingness to participate by presenting themselves to the interviewers. Referral agents, housing providers, community and funding partners were recruited by email through a third party. These individuals indicated their willingness to participate by contacting the interviewers by email. Interviews were conducted at a convenient and private location of the participant's choice most often their office or a room at the GVCEH.

Participants

Thirty semi-structured individual face-to-face interviews were conducted lasting from 20 to 75 minutes. Participants came from all major CASH stakeholder groups. Interviews focused on program knowledge, experiences and suggestions for program enhancements.

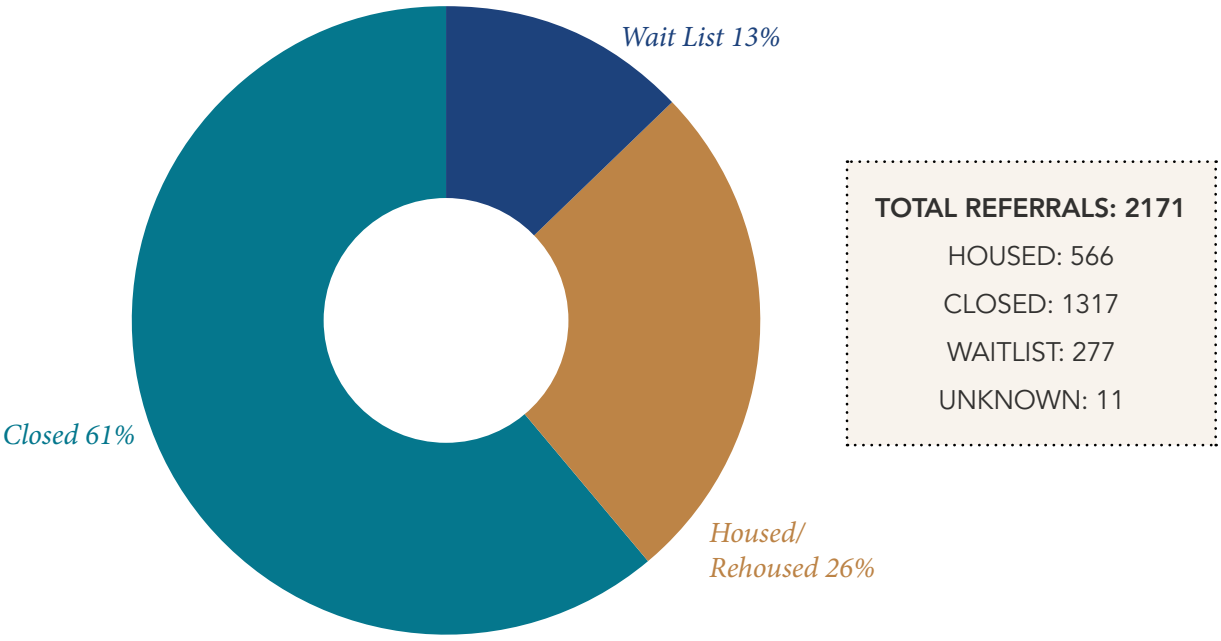
There were nine client participants with five identifying as male and four as female. They ranged in age from 31 to 60 years. Seven client participants identified as Caucasian, one as Aboriginal and one as other (Black, Asian or from Southern India). Clients were primarily staying at a shelter at the time of the study (six) with two sleeping outside and one person living in a supported housing program. Provincial disability assistance was the primary source of income for seven client participants and Canada Pension and Old Age Pension for two participants. Four client participants had college and university training; three had completed grade 12 and two completed at least grade seven.

The remaining stakeholders came from four groups including referral agents (eight), housing providers (seven), funding and community partners (three) and CASH staff. Eleven identified as female and nine as male. All were currently employed by either government or a not-for-profit social service agency.

Findings

During the three year period from June 1, 2012 to May 31, 2015, 2,171 referrals were received and assessed for placement on the waiting list. Of those referrals, 566 people were eventually housed and 1,317 referrals closed (see Figure 1). At the end of this period, there were 277 individuals (or 13% of all of those referred) on the CASH waiting list. The outcome of 11 applications is unknown. It is of note that 25% of those housed through the CASH process were already living in supported housing at the time of placement.

FIGURE 1 *CASH Referrals (June 1 2012 - May 31, 2015)*



OUTCOMES OF THREE YEARS OF CASH REFERRALS

In the analysis, several themes emerged from interviews, observations and document analysis. These themes are: one, CASH: A housing waiting list or a housing program?; two, CASH is a ticket in a supported housing lottery; three, CASH aims to be a fair and equitable process; four, lack of client engagement in the CASH process; and five, having CASH is better than not having CASH.

1. CASH: A housing waiting list or a housing program?

As described above, CASH provides access to a waiting list for housing. Housing providers may choose among several prospective tenants for each vacancy and thus make the final decision as to who is housed. It is not within the mandate of CASH to direct a provider to house any specific individual. Though this distinction is well understood by those closely involved with CASH, it likely creates confusion for others as documentation often refers to "accessing housing" rather than accessing the waiting list.

Through interviews and observations, it emerged that there was often a lack of understanding, information and transparency about the CASH program among users affecting their satisfaction with the program. One referral agent observed," CASH sometimes is thought of by people, both [those who] refer to it but certainly some clients, as this omnipresent beast that has tremendous housing, where technically it has no housing it's just a referral system." The referrer continued, "For the average person CASH becomes… housing. "I'm going to get housed through CASH.'"

The exact nature of CASH processes, where CASH is located, who the staff are and how the program operates was not entirely clear to many participants, particularly referral agents and clients. Among referring agents and housing providers there was reasonably clear knowledge of their role in the referral process but some referral agents did not know where the CASH office is located or had met CASH staff. One participant wryly noted, "CASH… that secret room in their secret building."

A majority of participants expressed a hope and indeed a belief that the wait-listing process was transparent. However, several admitted concerns around the application, review and process at selection committee. According to one referrer:

> *I think once you finish that application it feels like it goes off into the abyss… but I don't think it's very transparent as to what they do with it. Like what kind of information they gather and what the next steps are. I would have no idea what A through Z happens after I fax that referral to them.*

Many referral agents were not aware they could observe selection committee if they chose to do so. Basic information is available on the website yet critical processes such as information about review and selection seem difficult to discern. Few clients or referral agents knew of the CASH website or, if aware, used it. Others knew about the site but did not find it helpful. Though staff do outreach to various agencies to discuss the program, referral agents often lacked detailed information leading to questions of fairness in the wait-listing process.

For clients, what they believe CASH to be often varied greatly from reality. At best, clients knew a form needed to be filled out by a worker and that he or she would be placed on a waiting list for housing. A client participant noted:

Getting more information about CASH into the world, and what it is and what it does. Like I said, individual programs rather than, yes, it's centralized, but so what? You have centralized access to supportive housing, okay… What does that tell me, that I filled out this form and that I might eventually get contacted?

Most were unclear as to which agencies formed CASH and since clients may be placed in market housing through the Streets to Homes program, were very confused about which housing was part of CASH and what was not part of CASH. Generally, only referral agents may find out where an individual sits on a particular waiting list and must do so either by emailing or calling CASH. The website does not allow access to waiting lists for referral agents or clients.

We reviewed the length of time for each segment of the CASH process. We identified the median number of days from the time a referral is received until the client is wait-listed and until the client is housed. It may take up to 125 days for a decision to be made on a referral. Some referrals may never reach selection committee and others may be closed after review by the selection committee. The median number of days from receipt of referral to housed is 240 days. Clients must seek out the worker who referred them to receive updates on their waiting list status. This was challenging given the competing priorities facing clients with many opportunities for clients to be lost while in the wait-list process.

We identified the median number of days from the time a referral is received until the client is wait-listed and until the client is housed. It may take up to 125 days for a decision to be made on a referral.

In general, the CASH process was seen as lacking transparency, being slow and bureaucratic. A client reflected on his wait-list journey:

Yeah, the waiting part – it's the worst. Like I said, hope… it's the most powerful motivator we've got, is hope. But when there's no hope, it's the most powerful de-motivator we've got. Even if they don't say you're number one on the list, just saying, 'Yes, you're on the list. How're things going?' Check in, in a little bit. That would be so god damn helpful. Why don't they do shit like that?

This highlights the importance of providing information and transparency about what the program is and how it works but also the importance of clients and referrers having access to information about the status of their application.

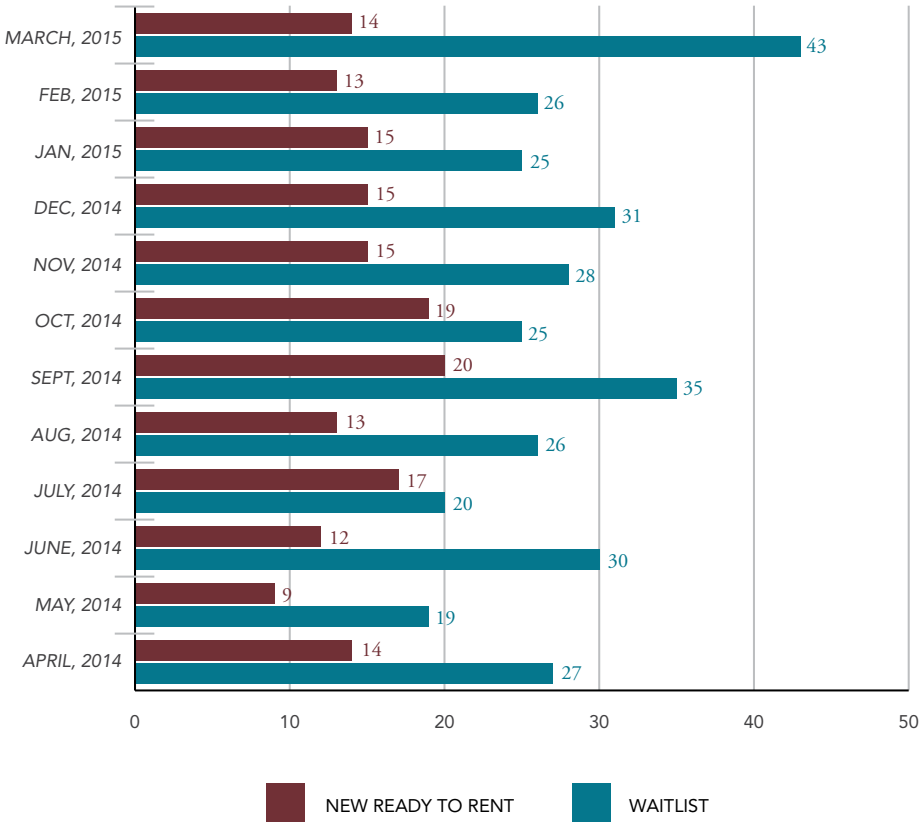
2. CASH: A ticket in a supported housing lottery

Current market conditions require that potential tenants pay more than 30% of their income on rent, making market housing unaffordable and market housing especially in the less than $700 range have a vacancy rate of about one percent (Pauly et al., 2013).

Every participant noted the lack of safe, adequate, affordable housing in the Greater Victoria area as a concern impacting homelessness and as essential to solving homelessness. Current market conditions require that potential tenants pay more than 30% of their income on rent, making market housing unaffordable and market housing, especially in the less than $700 range, have a vacancy rate of about one percent (Pauly et al., 2013). Supported housing is subsidized by government making rents affordable for individuals on various forms of income assistance and those who qualify for supported housing.

For the 2014/15 year, there were approximately 50 CASH referrals per month. Of those 50 referrals, approximately 28 referrals per month were wait-listed. In contrast, there were approximately 14–15 ready to rent supported housing spaces available on average per month (see Figure 2, below). Thus, the number of people being wait-listed per month exceeds the overall number of units available. As a result, there is an ongoing waiting list and inability to directly house people who are referred and met the criteria for placement.

FIGURE 2 *Number of People Waitlisted Compared to Vacancies Month by Month (2014/15)*



CASH then sits at the intersection of an affordable market housing crisis and access to supported housing. It is not surprising then that according to one CASH partner, "we are dealing with a housing stock that has a probably zero vacancy rate."[7] This means CASH must function in the untenable but required position of deciding who among an enormous group of those in desperate need should go on a list to wait for the prospect of receiving housing. One participant suggested the CASH process was more a "lottery for housing" rather than a process to obtain housing.

With the pressure of a large number of individuals seeking housing through the CASH process, there is a 'no-win' scenario for the CASH program staff, agency partners and, crucially, supported housing applicants. In the context of a scarce resource, CASH's primary goal of fair and equitable access to supported housing becomes paramount. To address this goal, strategies such as a detailed referral form, separation of referral and selection processes and prioritizing clients assessed as having the highest needs have been implemented.

3. CASH aims to be a fair and equitable process

Prior to the initiation of the CASH program in 2012 many providers kept individual waiting lists for their housing programs. Referral agents often depended on relationships with individual housing providers to facilitate housing placement. This could sometimes mean that a client with a strong advocate was housed before an individual on a provider's waiting list without such a person. Thus, access to housing was considered unequal at times. Separating referral and selection processes is aimed at promoting fairness and equity by removing referral agent ability to advocate for individual clients and facilitate appropriate matching of clients with a housing program. One result of this change is that referral agents often feel disconnected from CASH processes and unable to fulfill the advocacy role that is central to frontline work. Without this role referrers are often extraordinarily concerned with completing CASH forms in a way that will present their client as suitable for supported housing,

> *And so it's like you have to get this delicate balance. And so it becomes a bit of a game… Oh, I wonder who is going to review this. I have to say, okay, we can't make them [seem] too sick or they'll turn them down because they have too high needs.*

At selection committee, client files are reviewed and specific housing sites are recommended. A decision to wait-list or not wait-list is made at that time. Applications are scored to determine where each client sits on the waiting list. Clients with high needs and scoring in the range of 60–80 during the selection process are prioritized for housing placement. This means that a client placed on the waiting list today

7. One provider experiences a significant vacancy rate due to the transitional nature of their housing stock and difficulties locating wait-listed potential tenants quickly when vacancies arise. Individuals wait-listed for this program are often those who are staying in shelters or living outside and who may have no means of contact other than face-to-face interaction.

with a higher score will have a greater likelihood of being housed than someone who scores lower and who has been on the waiting list for six months or even two years. Scoring process at selection committee is "a best guess" according to one participant, based on all the available information. This includes information on the referral form, collateral information gathered by the facilitators, how a particular client is evaluated against scoring criteria and any knowledge a member may have of a particular client. Clients with lower scores and thus lower needs can remain on the waiting list for extended periods and may be unlikely ever to receive housing.[8] This reflects a process that prioritizes those with the greatest needs over first come first serve as the basis of fairness and equity.

Housing providers are requested to choose from among the three individuals from a CASH waiting list for any vacancy in a program. As often only individuals with high needs reach the top of the waiting list, providers may be faced with a program of all high-needs clients. This can put a good deal of stress on housing providers who must balance competing needs. As one provider noted, "The whole idea is to support the highest level of acuity that we possibly can, but still maintain some sense of… responsibility… to our neighbors. And in the building, the tenants have to be somewhat respectful of each other." He added:

> *So we review the … files of the individuals and then make the best choice, at that time, for that building. And what are the resources attached to the building? What neighborhood is that building in? So all of those things we take into consideration and we make a decision.*

Housing placement also depends on a referral agent remaining in contact with the client. Clients could sometimes not remember who referred them and, having heard nothing about their application, reapplied for CASH with another worker. This has resulted in some confusion both for clients and referral agents. Additionally, clients may lose a housing opportunity if they cannot be found when a vacancy occurs. Further, an application may be closed if the worker has had no recent contact with a client when an update by CASH staff is requested.

The CASH process does not allow for emergent situations, innovative or responsive approaches in housing placement. One participant noted that there is a "worry about any centralized process is that it becomes slow and bureaucratic and we only meet then, and we grind through this big list… and there's no way to deal with an emergency, a crisis, a special circumstance or to be nimble in situations where there's opportunities for thinking outside of the box." Thus how to be nimble in central access processes becomes an important consideration. For example, though shifting clients occurs 'in house' between programs of an individual provider, there is no simple mechanism for shifting clients between providers to achieve an optimum fit between client and level of supports in a particular program.

8. Clients who score lower, i.e. have lower needs, may be wait-listed for the Streets to Homes program, designed for those who can live in market housing with fewer supports.

4. Lack of client engagement in the CASH process

The CASH process lacks client involvement and choice. Participants across all sectors made note there was no place for clients in the CASH process. As one provider observed, "there is a lack of humanity… [CASH] eliminates the humanness side of it. And it just becomes a system and a number." Participants felt there should be a clear role for clients 'at the table' such as stating their case at selection committee, filling out the application form or accessing information on their wait-list status from their website or through other means. Notably, at the Access Point[9] program in Toronto, clients may fill out application forms online and begin the process of accessing supported housing and case management services. Access Point staff contact applicants directly to collect collateral information if necessary and individuals may either call or visit Access Point offices at any point to see the status of their application. Further, a client resource group (CRG) meets several times a year to provide input and feedback on Access Point services, processes and proposals for service changes.

One referral agent voiced the concerns of many around gathering client information – that such information may lead to a refusal for housing without a provider having an opportunity to interact or assess an individual applicant:

> *There's a lot of information that I don't think is really relevant to housing, especially if we're talking about hard to house people… I have a lot of issues with bringing information about a client upfront, before the workers ever meet that client. Like the historical record of violence form… If a client has never been into your housing before, certainly I can understand why you might want to know if that client has a history of violence, but at the same time… you should already have structures in place to be prepared for that.*

Or as another referral agent noted: "Is all this information really critical to make a final decision when it's a crapshoot [for housing] afterwards anyway?" Several participants expressed a concern about the potential for trauma and retriggering of trauma as part of the CASH referral process:

> *Not respecting the amount of trauma and emotional conflict that comes up when [they] constantly tell their life story over again. We're re-traumatizing them… and we're not even giving any supports after. I don't necessarily have the time… to properly debrief this person. Do I have the mental health resources to help them if I've now triggered their PTSD or whatever? And I've taken this information and can't really guarantee that it's going to be completely confidential. Now there's 10 other people sitting around reading their story.*

9. The Access Point information was gathered either from the website at theaccesspoint.ca or in conversation with Linda Brett, Access Point team leader, May 29, 2015.

While the CASH referral process aims to be fair and equitable, it was clear from participants, particularly clients as well as referral agents, that the lack of client engagement in the process was not only difficult and confusing but in some cases potentially harmful and re-traumatizing. People who have and are experiencing homelessness often suffer from past trauma, dismissal and lack of social inclusion. As described above, these experiences are reinforced and reproduced by the current lack of engagement in the CASH process. While it is not possible to quickly change the supply of housing, the CASH process could implement changes that humanize the process and reduce trauma for clients as well as connect them to other available services.

5. Having CASH is better than not having CASH

Though there are significant issues with the process many participants, particularly housing providers, viewed CASH as a useful approach that seeks to facilitate more fair and equitable admission to limited supported housing resources. Referral agents and housing providers often believe that CASH, as one referral agent suggested, "has certainly streamlined the housing process in Greater Victoria; it's reduced overlaps [of having] many waiting lists." Having one referral form is also seen as helpful. The ability to capture information through the database may provide support for new housing initiatives: "There's really good tracking and gathering of statistics, and I think that's very helpful in demonstrating what the issues are."

Bringing a range of housing providers to the table to work together has been an unexpected and valuable outcome of the CASH program according to one provider:

> *I think it's created a much improved relationship between housing providers because they're all part of the selection process and… the advisory committee. So I think that that's really been a benefit to develop those relationships with the different housing providers.*

A community partner offered:

> *I think the relationship between the housing providers and the health authority has strengthened… they're working together so much through CASH… I think the health authority has probably gained knowledge from the housing providers too. So I think there's been a deeper understanding both ways.*

A community partner summed his appreciation for the different way of working that the CASH program represents as follows:

> *I think access is one of the most highly coveted pieces of currency in any system. Who controls 'access'? So many different organizations have agreed to share that. That's a pretty remarkable thing, and I think that's at the core of this, and then from that brings, I think, a lot of other possibilities.*

DISCUSSION

CASH currently provides access to a waiting list of 976 supported housing units for people with mental health and addictions concerns who are homeless or at-risk of homelessness through six partner agencies in the Greater Victoria area. Given that referrals already come through community agencies that provide supports, the provision of supports is not part of the CASH referral process. CASH may be more clearly termed a referral process to access the waiting list for supported housing rather than a process to access supported housing. This subtle yet important distinction may further clarify and distinguish the role CASH plays in accessing supported housing. CASH then is a collaborative process that allocates a limited housing stock. Moving between housing sites, while potentially increasing efficiencies by achieving an ongoing better fit between client and level of support offered, does not result in increased vacancies.

Given the lack of supported housing, CASH offers a wait-listing service for those who seek supported housing. It does not offer direct access to housing or other programming. Streets to Homes, deemed to be a Housing First program, is a part of the CASH program and access to Streets to Homes is managed through the CASH referral process. CASH was not set up as a Housing First program. Given the current housing context in Victoria, it would be impossible for CASH to meet Housing First principles of directly placing people in housing or providing clients choice of placement into permanent housing.

Given the lack of supported housing, CASH offers a wait-listing service for those who seek supported housing. It does not offer direct access to housing or other programming.

Chief among the challenges CASH faces is a lack of affordable housing in Victoria, including a range of models and types of housing from supportive housing to market housing. Indeed, the need for more affordable housing was highlighted by all participants in this review and is consistent with previous research emphasizing the need for affordable housing to address the problem of homelessness (Pauly et al., 2013). Only adding new supported housing, new affordable housing stock or increasing rental supplements will effectively accelerate the CASH process or improve outcomes. Thus, we conclude that in order to be successful in contributing to ending homelessness, centralized access programs need to be coupled with an available and affordable supply of housing. This points to important questions about the role of CASH partners and other centralized programs in lobbying and advocating for increased investment in social, supported and affordable housing.

CASH then is stuck between a rock and a hard place in a sea of desperate individuals with little hope or likelihood of obtaining supported housing and a lack of 'mooring on the shore' (i.e. housing). As CASH is the process where the waiting list for supported housing is created and managed, it is then a focal point for concerns arising among stakeholders when individuals do not obtain housing. Recognizing the severely restrictive housing environment in which the CASH program operates there were several other issues of concern to participants.

The overall CASH waiting list is extremely long and there is often little movement, especially for sites that are suitable for many individuals. Obtaining housing once wait-listed is most often achieved by applicants designated as high needs. Those assessed with either very high or low needs are unlikely to obtain housing.

The CASH program is not well understood. Referral agents, clients and some providers lacked a clear understanding of CASH processes and processes are not transparent. As staff are the main interface with CASH, they must often deal with referral agent questions, concerns and frustrations with the wait-listing process. Staff also receive and respond to inquiries from client family members and the general public regarding the program. CASH staff were overwhelmingly viewed as doing their utmost with limited resources. Several referral agents and clients viewed a comprehensive and interactive website where they could find more information and where clients might check their wait-list status as one way CASH may be more transparent and accessible. Clearly, there is a need for attention to communication of program information and education about programs. In the CASH program, outreach by staff as well as opportunities to attend the selection committee were important strategies for providing awareness and education about the program. However, more is needed including printed materials and virtual resources such as a website that has detailed information about the process, provides FAQs and access to information about the status of applications for clients and referrers.

A significant concern for many participants is the lack of client involvement in CASH processes. There is no avenue for client input in the CASH process other than providing information at the time of completing the referral form. Indepth medical and social history information, that may require individuals to relive traumatic experiences, is gathered and shared among various individuals many of whom the client has never and may never meet. Completing the referral form is the only way to apply for supported housing. Thus, individuals are placed in the extraordinary position of enduring further trauma to gain a glimmer of hope that they will obtain the housing and supports they desperately need. As CASH is not an agile process there is little room for extraordinary situations or seizing opportunities that may arise.

Recent developments in HIV/AIDS (UNAIDS, 1999), substance use (Jurgens, 2005) and homelessness (Barrow, McMullin, Tripp & Tsemberis, 2007; Norman & Pauly, 2013; Owen, 2009) establish a view that services should be inclusive, designed and delivered in partnership with service users. The "nothing about us without us" motto developed by HIV/AIDS groups has been further taken up by peer-run organizations of people who use drugs and currently by people with lived experiences of homelessness. Increasingly, social inclusion and the right to participate in program development is being implemented as part of best practices in service provision and consistent with Housing First principles.

There are myriad ways that people who seek supported housing could be involved in CASH processes. Clients should have access to information about the status of their application and could be involved in redesigning CASH processes to be sensitive to client needs. With client input, referral forms and processes could be reviewed with a view to limiting information collected to only that most crucial for deciding waiting list placement. A balance should be sought between individual privacy rights and the need for adequate information to decide the most appropriate waiting list placement. A process for access to other types of referrals for those not deemed eligible for CASH should be given consideration. For CASH and any program, processes of meaningful client inclusion can and should be developed as part of the program.

The CASH program is also viewed as having several successes. A vast majority of participants believe that the process of wait-listing and accessing supported housing has improved since the implementation of the CASH program. Specifically, a single application and wait-listing process are desirable and seen as streamlining access to supported housing. Many participants hoped and a number believed accessing supported housing is now more equitable. Enhanced relationships among partners are welcome outcomes of the CASH program. Lastly, statistics now available through the CASH database may, through a variety of reports, provide evidence of the challenges CASH faces and point to potential solutions such as a need for more housing options and how groups of individuals such as people identifying as Aboriginal, individuals with complex needs and those in recovery may be better served by CASH or other programs.

The CASH program is also viewed as having several successes. A vast majority of participants believe that the process of wait-listing and accessing supported housing has improved since the implementation of the CASH program.

CONCLUSION

The primary question to be answered in this evaluation was: to what degree is CASH meeting its stated objectives? CASH clearly meets two of its stated objectives (a single housing application/access point and "any door is the right door" for submitting referrals). Several other objectives – a transparent and clear selection and referral process, timely referrals and efficient use of supported housing resources – are only partially met. This result stems from an intersection of four factors: a lack of affordable and supported housing, an unwieldy referral and wait-listing process, an absence of detailed information around waiting list processes and lack of client involvement and participation. We were unable to determine if housing providers are sharing best practices in delivering supported housing; however, there is evidence of enhanced relationships and collaboration among housing providers. Clearly, in the absence of an affordable supply of housing, it is impossible to align with critical Housing First principles such as direct and immediate access to housing, client choice and self-determination. However, principles of social inclusion and client participation could and should be incorporated given that such programs directly impact clients' lives.

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Program and Service-level Collaboration

1.3

L'ACTION INTERSECTORIELLE CLINIQUE : L'EXPÉRIENCE D'EMRII, UNE ÉQUIPE MIXTE POUR LES PERSONNES EN SITUATION D'ITINÉRANCE

Roch HURTUBISE & Marie-Claude ROSE

CROSS-SECTOR CASE MANAGEMENT: EXPERIENCE OF EMRII, A MIXED POLICE/SOCIAL/HEALTH TEAM WORKING WITH HOMELESS PEOPLE

Au Québec, la réponse sociale et politique privilégiée en matière d'itinérance a été le développement d'un réseau de services s'adressant spécifiquement aux personnes itinérantes (Roy et al, 2006; Fleury et al, 2014)[1]. Ce réseau est constitué d'un grand nombre d'organismes communautaires et de professionnels de différents secteurs qui œuvrent en collaboration pour offrir des services aux personnes. La situation québécoise se distingue par une longue tradition de concertation et de maillage, d'abord entre les organismes communautaires et ensuite entre l'ensemble des acteurs impliqués des réseaux de la santé, du social et de la sécurité publique. De ce point de vue, les solutions au problème de l'itinérance sont multiples et visent une diversité de finalités, de l'hébergement d'urgence à la réinsertion sociale en passant par la lutte à la judiciarisation et la défense des droits.

Plusieurs actions mises en place ont ciblé les difficultés d'accessibilité des services liées à la spécialisation, à la fragmentation et à l'absence de circulation d'information. Les approches de gestion de cas, d'approche et de suivi intensif dans le milieu, par exemple, se sont avérées pertinentes dans le soutien aux personnes, particulièrement pour celles ayant des problèmes de santé mentale, réputées difficilement accessibles par les interventions traditionnelles. Parmi les solutions originales développées, on retrouve les équipes en itinérance qui réunissent dans un même groupe de travail des professionnels de la santé et du social (Hurtubise et Babin, 2010; Hurtubise et Rose 2013). Ce chapitre concerne plus particulièrement une innovation de travail intersectoriel auprès des populations itinérantes, soit les équipes mixtes qui réunissent des professionnels de plusieurs secteurs, ici la sécurité publique, la santé et les services sociaux.

1. La politique du Gouvernement du Québec, Ensemble pour sortir de la rue (2014), repose sur cette logique de collaboration et de concertation entre l'ensemble des acteurs qui sont impliqués auprès des personnes en situation d'itinérance.

Les policiers sont fréquemment sollicités pour intervenir auprès de personnes itinérantes à la demande de citoyens et de commerçants qui jugent leur présence dérangeante[2]. Faute d'espaces privés, les personnes en situation d'itinérance occupent l'espace public et se retrouvent souvent en violation des règlements s'appliquant aux espaces publics ou privés. Sans compter qu'en raison de la grande précarité de leurs conditions de vie, elles recourent parfois à des activités jugées illégales (prostitution, vol, vente ou consommation de stupéfiants, squeegee, quête). Les tensions qui émergent de cette cohabitation avec les autres citoyens se traduisent par une pression auprès des autorités municipales et de la police pour répondre à cette présence jugée inquiétante. Les analyses de la criminalisation ont montré que les personnes qui vivent une situation d'itinérance, en vivant dans l'espace public et en adoptant des stratégies de survie, sont plus susceptibles d'être judiciarisées (Bellot et *coll.*, 2007, 2012).

L'idée que des pratiques d'intervention policière novatrices doivent être mises en œuvre afin de répondre au nombre croissant de personnes en situation d'itinérance fait consensus dans les milieux scientifiques et de pratiques. Si cette orientation est largement partagée et que des expériences d'équipes mixtes (policiers/intervenants sociaux et de la santé) ont été mises sur pied dans différentes villes aux États-Unis, peu d'études existent pour comprendre et évaluer l'impact et la perception de cette formule. L'initiative ici étudiée concerne le développement d'une équipe d'intervention spécialisée qui a vu le jour dans un contexte ou la judiciarisation de l'itinérance est dénoncée avec vigueur, sans toutefois que cette initiative prétende résoudre le problème de la judiciarisation dans son ensemble. L'Équipe mobile de référence et d'intervention en itinérance (EMRII), qui est l'objet de la recherche dont les résultats sont ici présentés[3], réunit des intervenants sociaux (travailleur social, éducateur spécialisé), des intervenants de la santé (infirmier) et des policiers.

2. À Montréal, les interventions policières auprès des personnes en situation d'itinérance sont fréquentes et complexes. Chaque année, le Service de police de la ville de Montréal (SPVM) doit répondre à plus de 10 000 appels de services qui contiennent le mot « itinérant » ou ses déclinaisons, auxquels s'ajoutent les nombreuses interventions effectuées par les policiers. Un dénombrement manuel indique une moyenne de 35 appels par jour qui contiennent spécifiquement « itinérant(s) », « itinérante(s) » ou « itinérance » (35 appels X 365 jours = 12 775 appels/année). Il s'agit d'une estimation conservatrice puisqu'elle n'inclut pas les cas où aucune référence n'est faite à la condition des personnes impliquées (ex. : « homme ivre couché dans la rue »), ni ceux où le libellé contient plutôt « sans-abri », « SDF », etc. (Boivin et Billette, 2012). Cette réalité est préoccupante pour le SPVM qui est dans l'obligation d'intervenir dans le cadre de sa mission première de protection et de gestion de l'ordre public.

3. Les deux institutions porteuses du projet ont mandaté les chercheurs pour faire un travail d'analyse de cette pratique et pour identifier des pistes qui pourraient permettre d'en assurer la pérennité. Les chercheurs impliqués dans le projet ont vu l'opportunité d'observer une innovation qui réunissait des professionnels issus d'organisations dont les mandats, les procédures et les stratégies d'action sont fort différents. Dans le cadre d'une recherche exploratoire, il s'est agi de problématiser les référents qui orientent le travail de l'équipe mixte SPVM – CSSS, mise sur pied en 2009 à Montréal. Les données ici présentées sont issues de cette recherche. (Rose, Baillergeau, Hurtubise et McAll (2012).

À LA FRONTIÈRE DE LA SANTÉ, DU SOCIAL ET DE LA SÉCURITÉ PUBLIQUE : UNE ÉQUIPE D'INTERVENTION

EMRII est un service de deuxième ligne de co-intervention entre des policiers du Service de police de la Ville de Montréal (SPVM) et des intervenants du Centre de santé et des services sociaux (CSSS) Jeanne-Mance. Portée conjointement par les deux institutions, cette petite équipe au mandat bien particulier doit innover sur plusieurs plans. En 2012, l'équipe est composée de 5 policiers du SPVM et de 4 intervenants du CSSS J-M (infirmière, travailleuse sociale, éducateur spécialisé, spécialiste en activités cliniques). Policiers et intervenants sociaux et de la santé travaillent à remplir la mission suivante :

> *Réaliser du travail de proximité pour rejoindre des personnes en situation d'itinérance ou à risque de le devenir qui font régulièrement l'objet d'interventions policières et présentent des facteurs de vulnérabilité; voir à les référer et/ou les accompagner vers des services appropriés en fonction de leurs besoins afin d'améliorer leurs conditions de vie et de favoriser leur réinsertion (Protocole d'entente sur la mise en place d'EMRII, 2011).*

Si le point de départ est le fait que ces personnes génèrent plusieurs interventions policières, il faut souligner que les personnes ciblées utilisent peu les services réguliers et présentent différents facteurs de vulnérabilité, santé mentale et toxicomanie, mais pouvant également inclure la déficience intellectuelle, des problèmes de santé physique, des traumatismes physiques ou des atteintes neurologiques. Souvent, on s'affaire autour de ces personnes dans un contexte de crises à répétition où l'intervention provient de la demande d'un citoyen dérangé ou gêné par une occupation de l'espace public jugée inappropriée ou par un comportement qui paraît inacceptable. Parfois, la « chronicité » et l'impression que toute intervention est vouée à l'échec viennent à bout de la patience à la fois des policiers patrouilleurs et des intervenants réguliers des services sociaux et de santé. C'est alors que les personnes sont référées à l'équipe spécialisée EMRII.

Au départ, tant les policiers que les intervenants de la santé et du social de l'équipe faisaient le constat d'une analyse de ces situations partielle, morcelée et incomplète. Le sentiment d'impuissance généré par ces situations étant notamment lié à l'impossibilité d'établir une collaboration continue avec les personnes en situation d'itinérance et à la difficulté d'accéder à des ressources disposées à les accueillir. La mise sur pied de l'équipe mixte se fait dans un contexte où l'intervention policière suscite de vives critiques. On pointe du doigt le profilage social et les impacts négatifs des interventions policières sur le parcours de réinsertion des personnes à la rue (entre autres, le Barreau du Québec, en 208, et la Commission des droits de la personne, en 2009). Si le SPVM souligne que la majorité des interventions policières envers les personnes à la rue ne sont pas de nature judiciaire[4], l'organisation va néanmoins noter dans ses nouvelles visions et orientations en matière d'itinérance (2009)

4. Dans la réponse aux personnes en situation d'itinérance, le nombre de résolutions sur le site et de transports à l'hôpital surpassent de beaucoup le nombre d'interventions qui se concluent par une arrestation ou un constat d'infraction (Boivin et Billette, 2012).

qu'il importe d'identifier les « *meilleures interventions policières pour qu'elles aient les effets escomptés (ex. : arrêter un comportement dérangeant, faire respecter la règlementation) tout en étant adaptées aux personnes itinérantes.* » On y reconnaît en outre qu'émettre à une même personne « *des contraventions à répétition en vertu du code de la sécurité routière ou des règlements municipaux a peu de conséquences sur les comportements qui provoquent l'intervention et peut nuire à ses possibilités de sortie de l'itinérance* […]. » (SPVM, 2009). C'est dans ce contexte qu'il est apparu pertinent pour les administrateurs du service de police de mettre sur pied une équipe spécialisée pour intervenir auprès de la population en situation d'itinérance qui représentait le plus de défis pour l'organisation policière.

Diverses études soulignent que l'intervention policière auprès de personnes en situation d'itinérance avec des problèmes de santé mentale donne lieu, outre des délais d'attente pour recevoir des services, à des traumatismes, des accidents et une criminalisation qui pourrait être évitée si les personnes étaient orientées vers les soins et services adéquats (Teller, 2006; Bellot et coll., 2005; Bellot et Sylvestre, 2012). L'absence de collaboration entre les policiers et le système de santé a été identifiée comme un des facteurs expliquant l'émergence du phénomène complexe de la judiciarisation des personnes souffrant de troubles mentaux (Alderman, 2003). D'ailleurs, aux États-Unis et au Canada, on observe une volonté de transformation des pratiques policières pour que les personnes en situation de marginalité souffrant de troubles mentaux soient dirigées vers des services plutôt que vers le système de justice (Compton et coll., 2014).

Les États-Unis ont été les pionniers des partenariats entre force de l'ordre et intervenants de la santé et des services sociaux pour répondre aux personnes à la rue (Compton et al., 2014, Steadman et al., 2000). Au cours des 25 dernières années, des policiers aux États-Unis et au Canada ont été formés afin d'agir à titre de répondants de première ligne auprès des personnes souffrant de troubles mentaux et en situation de marginalité vers des services plutôt que vers le système de justice (Compton & coll., 2008). Ces programmes, notamment basés sur une meilleure formation des policiers, mais également sur des collaborations avec le système de santé mentale, favorisent des solutions qui visent une amélioration de la situation des personnes. Ces partenariats se regroupent en trois catégories : le modèle de la police spécialisée, le modèle des patrouilles mixtes qui font de l'intervention de crise et le modèle des équipes mixtes en gestion de cas[5]. Les stratégies d'intervention préconisées par les policiers dans l'intervention auprès des personnes avec des problèmes de santé mentale varient selon les programmes mis en place, en établissant un continuum de réponses (approche de résolution de problèmes, techniques verbales pour désamorcer une crise, etc.), traitement (hospitalisation psychiatrique, désintoxication, évaluation psychiatrique, admission à l'hôpital), référence (ressource en santé mentale, hébergement) ou arrestation (charges criminelles, contravention, incarcération) (Adelman, 2003 ; Steadman et al., 2000). Parmi les différents modèles d'équipe réunissant santé et policiers aux États-Unis les initiateurs d'EMRII à Montréal vont particulièrement s'inspirer d'équipes de San Diego, en Californie qui semblait plus facilement transposable et qui correspondait mieux à l'idée de la collaboration entre deux organisations[6].

5. Dans le cas du modèle de la police spécialisée (crisis intervention team – CIT), des policiers sont spécialisés en techniques de désamorçage de la crise et ont une formation sur les enjeux de la santé mentale – dans chaque poste de quartier pour chaque quart de travail – pour améliorer les compétences de travail des patrouilleurs, réduire les risques de violence (à la fois pour les personnes interpellées et pour les policiers) et amener les personnes vers les services. Pour le modèle des patrouilles mixtes dans l'intervention de crise : les intervenants de la santé et les policiers patrouillent ensemble dans le milieu pour faire de meilleures évaluations des situations; référence aux services appropriés avec les outils conférés par chacune des institutions. Finalement, le modèle des équipes mixtes en gestion de cas met en commun les expertises de deux institutions afin d'apporter une réponse qui se veut durable (suivi à moyen et long terme) à des situations particulièrement problématiques dans l'espace public qui impliquent des personnes vulnérables.

6. Le Homeless outreach team (HOT) – est une équipe mobile ayant pour but d'intervenir en deuxième ligne auprès d'individus vulnérables, et à partir de laquelle on s'est inspirée dans la mise en œuvre de l'équipe mobile de référence et d'intervention en itinérance (EMRII).

Un des objectifs premiers d'EMRII est de privilégier des concertations entre des acteurs qui se caractérisent traditionnellement par l'écart de leurs philosophies d'action auprès des personnes à la rue. L'articulation entre les logiques d'action propres à la santé, aux services sociaux et aux policiers est inhabituelle. Si généralement, l'une commence là où s'arrête l'autre, dans le cadre de l'équipe EMRII se côtoient ces logiques d'action au sein d'une action commune. Une recherche exploratoire réalisée au cours d'une période de huit mois, entre mars et octobre 2012 permet de voir comment se fait concrètement ce travail commun. Comment cette rencontre de deux cultures professionnelles pour le moins contrastées s'opère-t-elle sur le terrain? À travers la description des trois moments de l'intervention « observer, analyser et agir », les logiques d'action, les espaces de collaboration et les registres d'intervention au sein de cette collaboration interprofessionnelle sont documentés.

Nous avons employé une méthodologie qualitative croisant travail d'observation, entretiens, consultation de la littérature grise et des dossiers institutionnels des usagers. Quatre semaines d'observation sur le terrain ont été effectuées, accompagnant au jour le jour policiers et intervenants dans leurs diverses interventions et assistant aux rencontres d'équipe hebdomadaires au cours desquelles sont discutés les enjeux d'intervention de l'heure. Dix entrevues, individuelles ou de groupe, ont été réalisées avec les professionnels de l'équipe afin de documenter certains suivis et les modalités de cette collaboration[7]. Sept entrevues ont également été réalisées auprès de personnes desservies par EMRII. Cette parole apporte un éclairage singulier dans la réflexion sur les retombées de cette équipe mixte.

7. Afin de favoriser la confidentialité des personnes, nous avons englobé sous le même vocable « intervenant » à la fois la parole de l'infirmière, de la travailleuse sociale, du spécialiste en activités cliniques et de l'éducateur spécialisé. Nous sommes par ailleurs conscients que ce choix tend à aplanir la spécificité des mandats et des points de vue des professionnels de la santé et des services sociaux qui ont des mandats spécifiques au sein d'EMRII.

DE LA COLLABORATION INTERSECTORIELLE À LA PRATIQUE INTERSECTORIELLE

L'équipe mixte propose une gestion de cas et un suivi intensif[8]. Dans leurs maraudes, policiers et intervenants demeurent en lien avec la personne, peu importe où elle se trouve : rue, hôpital, prison, refuge, centre de désintoxication, ressource communautaire. Cette équipe fait le pari d'inscrire le travail intersectoriel au cœur même de la clinique. L'espace d'intervention est celui de la rue, des lieux fréquentés par la personne auxquels s'ajoute la voiture de police, qui joue parfois le rôle de salle de réunion de l'équipe. La pratique se situe à l'interface des personnes et des services en travaillant simultanément deux axes : 1) la continuité et la complémentarité entre les acteurs en itinérance impliqués dans une situation donnée[9] et 2) l'accessibilité pour les personnes à des services adaptés à leurs besoins et susceptibles d'améliorer leurs conditions d'existence. Cette équipe constitue à la fois un filet de sécurité et de contrôle plus dense que ce que les institutions respectives sont habituellement à même d'offrir.

Les professionnels doivent travailler en concertation tout en étant tributaires de diverses obligations institutionnelles et corporatives, en bénéficiant d'une marge d'autonomie différente et en étant soumis à des formes de redditions de compte variables. Comment se décide et se partage l'intervention dans la rencontre de deux cultures d'intervention : gestion de l'ordre public/promotion de la santé et insertion sociale? Pour les professionnels impliqués au départ de l'équipe, le risque est double : celui de remettre en question ses repères et son fonctionnement en travaillant de manière inhabituelle, celui de se voir marginalisé dans sa propre organisation parce qu'on se transforme comme professionnel et devient susceptible de perdre sa légitimité de travailleur social, de psychoéducateur, d'infirmier ou de policier.

Les collaborations interprofessionnelles ont beaucoup été étudiées au sein des services de santé et des services sociaux (Reeves, 1996; Dupuis et Farinas, 2011). Si ces travaux considèrent des collaborations entre des univers à priori plus proches que ne le sont la santé/services sociaux et la police, ils nous permettent néanmoins d'identifier certaines dimensions relatives aux collaborations entre les secteurs d'activité qui se réunissent autour d'objectifs communs. Le concept de la collaboration interprofessionnelle poursuit deux objectifs :

> *Thus, the two constant and key elements of collaboration are: (1) the construction of a collective action that addresses the complexity of client needs, and (2) the construction of a team life that integrates the perspectives of each professional and in which team members respect and trust each other. The two purposes appear to be inseparable, inasmuch as one cannot collaborate without having taken the time to develop a collective life, and there is no use in developing a collective life without having first established the need to collaborate in responding to identifiable patient needs. (D'amour et al, 2005: 127)*

La collaboration interprofessionnelle qui se développe

8. EMRII a offert un suivi intensif à 95 personnes entre l'automne 2009 et l'automne 2012 (suivi d'une durée moyenne de treize mois). Plus de 150 autres personnes ont aussi reçu directement ou indirectement une aide ponctuelle de la part de l'équipe, afin de les orienter vers les services, d'arrimer les services entre eux et d'orienter le travail des patrouilleurs.

9. Services publics (hôpitaux, services sociaux, santé publique), policiers, réseau des organismes communautaires et divers acteurs concernés par ces populations, tels que le voisinage, les commerçants ou les propriétaires d'appartement.

dans un contexte intersectoriel est d'autant plus complexe qu'elle implique des organisations et des secteurs qui ont leur spécificité de fonctionnement. Tout en se rassemblant autour d'un but commun, les individus, groupes et organisations impliqués dans la collaboration interprofessionnelle ont des intérêts, des références et des agendas variés, voire conflictuels. La mise en œuvre d'une équipe d'intervention intersectorielle suppose un travail important de collaboration et de co-intégration (Axelsson et Axelsson, 2006).

Au départ, les organisations impliquées ont élaboré un protocole pour baliser les objectifs de l'équipe et son fonctionnement. Dès le départ, les promoteurs de l'équipe veulent favoriser une plus grande intégration des pratiques policières avec celles des services de la santé et du social.

PROMOUVOIR LA SANTÉ ET L'INSERTION SOCIALE, ASSURER LA SÉCURITÉ PUBLIQUE ET LA COHABITATION HARMONIEUSE : DES POINTS DE VUE DIFFÉRENTS

Du côté de la santé et des services sociaux, une expertise des enjeux liés à l'intervention en itinérance existe déjà au CSSS J-M au moment de la création de l'équipe mixte. Les intervenants de la santé et du social qui composent l'équipe EMRII favorisent les pratiques d'intervention de gestion de cas et de suivi intensif auprès des personnes en situation d'itinérance. Les caractéristiques du travail des équipes de suivi intensif issues de la santé et du social peuvent être résumées de la manière suivante : a) le dépistage proactif (outreach) qui cherche à rejoindre la personne là où elle est, c'est-à-dire dans les rues, les ressources, les espaces publics (parcs, métro) et semi-publics (hall d'immeuble, centre d'achats) dans l'objectif de bâtir un lien et d'assurer un suivi; b) le dépistage et la liaison qui visent à développer les collaborations avec les autres professionnels; c) le travail de liaison avec divers milieux – communautaire, justice, santé, etc. – qui favorise le développement d'un réseau de services et la complémentarité des ressources; d) la défense des droits et la protection des personnes, à travers la dénonciation des abus, la sensibilisation à la discrimination ou l'assurance que les personnes peuvent évoluer dans un environnement sécuritaire et salubre; e) la prévention de l'itinérance auprès des personnes qui sont inscrites dans des trajectoires susceptibles de leur faire vivre diverses ruptures et de se retrouver à la rue (Hurtubise et Babin, 2010 : Denoncourt et *al*, 2007). Ainsi, on va au-delà des objectifs de traitement, de la prévention de la santé et de la réduction des méfaits, pour inclure la promotion du bien-être au sens large, voire la justice sociale. Une partie importante du travail a consisté à traduire, expliquer et susciter l'adhésion des policiers à ces orientations.

Les interventions répétées des policiers patrouilleurs auprès de ces personnes sont de nature multiple, mais elles sont souvent liées à leurs conditions de vie précaires (dont la nécessité de subvenir à leurs besoins de base dans l'espace public) et aux multiples problématiques avec lesquelles elles sont aux prises. Confrontés à des plaintes et des désordres bien réels, les policiers doivent intervenir à l'aide des outils dont ils disposent. Si ce sont régulièrement des citoyens qui appellent Urgence santé pour signaler l'état inquiétant d'une personne à la rue, ces citoyens ne demandent pas nécessairement une judiciarisation de cette population : ils souhaitent que soit apportée une réponse à une situation qui dérange.

Du côté des policiers, les approches privilégiées lors de la mise en place de l'équipe s'inspirent des pratiques de police communautaire et de police préventive. Elles ont comme point commun de recadrer le mandat d'assurer la paix et l'ordre dans un cadre plus général de collaboration avec la population et de recours à des pratiques de dialogue et de médiation (Reisig et Kane, 2014). Dans la foulée du renouvellement des politiques de sécurité urbaine, on doit la notion de « police de résolution de problème » à Goldstein (1979) qui établit la nécessité de s'intéresser à l'origine des problèmes, particulièrement dans les cas de sollicitations répétés à la police. Voici quelques caractéristiques principales de l'approche de « résolution de problèmes » (Brodeur, 2011; Jenkins, 2014) :

- La police devient une agence dont les objectifs et les missions *dépassent le maintien de l'ordre*.
- Les outils conventionnels (arrestation, emprisonnement) ne sont plus des priorités; ils peuvent même être à éviter si leur emploi menace la cohésion du quartier ou la confiance des citoyens. Ceci est possible en partie parce que la performance policière n'est plus mesurée par les arrestations.
- En parallèle avec la variété des problèmes, la résolution de problèmes suppose que le policier puisse, et doive, établir des partenariats pour « régler » le problème.

EMRII s'inscrit dans le modèle d'une police d'expertise axée sur la résolution de problèmes afin de réduire la congestion créée par les interventions à répétition mettant en cause des personnes en situation d'itinérance.

LE QUOTIDIEN DE L'ÉQUIPE : DIVISION DES RÔLES ET INTÉGRATION HORIZONTALE

La division du travail au quotidien entre les divers professionnels sera souvent discutée au sein de l'équipe. Les rôles sont peu à peu précisés, par un travail de reformulation des rôles dans un contexte de collaboration. Nommer explicitement les rôles permet de préciser la place de chacun au sein des différents suivis : à la fois pour optimiser le travail et pour éviter les dérives qui consisteraient à manquer à ses devoirs professionnels. Au SPVM, le mandat premier dans le cadre d'EMRII est de supporter les patrouilleurs dans des interventions difficiles et récurrentes. Au CSSS, le mandat premier est d'améliorer les conditions de vie des personnes. Avec le temps, les divers professionnels de l'équipe s'entendent pour dire qu'EMRII se situe aux points de rencontre de ces mandats.

Pour penser l'action de manière plus intégrée, les membres de l'équipe ont dû développer une intégration horizontale de leurs pratiques, c'est-à-dire un maillage des actions qui vise plus de cohérence et une meilleure efficacité. Ce travail en « inter », c'est-à-dire selon les mandats et expertises de chacun, propose une articulation des rôles de chacun.

Le rôle des policiers EMRII diffère sensiblement de celui des policiers patrouilleurs habituels. Il s'agit d'un travail de deuxième ligne permettant de prendre la relève de situations complexes en y répondant par des pratiques de résolution de problème, de prévention, de médiation et de concertation. Au sein d'EMRII, le rôle des policiers consiste à favoriser une cohabitation harmonieuse, à assurer la sécurité publique, à répondre aux patrouilleurs et aux demandes des citoyens. Plus spécifiquement, il s'agira de faire une évaluation de l'espace public :

1. Rassembler les informations pour dresser un portrait des comportements d'un individu dans l'espace public (nombre d'appels et d'interventions, motifs d'interpellation, types de comportements).
2. Évaluer le danger pour la personne en situation d'itinérance et pour la communauté.
3. Établir un lien de confiance avec les personnes desservies, approche de la résolution de problèmes pour réduire le nombre d'interventions policières auprès des mêmes personnes, réduction de méfaits, prévention et sensibilisation aux services existants.
4. Établir un lien avec divers acteurs (patrouilleurs, système de justice, commerçants, résidents) pour favoriser une cohabitation harmonieuse et veiller à la sécurité publique. Démarches judiciaires et pénales. Informations et recommandations aux patrouilleurs.

Dans cette évaluation, les policiers s'intéressent de manière plus prépondérante aux motifs d'interpellation policière[10] et à la nature des demandes de l'environnement de la personne (commerçants, résidents). La nécessité de s'impliquer dans un suivi et le type d'interventions réalisées sont déterminés selon l'axe suivant :

Pour les intervenants de la santé et des services sociaux, les rôles sont de favoriser la santé et l'insertion sociale, de répondre aux besoins des personnes et de les arrimer aux services. Pour ce faire, il s'agit de faire une évaluation de la situation de la personne :

1. Évaluation de la situation et des besoins de la personne (vulnérabilité) – ce qui nécessite un certain temps, plusieurs mois, voire plus.
2. Évaluation des risques, mise en place des facteurs de protection et des filets de sécurité. Élaboration de plans d'intervention.
3. Travail d'accompagnement, de création de lien, approche motivationnelle, réduction des méfaits. Aller avec la volonté de la personne lorsqu'elle n'est pas évaluée comme un danger pour elle ou pour autrui.
4. Travail en lien avec divers acteurs (professionnels de la santé – hôpital, équipe traitante externe, psychiatre, prison, CLSC, pharmacie – et des services sociaux, propriétaires, voisinage, famille) pour favoriser une réponse aux besoins de la personne. Travail d'arrimage et de défense du droit à l'accès aux services.

10. Parmi les motifs d'interpellation, notons : des transports ambulanciers qui demandent une assistance policière, des entraves aux règlements municipaux, des appels au 911 par des citoyens qui s'inquiètent de l'état de santé d'une personne, des plaintes de résidents liées à la cohabitation dans l'espace public, des bris de condition de probation, des méfaits.

Dans cette évaluation, les intervenants de la santé et du social vont considérer les divers facteurs de protection et les facteurs de risque qui caractérisent la situation et l'état d'une personne. L'évaluation sera réalisée en considérant différentes dimensions à situer sur l'axe suivant :

Parmi les facteurs de protection que considèrent les intervenants du CSSS on retrouve : répondre à ses besoins de base (se loger, se nourrir, se vêtir), être orienté, avoir les capacités de ne pas se mettre en danger, avoir un réseau social, fréquenter les ressources, avoir un revenu, etc.

Parmi les facteurs de risque on retrouve : personne au jugement altéré, déficience intellectuelle, personne dont les besoins de base ne sont pas répondus, problème de santé mentale, problème de santé physique, isolement, perte d'autonomie, atteintes neurologiques, etc.

Les intervenants d'EMRII se partagent les dossiers selon ce double processus d'évaluation d'occupation de l'espace public et de la situation de la personne. Ils forgent alors une vision plus intégrée où ces deux finalités d'évaluation ne sont plus vues de manières contradictoires. Pour chaque suivi, les intervenants du CSSS vont élaborer un plan d'intervention, un outil clinique qui vise à établir les capacités et les besoins d'une personne, et à trouver des moyens et ressources pour l'accompagner vers un mieux-être, en mobilisant différents acteurs autour d'elle. Le rôle de l'infirmière, de la travailleuse sociale et de l'éducateur spécialisé y sont spécifiés en fonction des objectifs poursuivis dans la relation d'aide.

TROIS MOMENTS DE L'INTERVENTION EMRII : OBSERVER, ANALYSER ET AGIR

Les pratiques d'EMRII font l'objet de diverses négociations entre les professionnels de l'équipe et peuvent être décrites en trois temps : observer, analyser et agir. Ce découpage est théorique. Il nous permet de cerner les moyens trouvés pour concilier les exigences des divers professionnels. Dans la pratique, observation, analyse et action se chevauchent; une intervention auprès d'une personne permettant d'avoir de nouvelles informations à partir desquelles sont analysées la situation et les stratégies d'action. La réflexion sur cette pratique de gestion de cas fait partie du quotidien des professionnels, ils se questionnent régulièrement sur leur lecture d'une situation, le bien-fondé de leur action ou leur compréhension d'une dynamique.

Nous verrons dans ce qui suit que la rencontre de deux institutions donne lieu à divers débats cliniques et éthiques, balisés par les mandats des institutions partenaires et les rôles des professionnels de l'équipe. Parmi les zones grises au sein desquelles se négocie et s'aménage l'intervention, notons : le rythme de l'intervention; l'échange d'informations vs la confidentialité; l'accompagnement des personnes vs l'arrêt d'agir; l'évaluation des risques; l'obligation de résultat vs l'obligation de moyens; la place des différents acteurs autour de la personne.

Observer

Observer : rassembler les informations au sujet de la personne référée et établir un portrait d'ensemble qui tient compte de divers paramètres tels que la santé, les capacités, les besoins, les interventions policières et les comportements dans l'espace public. Comment les informations sont-elles partagées au sein de l'équipe et comment servent-elles dans l'intervention pour solliciter les acteurs autour d'une personne?

La diversité des points de vue, qui constitue l'essence même de la collaboration interprofessionnelle, est aussi un des plus grands défis qu'elle rencontre. Les professionnels ne regardent pas les situations avec la même lunette et de ce fait, ils ne voient pas tout à fait la même chose. Un enjeu central est que les informations et les pouvoirs d'action que possèdent les policiers et les intervenants de la santé et des services sociaux soient mobilisés dans une même direction, c'est-à-dire qu'on tente d'avoir une vision d'ensemble de la situation de la personne.

Au départ de la plupart des dossiers, les membres de l'équipe ne savent pas « dans quoi ils sont ». Dans la pratique, parmi les personnes référées par les patrouilleurs à l'équipe EMRII, il n'est pas toujours aisé de savoir si on s'adresse effectivement à des personnes en situation d'itinérance et qui présentent un cumul de facteurs de vulnérabilité. Un suivi débute par un travail pour rassembler les informations au

sujet de l'état de santé, ainsi que des préoccupations liées à la sécurité publique et à la cohabitation. Ce que signifie « documenter un dossier » est différent selon les professionnels : obtenir les informations pertinentes, les stratégies pour les obtenir, l'analyse à en faire. .

Pour les policiers, documenter un suivi consiste à rassembler l'information sur les interventions policières et sur les comportements d'une personne dans l'espace public, notamment à partir des banques de données du service de police. Puis, tout au long d'un suivi, une recherche constante s'opère pour connaître les nouvelles interventions policières, les interpellations, les transports hospitaliers, les comparutions à la cour, les conditions émises par un juge dans les bases de données et par des échanges directs avec un réseau d'observateurs constitué d'autres policiers. Ce travail de documentation permet d'observer la trajectoire d'une personne dans le réseau des services, de saisir les mouvements inhabituels qui pourraient être significatifs d'une modification du comportement et symptôme d'une aggravation de la situation. L'observation prend la forme d'une vigie qui poursuit un double objectif : avoir le meilleur portrait possible des déplacements de la personne et sensibiliser le réseau de policiers au fait qu'un suivi est en cours et que les comportements problématiques d'une personne doivent être observés dans une perspective plus globale.

Au CSSS, documenter la situation d'une personne consiste à aller à sa rencontre, là où elle se trouve pour s'informer de ses besoins et de ses demandes. L'information obtenue lors de ces rencontres dans le milieu de vie des personnes permet de cerner les potentiels, les ressources et les forces de la personne de manière plus sensible. Cette prise en compte du point de vue de la personne est complétée par l'information obtenue auprès d'intervenants et de la consultation des dossiers médicaux et psychosociaux, afin de reconstituer le plus fidèlement possible l'histoire médico-sociale. Puisque la frontière entre la part toxicomanie et la part santé mentale d'un problème est souvent mince, la consultation d'autres professionnels est fréquente pour clarifier les enjeux d'une situation. Tout comme le font les policiers, les intervenants assurent une vigie pour connaître les déplacements et la mobilité de la personne. On s'informe auprès de la personne elle-même, on fera également appel à l'environnement de la personne (intervenants, travailleurs de rue, autres personnes en situation d'itinérance).

Pour les membres de l'équipe, cette collaboration par la mise en commun des stratégies d'observation favorise un meilleur suivi des personnes dans la communauté, en permettant d'avoir un portrait plus complet et plus global. Dans ce contexte, l'événement dérangeant peut souvent être interprété dans un contexte plus large, ce qui peut dans certains cas éviter qu'on agisse trop rapidement sur une situation en choisissant de la judiciariser. En fait, tant les policiers que les intervenants santé/social ont une expertise de la rue, une capacité à dresser un certain portrait d'une situation qui permet d'enrichir l'observation. La mise en commun de ces expertises permet une efficacité plus grande, par exemple parce qu'on réussira plus facilement à retrouver une personne ou qu'on comprendra mieux son état à la lumière d'événements récents (crise, interpellation, etc.).

Les points de vue divergent au sein de l'équipe quant à l'usage des informations disponibles au sujet des personnes. La confidentialité et le respect du droit à la vie privée des personnes desservies constituent des balises centrales du travail des intervenants du réseau de la santé et des services sociaux. En ce sens, ils sont prudents sur la transmission des informations. Hormis dans les situations où on estime devoir protéger la personne ou son environnement d'un danger immédiat, le consentement de la personne est requis pour partager des informations aux fins de l'intervention. En fait, pour tout autre professionnel que le policier, l'usage non consenti de l'information constitue une violation caractérisée des libertés individuelles. Aussi, ce risque n'est-il pas vécu de la même manière chez les policiers, pour qui la transmission de l'information sur les comportements des personnes est une pratique plus courante lors de leurs échanges avec les services de santé.

Par ailleurs, il importe pour les policiers de l'équipe de pouvoir informer les patrouilleurs sur les suivis en cours afin de solliciter leur collaboration dans le cadre d'interventions auprès des personnes suivies par EMRII. Fournir certaines informations aux patrouilleurs permet d'avoir la crédibilité nécessaire pour que ces derniers adhèrent aux stratégies d'intervention proposées. D'un point de vue clinique, les intervenants du CSSS reconnaissent que le partage des informations entre les acteurs est essentiel pour éviter les ruptures de services et permettre un meilleur accès aux soins. Dans certaines situations, on estime également qu'il faut divulguer certaines informations dans une visée de gestion des risques. Ainsi, s'il ne faut pas tout dire, il faut doser entre ce qui peut être dit et la manière dont il est possible de le dire. Cette question se pose particulièrement pour le diagnostic ou encore les antécédents personnels et familiaux. Dans le cadre du travail des policiers pour communiquer avec les patrouilleurs, les intervenants du CSSS veulent être consultés afin de respecter le droit à la vie privée des personnes desservies[11]. On se retrouve ici avec des cultures professionnelles différentes en matière d'éthique.

Analyser

Analyser : évaluation des risques et réflexions sur la relation d'aide : prioriser la demande, respect du rythme, accompagnement, se positionner à l'égard des rapports de pouvoir dans l'intervention. Quelle intervention servira au mieux la personne, tout en respectant la sécurité du public et une cohabitation harmonieuse? Quels sont les enjeux cliniques et éthiques soulevés par le travail de collaboration?

Une importante partie du travail de collaboration de l'équipe mixte va consister à convenir du registre dans lequel se situe l'intervention avant de passer à l'action. Le choix des actions à réaliser est continuellement évalué à la lumière de la relation avec la personne, des nouveaux faits et informations, ainsi que des stratégies d'intervention antérieurement déployées. Les informations colligées par les différents professionnels au sujet d'une personne et d'une situation permettent de faire une première analyse qui consiste à évaluer les risques et à déterminer si la personne est dangereuse pour autrui ou pour elle-même. Dans ces situations exceptionnelles, on réagit rapidement par une demande d'évaluation médicale ou une garde préventive. Les intervenants du CSSS reconnaissent ici aux policiers une expertise dans la lecture de l'environnement et du risque. Dans la majorité des situations, on parle moins d'intervention d'urgence que de la recherche de solutions à moyen et long terme et de la planification des interventions. Au sein de cette collaboration, les intervenants de la santé et du social chercheront à favoriser une vue d'ensemble et une analyse approfondie, ce qui s'inscrit parfois à contre-courant des habitudes de travail des policiers qui sont plus souvent

11. La mise en œuvre d'un « tableau des recommandations » à l'intention des patrouilleurs de différents postes de quartier a soulevé des enjeux éthiques en ce qui concerne le respect de la vie privée et le droit à la confidentialité. Ce tableau de recommandations au sujet des différents suivis en cours qui sert à informer les patrouilleurs du travail de l'équipe et des recommandations d'intervention est un outil important pour les policiers EMRII. Une pratique se mettra en place où l'information divulguée sera d'abord entérinée par les intervenants du CSSS.

dans l'intervention d'urgence et le court terme. Pour que l'analyse d'une situation bénéficie du point de vue de chacun, il est nécessaire de convenir d'un mode d'échange et de discussion.

Globalement, l'analyse réalisée au sein de l'équipe EMRII consiste à situer la condition de la personne et les enjeux liés à son occupation de l'espace public pour établir des priorités d'action qui peuvent ou non impliquer un suivi de l'équipe. Lorsqu'on décortique les situations observées, cinq cas de figure peuvent être identifiés. Dans certaines situations, (1) la personne est évaluée dangereuse pour elle-même ou pour les autres et l'équipe mixte ou les acteurs autour de la personne visent un arrêt d'agir dont l'objectif est de mettre un terme à un comportement problématique – via l'incarcération ou l'hospitalisation. L'équipe reste en lien avec la personne et communique avec le personnel hospitalier ou la cour afin d'offrir un portrait d'ensemble de la situation et de favoriser que la personne accède aux services dont elle a besoin. Un deuxième cas de figure (2) est celui où la personne est évaluée très vulnérable : il y a hypothèse d'inaptitude en lien avec des problèmes de santé mentale ou de déficience intellectuelle, et, à côté du travail d'accompagnement de la personne, il y aura d'importants efforts, dans une optique de protection, pour sensibiliser son environnement à sa situation, l'arrimer aux services et éviter qu'elle soit judiciarisée. Dans un nombre important de situations (3) la personne est considérée vulnérable en ce qu'elle cumule plusieurs difficultés (toxicomanie, santé mentale, santé physique, perte d'autonomie), constituant le troisième cas de figure. Le travail de l'équipe est alors d'accompagner la personne en misant sur ses capacités et le respect de ses choix, de proposer de nouvelles avenues et de l'arrimer à divers services, mais également de concerter les acteurs qui l'entourent, et d'agir à titre de médiateur vers de meilleures conditions de vie et trouver des alternatives à la judiciarisation. Un autre cas de figure (4) est celui de la personne dérangeante ou marginale, mais qui après évaluation de ses capacités et de ses limites, est considérée comme relativement bien outillée (on ne parle pas de problème de santé mentale ou d'incapacités importantes.) On relaye alors ces situations qui suscitent des appels récurrents aux policiers à une prise en charge habituelle par la justice. Dans des cas exceptionnels, les policiers EMRII vont travailler activement pour favoriser la judiciarisation, qui apparaît dans ces cas comme la seule solution possible pour répondre aux plaintes des commerçants et des résidents. Finalement, quelques dossiers concernent (5) des personnes vulnérables ou très vulnérables ayant été référées par des patrouilleurs bien qu'elles suscitent peu d'appels policiers, mais pour qui l'on s'inquiète. Les policiers sont ici essentiellement dans un rôle de prévention et d'entraide, en appui au travail des intervenants du CSSS qui vont miser sur la création du lien, l'arrimage aux services et la défense de droits. Le travail de l'équipe visera alors à favoriser la cohérence des interventions à la fois policières et de santé pour contribuer à la réinsertion sociale des personnes.

À travers les années de travail, les policiers EMRII parlent d'une certaine tolérance à l'impuissance dans l'intervention, forgée à même l'expérience de terrain, identifient le droit à l'autodétermination et reconnaissent aux personnes le droit d'apprendre et de faire des erreurs. Cette vision de la réalité de l'itinérance et de l'intervention va également teinter les recommandations faites aux patrouilleurs en première ligne.

Agir

Agir : accompagner la personne et mobiliser différents acteurs, un travail de référence, de collaboration et de partenariat pour le rétablissement de la personne. Régulièrement dans le cadre de patrouilles mixtes, parfois en co-intervention.Les professionnels de l'équipe distingueront : 1) le travail auprès de la personne et 2) le travail d'interpellation des différents acteurs autour de la personne. Comment se rencontrent les expertises des divers professionnels dans le cadre d'une intervention conjointe?

1) Travail auprès des personnes : création du contact, en faire un lien de confiance, accompagner, respecter le rythme

Traditionnellement, le travail auprès des personnes est au cœur du quotidien des intervenants santé/social. Il s'agit d'une intervention basée sur les principes du rétablissement : création du lien, entrevue motivationnelle, reflet, respect du rythme, accompagnement dans les démarches (logement, désintoxication, santé mentale et santé physique, revenus, cartes d'identité), faire avec, réduction des méfaits. Les intervenants restent en lien avec la personne à travers les différents lieux où elle se trouve (hôpital, rue, prison, ressource communautaire), afin de favoriser un rapport de confiance, de travailler la motivation, de faire des plans de sortie, redonner du pouvoir aux personnes. L'établissement d'un lien de confiance et la connaissance de la personne seront par la suite mis à profit pour personnaliser l'arrimage vers d'autres services.

Certains principes d'intervention généralement portés par les intervenants sociaux et de la santé ont été au fil du temps adoptés par les policiers d'EMRII. Il y a consensus qu'on s'adresse à des personnes peu reconnues, peu entendues : un travail de tous les membres EMRII consiste à faire exister la personne à travers la création d'un lien. On estime que, pour avoir un impact sur la vie des personnes (favoriser l'accès aux services, améliorer les conditions de vie), on doit établir un lien de confiance avec ces personnes qui ont connu de mauvaises expériences avec les institutions et qui sont parfois devenues méfiantes. L'accompagnement est perçu comme une des conditions les plus efficaces pour faciliter l'accès aux services (santé, logement, aide sociale, régularisation de la situation judiciaire, désintoxication). L'accompagnement suppose le respect du rythme des personnes. S'en trouve redéfini ce que sont des réussites dans l'intervention : on reconnaît les petits pas et l'établissement d'une relation avec une personne comme un pas vers son intégration sociale.

2) Arrimer les acteurs autour des personnes

Les professionnels d'EMRII définissent leur travail comme l'établissement d'un chaînon manquant entre les services et les acteurs qui gravitent autour des personnes vulnérables vivant en situation d'itinérance. Sur la base d'un portrait d'ensemble de la situation d'une personne, un rôle central de l'équipe consiste à interpeller les différents acteurs pour favoriser une intervention cohérente qui tienne compte de la réalité et des besoins de la personne. Il existe également un réseau informel autour de la personne avec lequel travaille l'équipe, à divers niveaux.

Au fil du temps, les professionnels ont investi divers espaces fréquentés par les personnes qu'ils desservent, afin de favoriser le dialogue avec les acteurs des institutions et services par lesquels elles transitent, dont les hôpitaux, les tribunaux et la prison. L'équipe a fait le choix non seulement de référer les personnes aux différents services, mais également de travailler à susciter la collaboration des différents acteurs et de rester au dossier le temps nécessaire pour que la personne soit bien arrimée. Les professionnels parlent de la nécessité d'être créatif pour trouver des solutions à des situations de portes tournantes qui perdurent parfois depuis des années, et face auxquelles les acteurs des services ont parfois démissionné.

Pour les intervenants du CSSS, un enjeu important consiste à trouver des collaborateurs dans le système de santé et des services sociaux pour des personnes qui le plus souvent ne correspondent à aucune catégorie de service. Dans le travail de liaison, d'arrimage et de défense de droits auprès des différents acteurs de la santé et des services sociaux, les intervenants font face à des procédures d'admission et de références parfois complexes, doivent contourner les filières d'accès et se battre contre les pratiques de « dumping ». Une part importante du travail se réalise dans le dialogue avec divers services : pratiques de discussion de cas, rencontres réseau, plan de soin infirmier, plan d'intervention. Cette finalité de développement d'un

réseau autour des personnes nécessite un travail de sensibilisation et d'éducation qui consiste à partager une analyse commune de la situation pour favoriser un meilleur suivi et une concertation plus grande. D'ailleurs, les intervenants estiment qu'au fil du temps, ils ont acquis une crédibilité qui favorise la collaboration des différents acteurs interpelés pour assouplir les règles d'accès aux services.

Le travail des policiers EMRII consiste à être en lien avec l'environnement de la personne (patrouilleurs, résidents, commerçants) afin de favoriser une cohabitation harmonieuse et de rassurer ces derniers qu'ils sont entendus et qu'on répond à leurs préoccupations. Pour les policiers de l'équipe mixte, le travail auprès des patrouilleurs est central. Ils sont en contact régulier avec ces derniers, les tenant informés du développement des suivis et faisant régulièrement des recommandations sur les interventions préconisées auprès des personnes desservies par l'équipe. Ce travail nécessite le développement d'outils de communication avec les patrouilleurs, pour favoriser une continuité dans les interventions.

Les policiers EMRII font des recommandations aux patrouilleurs d'un secteur sur des façons d'intervenir auprès d'une personne. C'est notamment sur la base du portrait des facteurs de vulnérabilité d'une personne et de l'historique des interventions auprès d'elle que seront faites des recommandations aux patrouilleurs. À travers le travail de collaboration avec les patrouilleurs, l'équipe va proposer de nouvelles pratiques policières en prévention. Il s'agira notamment de faire un recadrage des comportements jugés problématiques pour proposer une analyse qui introduit le point de vue de la personne concernée et les impacts de certaines interventions policières sur cette personne. Ainsi, on fera valoir que certains comportements de survie sont à distinguer d'un méfait, ou qu'il peut être préférable de relayer l'évaluation du risque, notamment du risque suicidaire, à un service spécialisé dans l'évaluation de l'état mental.

LE SUIVI INTERSECTORIEL, UNE FORME ÉMERGENTE D'INTERVENTION EN ITINÉRANCE

Si l'intervention est balisée par les obligations d'agir des uns et des autres, on voit dans les sections qui précèdent que cette collaboration permet une meilleure compréhension des obligations et jugements professionnels du partenaire et l'établissement de nouveaux critères dans l'évaluation des situations. Les axes d'évaluation qui balisent le travail des professionnels sont enrichis par la rencontre intersectorielle. Cette rencontre élargit de manière significative les possibilités d'action. Voici un résumé des acquis de cette collaboration.

Pour les professionnels de la santé et du social (axe facteurs de protection/facteurs de risque) qui privilégient l'évaluation de la condition de la personne :

- Le travail en collaboration avec les policiers apparaît comme un potentiel facteur de protection pour les personnes et comme complément d'évaluation : il permet de suivre de manière plus efficace la personne à travers les services et les institutions et d'avoir des informations sur son état général de santé et sur ses comportements dans l'espace public via les rapports des patrouilleurs.
- Le déploiement des pratiques d'interventions dans des espaces habituellement inaccessibles, par exemple en centre de détention, pour favoriser la création du lien, préparer la sortie de prison et évaluer l'état mental ou la santé physique.
- La contribution à l'élaboration de recommandations à faire à la cour, afin d'aller dans le sens du rétablissement de la personne.
- La participation à la réflexion sur les recommandations à faire aux patrouilleurs afin de trouver des alternatives à la judiciarisation et améliorer les conditions de vie à la rue des personnes.
- En dernier recours, la judiciarisation est saisie comme un levier pour une évaluation psychiatrique ou proposer la thérapie au lieu de la détention. C'est une avenue que les intervenants de la santé et du social adoptent plus difficilement, mais dans tous les cas, on reste en lien avec la personne.

Le travail du SPVM (axe comportements non problématiques/problématiques)

- On assiste à l'établissement de nouveaux repères dans l'intervention policière sur la base de l'évaluation des facteurs de vulnérabilité par les intervenants du CSSS (incapacités ou non-collaboration/problème de santé mentale ou intention criminelle/ droit à l'autodétermination/dérangeant ou dangereux).
- Développement d'une expertise judiciaire en matière d'itinérance. Recommandations à la cour autour des questions liées à la sécurité et à la cohabitation harmonieuse (en tenant compte de l'évaluation de l'état physique et mental d'une personne).
- Se développent de nouvelles façons de favoriser la cohabitation par la sensibilisation de l'environnement de la personne à la complexité des enjeux de l'itinérance, le travail réalisé, les différents acteurs au dossier, etc.

- Développement d'une expertise au niveau des accusations criminelles. En dernier recours, nouvelles pratiques pour monter des accusations criminelles lorsqu'il y a récurrence des interventions policières qui s'échelonnent sur des années et concernant des personnes peu vulnérables qui contreviennent continuellement aux règlements municipaux et à l'égard de qui les patrouilleurs ont peu de leviers.
- On assiste également au développement d'une plus grande vigilance à l'égard de certains facteurs de risque et bien exercer son rôle de protection comme policier – canicule, hydratation, symptômes de sevrage.
- Ainsi qu'à l'acquisition de nouvelles connaissances pour mieux interpeller les acteurs de la santé (UPS-J pour faire l'évaluation, meilleures liaisons avec hôpitaux, CLSC, ressources communautaires).

L'inscription de l'intersectorialité au cœur du suivi offert aux personnes est une pratique innovante qui soulève plusieurs défis tant pour les policiers que pour les intervenants santé/social qui œuvrent dans une équipe mixte. Les défis et les obstacles de la mise en œuvre de cette forme de pratique sont nombreux et les acquis sont fragiles.

There are many different organisational arrangements that may be used to promote inter-organisational integration, but intersectoral collaboration in public health is organised mainly in the form of multidisciplinary teams. This means, in effect, a matrix structure, where the teams provide horizontal integration between different organisations and sectors of the society. A multidisciplinary team is, however, a fragile and volatile form of organisation, which needs a constant nurturing in order to survive. In fact, the management of inter-organisational collaboration seems to be a challenge for practitioners as well as researchers in the field of public health.
(Axelsson et Axelsson, 2006: 85)

En se plaçant du point de vue du parcours des personnes dans les services, les membres d'EMRII ont développé une vision d'ensemble des services disponibles pour les personnes en situation d'itinérance à Montréal. Le regard qu'ils portent sur les services combine à la fois une connaissance fine de l'état du réseau des services, des contraintes et limites propres à chacun des professionnels dans l'exercice de leur travail, ainsi que du point de vue des usagers de ces services qui vivent des problématiques complexes. EMRII devient ainsi un observatoire permettant de réfléchir à l'état des services à Montréal concernant la réponse aux personnes en situation d'itinérance, et notamment celles qui sont les plus difficiles à rejoindre pour les services traditionnels.

CONCLUSION

EMRII démontre que le travail des professionnels issus des deux institutions que sont le réseau de la santé et des services sociaux et le Service de police est possible, et que cette collaboration est utile pour répondre plus adéquatement aux personnes à la rue. EMRII devient un exemple d'alternative au travail en silo et des possibilités de changement des cultures professionnelles policières qui démontrent souvent peu d'ouverture au problème de l'itinérance. Cependant, cette collaboration au sein de l'équipe mixte se réalise entre des acteurs mobilisés et dans le cadre d'une initiative modeste qui réunissait neuf professionnels en 2012. Que cette expérience de partenariat au sein d'EMRII contribue au maillage de deux cultures organisationnelles et qu'elle ait des retombées sur les manières de faire de chacune des organisations constitue cependant un autre défi. Comment changer globalement et de manière durable les attitudes policières et mettre fin au profilage social? Si l'existence d'une équipe spécialisée est une réponse intéressante, il faut toutefois éviter la tendance à penser que la solution réside dans la simple mise en place de policiers experts plutôt que dans la transformation des attitudes du policier moyen. L'innovation démontre cependant qu'il y a au sein des services policiers une ouverture et un potentiel de changement qui constitue un premier pas vers un respect et un service plus adapté pour les personnes en situation d'itinérance.

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Les recherches de Marie-Claude Rose privilégient la prise en compte du point de vue des acteurs (personnes en situation de pauvreté, intervenants, gestionnaires) pour comprendre les réalités sociales. Utilisant une approche qualitive de type ethnographique, sa préoccupation est de rendre compte de la parole des acteurs.

Program and Service-level Collaboration

1.4

A RESPONSE TO HOMELESSNESS IN PINELLAS COUNTY, FLORIDA: AN EXAMINATION OF PINELLAS SAFE HARBOR AND THE CHALLENGES OF FAITH-BASED SERVICE PROVIDERS IN A SYSTEMS APPROACH

Megan SHORE & Scott KLINE

The primary purpose of this chapter is to introduce the systems approach to homelessness that Pinellas County, Florida, has developed around a 470-bed 'come-as-you-are,' entry portal shelter called Pinellas Safe Harbor (PSH).[1] The approach was devised, in large part, by Robert Marbut, a homelessness consultant and the founding CEO and president of Haven for Hope in San Antonio, Texas, a shelter that helped San Antonio address their structural issues related to homelessness. As with any systems approach to homelessness, the PSH-centred system had to bring together various levels of government and civil society in order to address the multi-faceted issue of homelessness. In this case, before any of Marbut's recommendations could be implemented, he had to ensure that (a) the various levels of government were committed to working with one another, (b) law enforcement leadership – in particular the St. Petersburg Police Department and the Pinellas County Sheriff's Office – were open to changing their culture related to the criminalization of homelessness, (c) there was a high probability of convincing public officials and tax payers of the cost-effectiveness of the approach and (d) a critical mass of service providers, including a number of key faith-based organizations (FBOs), were willing to cooperate in the formation of a newly designed integrated system.

This latter concern over the participation of service providers is what initially piqued our interest in PSH. In particular, we were interested in the challenges associated with bringing FBOs and service providers into a government-run systems approach to address homelessness. In general, FBOs have a long history of advocating for and addressing the needs of the homeless and in many cases they are better placed than government agencies to effect changes in the services typically provided to people experiencing homelessness (Winkler, 2008). In the case of PSH, a number of high-profile faith-based service providers opted not to participate formally in the establishment of the system, most notably the well-resourced Catholic Charities of St. Petersburg. As of Summer 2015, Catholic Charities remained largely outside of the system coordination and integration concentrated in PSH, although it was acting as an important next-level point of contact for some chronically homeless people transitioning out of

1. In this chapter, we use the term 'systems approach to homelessness' to mean a formalized, coordinated and integrated system or systems that bring together design, funding, operations and service delivery.

PSH and into more permanent housing. This chapter highlights some of the challenges facing FBOs such as Catholic Charities when considering the integration of their services into a broader system.

We have organized this chapter into five sections. Section one provides a brief history of how a systems approach to homelessness developed in Pinellas County. Section two considers the initial systems planning led primarily by the homeless consultant. Section three examines the emergence of two overlapping and mutually supporting countywide systems: one that was largely administrative in nature and one that used PSH as its hub. Section four highlights the various roles FBOs play in the system and a number of challenges they present to the system. The fifth and final section highlights key factors that contributed to the formation of the system that developed around PSH. This final section also identifies and critically assesses a number of outstanding questions and concerns with regard to the system as it has developed.

"THE CITY WITHOUT A HEART"

In late December 2006, more than a hundred homeless people erected a tent city on four acres of vacant land owned by the St. Vincent de Paul Society South Pinellas, a popular centre providing some 500 meals a day to Pinellas County Florida's hungry, homeless and working poor.

In late December 2006, more than a hundred homeless people erected a tent city on four acres of vacant land owned by the St. Vincent de Paul Society South Pinellas, a popular centre providing some 500 meals a day to Pinellas County Florida's hungry, homeless and working poor.[2] Just three kilometres (two miles) west of downtown St. Petersburg, Florida and next to the heavily travelled Interstate 375, the vacant lot had become overgrown with weeds and was, prior the newly settled residents cleaning it up, full of trash and debris. Early on, residents had established rules for the tent city and each resident signed a contract that outlined the duties people would carry out while living there, including spending at least four hours a week picking up any trash, cleaning the portable toilets and working in the tent city office. For many residents, it was the first night's sleep they had had in months. Living among people they could trust, residents said they felt secure while sleeping and weren't afraid that their belongings would be stolen during the night. For many, the tent city provided a sense of community and belonging (St. Pete for Peace, 2006).

From the outset, residents believed that their makeshift city was only a temporary measure addressing the lack of housing and adequate services while a longer-term solution was worked out by city, county and state officials. During the 1990s and early 2000s, downtown St. Petersburg had experienced tremendous growth, with multi-million dollar condominiums going up and ambitious plans for economic development projects along the city's picturesque waterfront. But along with revitalization the city saw a rise in the number of homeless people living on the street, which was attributable to a lack of affordable housing, inadequate government support services and a slowing Florida economy. St. Petersburg and Pinellas County officials began to express their concerns over the increasing concentration of visible homeless persons near the city and the need for "containment" (Ulferis, 2007). The tent city only exacerbated those concerns.

2. Pinellas County has a population of 900,000 people. It includes 24 incorporated cities, including St. Petersburg, Clearwater and Pinellas Park. St. Petersburg is the largest city in the county.

In early January 2007, Pinellas County officials called an emergency meeting to address the tent city and problems created by the concentration of homeless persons near St. Petersburg. At this meeting, officials agreed that St Petersburg's homeless situation constituted a crisis and immediate measures were needed. Although city officials could not force the residents off the site, since the tent city was on private land owned by St. Vincent de Paul, law enforcement could intervene, they argued, because the tent city violated a number of city ordinances, including those related to public hazards and safety. City officials made it clear that St. Vincent de Paul would be fined anywhere from one dollar to $250 a day if it did not evict the tent city residents and remove their tents by Friday, January 12th. St. Vincent de Paul conceded, stating it would comply (Ulferis, 2007).

Although city officials could not force the residents off the site, since the tent city was on private land owned by St. Vincent de Paul, law enforcement could intervene, they argued, because the tent city violated a number of city ordinances, including those related to public hazards and safety.

Although residents of the camp requested more time to make alternative arrangements, St. Vincent de Paul chose to comply with city ordinances and closed the site as requested. Uprooted once again, many of the former residents moved a few blocks away to two different locations. Tragically, a few days later two homeless men were found beaten to death, one of whom had been a resident in the tent city. The tension between the homeless and St. Petersburg city officials immediately escalated and city officials declared the homeless situation a state of emergency. On January 19, 2007, approximately two-dozen police officers raided the impromptu tent cities, citing numerous public hazard and safety code violations. They destroyed the tents with box cutters and knives, even while many of the residents were still in their tents (Raghunathan & Ulferis, 2007). Online videos of the tents being destroyed by the police went viral, sparking national outrage. It even prompted Fox News to call St. Petersburg, "the city without a heart" (DeCamp & Nohlgren, 2010).

Although the tent city had been destroyed, the homeless situation was far from resolved. As city and county political leaders, police departments, the sheriff's office, the homeless people themselves and people advocating for the homeless considered a variety of options to resolve the homelessness crisis, Catholic Charities of St. Petersburg came forward in Fall 2007 with a stopgap proposal to donate 10 acres of land on the outskirts of Clearwater, Florida and to establish a 'tent city' emergency shelter on the donated land. Catholic Charities offered to set up tents, feed people and provide various social and health-related services. In return St. Petersburg and Pinellas County would donate approximately a million dollars to run the shelter as a six-month pilot project. Known as Pinellas Hope, the 'shelter' (or the "bureaucratized and controlled tent city," as skeptics initially called it) opened its doors on December 1, 2007, with the support of the City of St. Petersburg and Pinellas County. What was supposed to be a six-month pilot eventually turned Pinellas Hope into the second largest emergency shelter currently operating in Pinellas County, with a program for almost 300 homeless men and women and a mission to provide a safe living environment and support to become self-sufficient (De Camp, 2009).

Even though Pinellas Hope relieved some of the pressure in the months following the forced closure of the tent cities, the homelessness crisis in Pinellas County continued over the next three years without the implementation of any further significant measures. During this time, tension had been mounting among some government officials as law enforcement officers continued to arrest homeless persons for violating ordinances related to panhandling around the St. Petersburg area, prohibiting the storage of personal belongings on public property and making it unlawful to sleep

outside at various locations. Already in January 2007, the Pinellas-Pasco Public Defender had announced that he would no longer represent indigent people arrested for violating municipal ordinances to protest what he called excessive arrests of homeless individuals.

The Great Recession of 2008 only ratcheted up tensions as the homeless population in Pinellas County increased. Counting homeless can be controversial (Wasserman and Clair, 2010), but according to Richard Linkiewicz, who was a police officer for the City of St. Petersburg and a homeless-outreach officer during the height of the economic crisis, there were 5,500 homeless in Pinellas County in 2008. By 2009 the number had risen to approximately 7,500, including 1,300 children in homeless families (Bazar, 2009). In March 2010, there were 46,391 filings for foreclosure in Florida, up by 70% over March 2009 filings. Indeed, in 2010, Florida ranked second in the United States in the number of foreclosures (State of Florida, Department of Children and Families Office on Homelessness, 2010: 3). According to the U.S. think-tank The National Alliance to End Homelessness, by 2011 the Tampa-St. Petersburg metropolitan area (which includes Pinellas County as well as neighbouring Hillsborough County) had the highest rate of homelessness in the United States (National Alliance to End Homelessness Report, 2011: 50). In this area there were 57.3 homeless people for every 10,000 residents. According to some estimates, there were about 16,000 homeless people in the Tampa area and one in five of them were children (Hirschkorn, 2012).

In October 2010, the City of St. Petersburg, with the support of Pinellas County, hired an outside consultant, Robert Marbut of San Antonio, Texas, to draft a strategic plan to address the crisis. A former White House fellow in the George H.W. Bush administration and a former chief of staff to San Antonio Mayor Henry Cisneros, Marbut delivered the central phases of his eight-phase "Strategic Homelessness Action Plan" in March 2011. In essence, the plan was a proposal to create a system of coordinated and integrated homelessness services in Pinellas County. At the core of the plan was the creation of a countywide system designed around an 'entry portal' service facility for chronically homeless men and women. One of Marbut's recommendations was to convert an empty jail facility, which would be known as Pinellas Safe Harbor (PSH), into the countywide hub that would align the 'service magnets' (e.g. food, bathrooms, showers, shelter and safety) for the chronic homeless and as the hub for service providers, including case management, healthcare and legal assistance staff.

DEVELOPING A SYSTEMS APPROACH

In 1995, the Department of Housing and Urban Development (HUD) began to require communities to submit a single application for McKinney-Vento Homeless Assistance Grants in order to streamline the funding application process, to encourage coordination of housing and service providers on a local level and to promote the development of the Continuum of Care (CoC) initiatives at the regional or, in the cases of urban centres, local levels. In essence, a CoC is a regional or local planning body that coordinates housing, services and funding for homeless families and individuals through nonprofit providers, the state and local governments (U.S. Department of Housing and Urban Development, HUD Exchange, Continuum of Care). It provides programs and services for people experiencing homelessness, helps rehouse them and works toward self-sufficiency. The hope was that a more structural and strategic approach to housing and services would emerge by requiring communities to submit a single application.

The HMIS collects "client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness"

An important tool used by the CoCs is a software program called the Homeless Management Information System (HMIS). The HMIS collects "client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness" (U.S. Department of Housing and Urban Development, HUD Exchange, Homeless Management Information System). It is an electronic administrative database that is designed to record and store information on the characteristics and service needs of homeless persons. Each CoC uses a software solution that complies with HUD's data collection, management and reporting standards. One key feature of the HMIS is that it facilitates a reasonably accurate census of both sheltered and unsheltered homeless populations over a full year and establishes Point in Time (PIT) counts. By using standard HMIS, then, CoCs make applications for funds based on data that is consistently collected, managed and reported across communities. When the City of St. Petersburg and Pinellas County hired Marbut in Fall 2010 to develop a strategic action plan, there was virtually no formal coordination among government agencies. If there was any coordination in the county, it was largely through a variety of homeless coalitions and church groups working in relatively loose association with each other around advocacy, sheltering and feeding. As a result, one of Marbut's initial steps was to provide a set of guiding principles to establish a unifying vision for the plan. He offered the following seven principles:

1. Move to a culture of transformation (versus the old culture of warehousing).
2. Work toward co-location and virtual e-integration of as many services as possible.
3. [Develop] a customized case management system in which one person coordinates the services in a customized manner.
4. Reward positive behavior because this will increase responsibility and privileges.
5. Have consequences for negative behavior so that there are proportionate consequences that encourage responsibility.
6. Stop external activities such as 'street feeding'… and redirect to a co-location.
7. Stop panhandling because it enables homelessness (Marbut, 2011: 38).

For Marbut, these principles were not vague philosophical concepts but, rather, achievable, even if controversial, outcomes that would drive activities in the plan. Focusing almost exclusively on chronically homeless individuals – that is, not families – Marbut aimed to establish "transformational communities,"

which are, he argued, an essential part of the "overall service system design, structure and operations (e.g. systems approach)" (Marbut, 2014: 9).

Marbut's efforts to establish a system around a "transformational community" involved an eight-phase analysis of the homeless situation in Pinellas County. Phase one consisted of an in-person inventory and review of the homeless-serving services throughout Pinellas County through formal and informal site visits. Phase two and three focused on research on and an assessment of the types (quality) and capacity (quantity) of services available in Pinellas County. These phases were conducted simultaneously because of the interconnectivity between needs assessment and gap analysis. Phase four involved in-person meetings with government officials, staffers and volunteers from government, business, faith-based, non-profit, civic and educational agencies. This phase was crucial in development of the system for it was here that Marbut began finalizing commitments. Phase five to seven were also conducted simultaneously because of some technical overlap. Phase five was a review of national best practices, phase six was the identification of action steps and phase seven was the submission of the final report. Phase eight, the final phase, was the visioning, development and eventual start-up of an "entry portal" (Marbut also called it a "transformational housing portal") and service facility for men and women of Pinellas County (Marbut, 2011).

In terms of the state of the homeless sector as it had developed to 2011, the final report highlighted the considerable number of service providers in the community; however, it stated, the "services are neither strategically nor formally coordinated within an integrated system, especially at the tactical level" (Marbut, 2011: 4)

Marbut's initial assessments in phases one through four focused primarily on the areas of design, funding, operations and service delivery. In terms of the state of the homeless sector as it had developed to 2011, the final report highlighted the considerable number of service providers in the community; however, it stated, the "services are neither strategically nor formally coordinated within an integrated system, especially at the tactical level" (Marbut, 2011: 4). This meant, for example, that services provided by different organizations often conflicted with one another, resulting in clients having to choose one of several needed services. The report recommended that the overall homeless system in Pinellas County should be streamlined, transformed and re-branded so that all solutions are countywide coordinated initiatives.

In terms of funding, the final report concluded that most of the agency funding and service delivery funding in Pinellas County had been "agency centric," and not coordinated or strategic and that at times this situation had created competition among service providers and misaligned objectives. The final report recommended that funding be proactively coordinated. It stated funding "should be pooled, coordinated and allocated based on strategic objective outcomes" (Marbut, 2011: 5). Moreover, the streamlined integrated services and funding must include the two largest emergency homeless shelters, Pinellas Hope and PSH, which were not previously included.

The final report called for the transformation of operations in the homeless-serving sector. It cited the need to establish one lead organization to coordinate service decisions being made countywide in an integrated system. Service agencies within the newly designed system were encouraged to embrace national best practices in their operations. It called for the development of a robust master case management system. This master case management system would enable case managers and assigned case staff to follow through with clients as they progressed through the system. It would also allow for the coordination of

other services, including healthcare, legal assistance and educational training. Because it had master case management capacity, the HMIS, called the Tampa Bay Information Network (TBIN), needed to be upgraded to serve as a proactive case management tool within the integrated system. Finally, the entry portal and hub of the newly integrated system, PSH, first had to be adequately equipped, both in terms of infrastructure and trained personnel, to accommodate the enhanced activities and, secondly, the relationship between the 470-bed PSH and the Pinellas Hope tent facility needed to be strengthened as Pinellas Hope provided a next step toward permanent housing.

In terms of service delivery, one key recommendation, and one of the most controversial, in the final report was that all street feeding cease and be redirected to the entry portal, the service hub in the system and to service programming. While not outright recommending the criminalization of street feeding, as has been the case in other urban centres (Stoops, 2012), the report asserted that street feeding had to be redirected to PSH or stopped. Additionally, system stakeholders and particularly law enforcement as well as the media would need to play a crucial role in educating restaurant, supermarket and convenience store staff about the 'enabling' effects of street feeding. Churches and other FBOs also needed to understand that street feeding likely meant that those being fed were not involved in programming that could help them transition off the streets. According to the final report, these outreach efforts would be effective only if there was an integration of service delivery and an improved master case management system in place, which could be achieved with an upgraded HMIS/TBIN.

We should highlight the fact that the final report did not anticipate or recommend rapid re-housing or Housing First, as it is often called, to address the systemic problems of homelessness. This is in spite of the fact that, since 2008, the federal government has been attempting to fund rapid re-housing initiatives (e.g. the United States Interagency Council on Homelessness, 2015). Indeed, the recommendations in the final report are rooted in the more traditional CoC model, which makes housing conditional upon a client's enrollment in service programming, including health care, mental health support and job re-training. The Housing First model, by contrast, is based on the premise that housing is a right, rather than a privilege, and that the CoC model can too often lead to the dehumanization of people experiencing homelessness (Padgett et al., 2015). The homeless advocates and FBO executive directors we interviewed were fully aware of the ethical challenges presented by the PSH shelter-continuum approach and at least one FBO executive director raised ethical concerns about Marbut's approach and the political motivations supporting Marbut's plan. Yet most supported the formation of the PSH, though some quite reluctantly, because there were no other viable options and there was a pressing need for greater service coordination and support. There was, for example, no local political will at the county and municipal levels to invest in Housing First initiatives but there was political will, whatever the motivations, to support efforts to provide new facilities and enhanced support to homeless people.

IMPLEMENTING COORDINATED AND INTEGRATED SYSTEMS

It is important to note that, in the final report, Marbut is essentially calling for the development of two countywide systems that are overlapping and mutually supportive – (1) a macro-level system that concentrates on administrative and financial leadership and (2) a micro-level system developed around PSH. The formation of the first system had at least three drivers: (a) accessing government funding channels; (b) responding to HUD's insistence that local CoCs work collaboratively in the design, funding, operations and service delivery in the homelessness sector; and (c) responding to the final report's recommendation to establish a single countywide body to ensure the coordination and integration of services. For many years, Pinellas County had two homeless initiative leadership organizations: the Pinellas County Coalition for the Homeless (PCCH) and the Homeless Leadership Network (HLN). PCCH had a mission to provide community education, advocacy, program support, capacity building and technical assistance for the communities, agencies and organizations concerned with homelessness and to secure government and private funding for needed homeless services. HLN focused more on the policy matters and it consisted of 35 elected officials, community leaders and institutional representatives. HLN was the planning body in charge of addressing local homelessness. The final report called for "one streamlined organization that has only one vision/mission, one board, one chair and one CEO" (Marbut, 2011: 4). In direct response to this recommendation, PCCH and HLN merged, in February 2012, to become the Homeless Leadership Board (HLB).

The HLB consists of eight elected officials and 13 community leaders. The 13 community leader positions on the board are allocated to ensure broad stakeholder representation. Four members are service experts, two represent FBOs, two represent county businesses, one sits as a representative of the Juvenile Welfare Board, one represents healthcare providers, two members are at-large representatives and one member must be homeless or formerly homeless (Pinellas County Homeless Leadership Board Inc.). The HLB is now the lead organization in the coordination of the wide-ranging homelessness services in Pinellas County. The HLB also acts as the CoC for Pinellas County, which means it serves as the point of contact for government funding through HUD. The HLB does much of its work through two major councils, the Providers Council and the Funders Council, and their various committees which provide "comprehensive information and recommendations for action and approval to the Board" (ibid). The Providers Council and the Funders Council each has sitting representatives from the HLB.

The second system revolves around PSH. This system emerged primarily for pragmatic reasons. In late 2010, just as Marbut had agreed to work with St. Petersburg, Clearwater, Pinellas County and a coalition of other major municipalities in the county, then Chief Deputy Sheriff Bob Gualtieri, "initiated a meeting with stakeholders from the judiciary, the Office of the State Attorney, the Office of the Public Defender and local incorporated cities to look at the inmate jail population more strategically. This dialogue started a conversation about how to reduce the number of nonviolent, homeless individuals in the Pinellas County Jail" (McGillen, Sinovich & Marbut, 2012: 4). The sheriff's office had struggled with how to deal with the growing homeless population in Pinellas County and it was looking for a way to keep homeless people out of jails and off the streets. Like many cities in the United States with a high number of homeless people, municipalities in the county had adopted a number of quality-of-life ordinances, some of which had been invoked in early 2007 with the removal of the tent city. Many stakeholders, including the sheriff's office, understood that placing nonviolent, chronically homeless in jail not only overloads the

law enforcement/legal corrections system, it also fails to address the root causes of homelessness. Bluntly put, the cycle of (a) arresting non-violent homeless individuals, (b) jailing them for 12–24 hours, (c) perhaps meeting with the public defender, (d) releasing them and (e) starting the cycle over again with a rearrest had essentially clogged up the system with low-level non-violent offenders. Using the corrections system to address street homelessness was hugely costly. Moreover, Gualtieri and the sheriff's office in general understood that jails were not equipped to deal with some of the root causes of homelessness, such as mental health issues, life skills, job training or placement and medical care (Marbut & Simovich, 2012: 24–25; Wasserman and Clair, 2010: 69–96). Prior to 2011, however, there were no viable alternatives available to law enforcement.

In dialogue with Marbut in late 2010, the Pinellas County Sheriff's Office proposed that a recently closed minimum-security facility in Clearwater could be converted to serve as the entry portal shelter. In an attempt to raise the necessary funds to start the conversion, the proposal included the use of a government grant intended to develop jail diversion initiatives. Furthermore, the sheriff's office offered to take the lead in managing the facility, training its personnel, providing the majority of operational funding and coordinating local social service agencies in the facility (McGillen, Sinovich & Marbut, 2012: 5). Indeed, PSH is unique in the United States in that it is the only shelter of its kind to be managed by the law enforcement and correctional communities and still function as hub for a wide range of service providers, including FBOs, non-profit agencies and government agencies.

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As of Fall 2015, PSH operates as a 24 hours a day, seven days a week, 365 days a year one-stop "come as you are" emergency homeless shelter and service provider for chronically homeless adult men and women. It operates with a budget of approximately $1.8 million (Lindberg, 2015). It houses an average of 425 people a day and provides three meals a day, a shower and a mat (or bed) to sleep on. It has a customized master case management system. There are a team of case managers onsite to work with the residents as they begin the process toward stable housing and self-sufficiency. Social workers hired by the county offer needs assessment and coordination of services and placements. Directions for Living, a local non-profit organization, also provides case managers who offer needs assessment, mental health and substance abuse referrals. Westcare, a group of non-profit organizations, offers substance abuse evaluations, counselling and recovery services. A number of support groups run classes at PSH, including Alcoholics Anonymous and Narcotics Anonymous. Other groups offer HIV awareness, life skills, vocational rehabilitation, pedestrian safety and transitional help classes. A variety of religious groups provide worship services. Once a week, basic healthcare and referrals for medical, dental and mental health services are provided by Pinellas County onsite. However, one significant gap in service has been the lack of full-time onsite medical staff, which has resulted in PSH having to access emergency medical services for fairly routine medical

events (*Tampa Bay Times*, 2014). All meals at PSH are provided by FBOs and the meal service is coordinated by Metropolitan Ministries (PSH, Services; & Pinellas County Sheriff's Office Statistical Summary, 2014).

In Spring 2014, the City of St. Petersburg hired Marbut to conduct a follow-up review of homelessness in the city. In June 2014, Marbut delivered his action plan, which included a reassessment of the street-level homeless population in the city, a re-evaluation of the homeless servicing capacity and six recommendations (Marbut, 2014). On the whole, Marbut concluded that efforts to develop a system around PSH had continued to yield desirable outcomes: for instance, between June 2010 and March 2014 night-time street-level homelessness in the city had decreased by 84%. He did, however, observe that there were weaknesses in the system that needed immediate attention: (a) St. Petersburg's failure to meet its financial commitments to support PSH, (b) the shuttering of the Pinellas County Sheriff's Homeless Diversion Program, (c) the decline in training and engagement on the part of St. Petersburg Police Department (SPPD) resulting in decreased positive interactions between the police and people who are experiencing homelessness, (d) the redirection of the SPPD's homeless outreach teams (HOTeams) away from chronically homeless individuals (the HOTeams had become focused on families), (e) gaps in service at a faith-based facility near downtown St. Petersburg that created high concentrations of homeless on the streets between 6:00 a.m. and 11:00 a.m. and (f) the need for increased capacity, largely through the Juvenile Welfare Board of Pinellas County, to address homeless families. These identified weaknesses in the system provided the basis for each of the six recommendations in the action plan.

On the whole, Marbut concluded that efforts to develop a system around PSH had continued to yield desirable outcomes: for instance, between June 2010 and March 2014 night-time street-level homelessness in the city had decreased by 84%

It is important to note that five of the six weaknesses identified by Marbut are directly linked to government agencies and that one is associated with a FBO, namely the Society of St. Vincent de Paul South Pinellas. Marbut observed that St. Vincent de Paul's overnight sleeping program, which provided 70 sleeping spaces, was, in effect, a part-time program that closed its night shelter at 6:00 a.m. This meant that individuals were back on the street early in the morning, many milling about the facility awaiting the opening of a weekday services program at 11:00 a.m. To address this service gap, Marbut recommended that St. Vincent de Paul become "a self-contained 24/7 holistic program that addresses the root causes of homelessness" and offers the same number of daytime slots as nighttime mat-bed slots (Marbut, 2014). Moreover, "all services offered by the Society of St. Vincent de Paul, including meals for the chronic homeless population, should be tied to active participation in case management services" (ibid).

This recommendation that active participation in case management services should be a prerequisite for homeless people to receive access to food raises both ethical and practical challenges. Ethically, critics of the CoC model, such as those who support Housing First approaches, argue that the conditions placed on access to food and housing reinforces a power relationship that subjugates homeless people as sick people in need of healing or sick souls in need of salvation (Wasserman & Clair, 2010). Practically, this recommendation points to a fundamental challenge not only in the Pinellas County systems approach but in any systems level approach that includes a mixture of government agencies and FBOs; that is, with the exception of any centralized funding being linked to FBO activities, there are virtually no formal levers in place to ensure that an FBO remains aligned with system-wide coordination and integration. There are, of course, informal measures, such as 'naming and shaming,' but these can often breed resentment, retrenchment and even further marginalization in the system.

FBOS IN THE SYSTEM

In Pinellas County, FBOs play an essential role in efforts to provide shelter, housing and services, especially food services. According to HUD's 2014 "CoC Homeless Assistance Programs Housing Inventory Count Report," the largest emergency shelter for adults in Pinellas County is PSH, with a maximum of 470 beds. The next three largest shelters are run by FBOs: Catholic Charities of St. Petersburg has 294 beds; Homeless Emergency Project (HEP) has 136 beds; and St. Vincent de Paul has 77 beds. Of the nine main emergency shelters for adult individuals in Pinellas County, five are run by FBOs. Pinellas County has 1,131 beds available for emergency shelter for adult individuals and 559 of these beds are run by FBOs. Furthermore, a number of FBOs, including Pinellas Hope and HEP, have been integral to efforts in the county to provide permanent or semi-permanent housing. In fact, in November 2014, Pinellas Hope announced that it would be creating permanent housing for an additional 76 people, bringing the total permanent supportive housing capacity on its ten-acre campus to just a little more than 150 units.

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FBOs have taken the lead in feeding street-involved people in Pinellas County. According to the HLB's "Pinellas County Homeless Resource Guide," of the 15 organizations in the county that provide meals, 14 of these are run by FBOs. As previously mentioned, Metropolitan Ministries is responsible for managing food services at PSH. Based in Tampa, in Hillsborough County, Metropolitan Ministries has been working with homeless people since 1987, providing food, shelter and services to families. In 2004, they adopted a distributive model of feeding the hungry, which meant that they provided food to local churches so that the churches could feed the hungry and homeless in their own communities. One of these outreach partnerships was with Pastor Brian Pierce, who ran a non-profit organization called Taking It to the Streets Ministry, in Pinellas County. When PSH was founded in 2011, food service was initially managed through the jail commissary, which meant that feeding the residents of PSH was relatively expensive. Operating on a tight budget, the Pinellas County Sheriff began to reach out to the community for support. In response, Pierce offered to give up his ministry so that Metropolitan Ministries could provide food services at PSH. Seeing value in a coordinated food service plan, Tim Marks, the CEO of Metropolitan Ministries, met with then Deputy Sheriff Gulateri and eventually agreed to take on this responsibility (Marks, Personal Communication, April 29, 2015).

A number of FBOs in Pinellas County have chosen not to participate directly in the system developed around PSH; however, all of the larger FBOs, such as Catholic Charities, the Society of St. Vincent de Paul, HEP and the Salvation Army have chosen to play a role on the HLB Providers Council. In fact, Michael Raposa**,** executive director of St. Vincent de Paul South Pinellas, is a two-term chair of the HLB, a position he holds until the end of 2016.

The Providers Council consists of service providers either serving people experiencing homelessness or those at risk of becoming homeless. They provide formal input and provide recommendations on all CoC policies and procedures that come to them via the HLB. They also raise and discuss critical issues that may be occurring in the homeless arena; as a result, there may be collaboration among the agencies to work toward a solution to address issues and problems. At times, this group makes decisions regarding state or local funding applications. It is through the Provider's Council that the HLB stays in close communication with the provider community (Abbott, Personal Communication, April 29, 2015).

There is little doubt that there is potential for greater communication among the FBOs in Pinellas County as a result of their involvement in the newly revised HLB governance structure. However, there is not much evidence that these FBOs in Pinellas County have experienced any significant changes in their day-to-day operations. In other words, those FBOs outside the PSH system continue to operate independently, much as they did prior to the establishment of the new HLB. From our perspective, the lack of coordination between service providers outside the PSH system has created a number of serious problems which are actually adversely affecting homeless populations in the county. For example, there is an FBO in Clearwater that provides meals from 9:30 a.m. to 11:00 a.m., 365 days a year. It proudly promotes the fact that they serve more than 200 people each day. When we asked stakeholders in the area about why this ministry continues to offer food at this time, knowing that few, if any, of those they feed would be able to access the many programs and services offered during this time, a common response was "this is the time that their volunteers are able to serve meals" and "they believe they are meeting the homeless 'where they are.'"

We are sympathetic to the various challenges that face this organization and many similar FBOs. Let us highlight three of them: First, many FBOs with a homeless ministry tend to focus on activities or outputs – for example, how many meals they serve, how many individuals they engaged, the number of beds and so on. This makes sense given that Christian organizations, in particular, understand their work as a response to the gospel teaching to give food to the hungry, drink to the thirsty, shelter to the stranger, clothing to the naked and care to the sick (cf. Matthew 25: 31–36). It can be difficult for an FBO to think in terms of objectives or outcomes – that is, once we have provided food, drink, shelter, clothing and care, how do we assist this person in moving from a state of crisis to a more self-sustaining state, all the while preserving the person's human dignity? One reason why this is so difficult is that many FBOs have not historically been able to provide the necessary suite of services required to address the range of issues facing people experiencing homelessness.

Second, many FBOs have not had an opportunity to consider how their activities or outputs are contributing to long-term and broad-based change (or in the parlance of strategic planning, they have not developed a 'theory of change'). It is difficult for some FBOs, particularly those that are smaller or prone to working independently, to get a clear sense of what role they are playing in making changes in the culture in relation to other providers and in individual lives. By participating in a system, FBOs become part of the planning process around coordination and integration – they see firsthand how their activities or outputs contribute to system-wide agreed upon objectives or outputs. In Pinellas County, there is a tremendous amount of potential for this type of collaborative work through the HLB and Providers Council and especially through the system built around PSH.

And third, it can be a challenge for FBOs with homeless ministries to operate under a government-run umbrella organization, such as a sheriff's department or a secular lead agency, perhaps a privately funded one-stop centre or an organization like Goodwill. There are many potential factors at play: for instance, concern over the loss of autonomy, concern over the quality of the outreach programming, anxiety over the loss of revenue if activities are not unique and, most fundamentally, concern over a shift in identity. In many respects, these factors are common to all service providers contemplating participation in a systems-level approach. But for many FBOs, it can be especially difficult to align their mission with any changes to the way they engage not only homeless people but also one another. If an FBO's executive director or board is unable to see this alignment, this will be enough to persuade an FBO to opt out of a system.

CONCLUSION

The system designed around PSH is one built on a 'first-step programming' or 'low-demand shelter' for nonviolent homeless men and women who do not have to be alcohol or drug free to reside there (Marbut & Simovich, 2012). In our observations of the system that developed around PSH, there are at least six interrelated factors that facilitated broad-based stakeholder support of PSH: First, the situation in Pinellas County fit well with the entry portal or hub model proposed by Marbut. Prior to 2011, there were a high number of chronically homeless people in the county and there was very little coordination and integration of services. PSH provides the structure needed to sustain the system that has developed around it. Moreover, according to Marbut, it is a cost-effective approach: the average cost per person to run PSH is about $20 a day, whereas the daily per person cost to run Pinellas County Jail is about $106 a day (ibid). For many politicians, the cost-effectiveness of PSH was a determining factor in choosing this approach. In sum, the system that emerged was a coming together of often diverse motivations: from those advocating for enhanced funding, coordination and integration of services that were of value to street-involved people to those seeking a cost-effective way to contain homeless populations.

According to Marbut, it is a cost-effective approach: the average cost per person to run PSH is about $20 a day, whereas the daily per person cost to run Pinellas County Jail is about $106 a day (ibid). For many politicians, the cost-effectiveness of PSH was a determining factor in choosing this approach.

Second, there was a core group of stakeholders in the county who committed to working collaboratively: elected officials, the public defender's office, law enforcement agencies and a variety of service providers. This willingness to collaborate was limited, however. Given the political climate in Pinellas County, there was, for example, no appetite to consider rapid re-housing or systemic factors that contribute to homelessness such as poverty, the health care system or the region's political economy.

Third, while a major concern at the outset, the placement of PSH in a more industrialized area in Clearwater and away from traditional homeless gathering sites in St. Petersburg and near Clearwater Beach meant that public officials did not have to deal with NIMBYism (not in my back yard). Perhaps fortuitously, the Pinellas County Sheriff had an unused jail facility that could be affordably transformed into a homeless facility large enough to accommodate a high number of residents and key service providers.

Fourth, there was strong official leadership to champion the system. In particular, Deputy Sheriff and, as of November 2011, current Sheriff Bob Gualtieri saw the inherent pragmatism of Marbut's recommendations, offered to provide the facility and committed to train sheriff staff to operate PSH and to engage homeless men and women in a constructive way at the street level.

Fifth, there was a commitment on the part of officials and providers to use an enhanced master case management program, the HMIS/TBIN, when engaging homeless individuals. This management tool is essential in tracking the progress of individuals and the services they have required as they move toward permanent housing and stability. There is, however, a gap in the ability to continue tracking the progress of

individuals who move from PSH and into more permanent housing. While Pinellas Hope and HEP are key partners with PSH in the effort to provide more permanent housing, tracking the progress of residents as they engage these and other housing providers has been difficult.

And sixth, a critical number of faith-based service providers have agreed to work directly with PSH, including Metropolitan Ministries in the key area of food service. Additionally, major FBOs such as Catholic Charities of St. Petersburg and the Salvation Army continue to provide integral services in the broader countywide system, which often function as next phase services after leaving PSH.

In terms of national trends and funding opportunities for homeless initiatives, PSH and the systems approach that Pinellas County has adopted are bucking the trend toward rapid re-housing and, in the process, finding it difficult to draw on funds available to Housing First approaches. On our last visit to Pinellas County in Summer 2015, we were still unable to find anyone with either political or financial influence interested in supporting a major Housing First initiative. Moreover, the CoC model is strongly embedded in the current system, though many stakeholders we spoke to would welcome a change toward Housing First. In our view, PSH developed as a compromise among various stakeholders at a crisis point in the county. The next step in the evolution of the systems approach in Pinellas County may well be a consideration of how to encourage and support rapid re-housing and a long-term commitment to address the many causes of homelessness. Here there remains much work to be done.

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Program and Service-level Collaboration

1.5

VIGNETTE: THE BELL HOTEL SUPPORTIVE HOUSING PROJECT: EARLY OUTCOMES & LEARNINGS

Catherine CHARETTE, Sharon KUROPATWA,
Joanne WARKENTIN & Réal CLOUTIER

INTRODUCTION

The Bell Hotel was built on Main Street Winnipeg in 1906 near the Canadian Pacific Railway Station. In its infancy, the Bell was considered to be one of Winnipeg's finer medium-sized hotels. Over the years, the hotel deteriorated and became a single room occupancy (SRO) hotel – home to 72 persons with little or no income and few other housing options, many of whom were dealing with poor mental health and substance abuse issues. Health and safety violations eventually closed the hotel. In 2007, the hotel was purchased by an arms-length development corporation of the City of Winnipeg and a first-of-its-kind partnership involving multiple housing, health and business-focused sectors was formed to redevelop the hotel into The Bell Hotel Supportive Housing Project (The Bell). Four years later, The Bell opened its doors to provide 42 self-contained suites of permanent supportive housing for single adult men or women who are chronically homeless and who have complex health and social needs.

In this chapter, we describe The Bell partnership model and approach. Next, we present an analysis of tenants' housing history, visits to hospital emergency departments and involvement with police services 13 months pre- and 13 months post-tenancy at The Bell based on data obtained from The Bell, the Winnipeg Regional Health Authority and Winnipeg Police Services. Following that, we present an analysis of the successes and challenges of the partnership model drawing on qualitative data gathered through individual interviews (15) with Bell project partners and non-partner stakeholders. Finally, we discuss the project's early outcomes and learnings.

THE BELL PARTNERSHIP MODEL AND APPROACH

Collaboration and Partnership Across Sectors

The redevelopment of The Bell was made possible by an innovative model of partnership in Manitoba across a number of organizations and sectors:

1. CentreVenture[1] – as property owner and developer;
2. Manitoba Housing and Community Development[2], Manitoba Health, Healthy Living and Seniors[3], Manitoba Cross-Department Coordination Initiatives[4] and the federal government's Homelessness Partnering Strategy[5] – as project funders;
3. Winnipeg Housing and Rehabilitation Corporation[6] – as property manager; and
4. Winnipeg Regional Health Authority[7] and Main Street Project[8] – as service providers.

The Cross-Department Coordination Initiatives (the project lead) and the Health Authority were the project champions who pulled the project components together to develop a service and system response to address the needs of long-term chronically homeless persons with high and complex health and social needs who were high users of emergency services. Two formal mechanisms for partner communication and relationship building were the steering committee and the operations and services committee where partners provided education around their roles and responsibilities as partner functions and mandates were being clarified.

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1. **CentreVenture Development Corporation** – an arms-length agency of the City of Winnipeg that is an advocate and catalyst for business investment, development and economic growth in downtown Winnipeg.
2. **Manitoba Housing and Community Development** – a department within the Government of Manitoba with a broad mandate that includes a range of housing and community development programs and activities.
3. **Manitoba Health, Healthy Living and Seniors** – a department within the Government of Manitoba that guides the planning and delivery of health care services for Manitobans.
4. **Manitoba Cross-Department Coordination Initiatives** – a partnership between Manitoba Family Services, Manitoba Health, Healthy Living and Seniors, and Manitoba Housing and Community Development that, in concert with Regional Health Authorities and community service providers, develops and implements cross-government policy and programs that improve access to health and social services for vulnerable populations.
5. **Homelessness Partnering Strategy** – a federal initiative that seeks to address homelessness by working in partnership with communities, provinces and territories, other federal departments and the private and not-for-profit sectors.
6. **Winnipeg Housing and Rehabilitation Corporation** – a non-profit charitable corporation involved in the development, renovation, ownership and management of affordable housing primarily in Winnipeg's inner city.
7. **Winnipeg Regional Health Authority** – the public corporation responsible for providing health care to the citizens of Winnipeg and the surrounding rural municipalities of East and West St. Paul and the Town of Churchill, located in northern Manitoba.
8. **Main Street Project** – a 24-hour crisis centre that provides emergency shelter and food services, a drug and alcohol detoxification unit, on-site counseling, transitional housing and a range of other critical services.

Project partner roles evolved over the first year. As planned from the outset, toward the end of the first year the leadership role for coordinating The Bell services transitioned from the Health Authority to the Main Street Project. The Main Street Project became responsible for providing tenant-related supports and the Health Authority provided support around clinical services and service coordination. Also late into the first year, the leadership of the project was taken on by the Department of Housing and Community Development (HDC) when the HDC assumed leadership within the provincial government for homelessness. Project leadership and oversight was led by HDC staff in collaboration with other project participants. After the first year, other agencies were engaged. In the second year of operation, for example, Canadian Mental Health Association's Winnipeg Community Housing with Supports Program became a partner in the referral process and began to operate a scattered site supportive housing model.

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The Bell Approach

The Bell is managed using housing first[9], harm reduction[10] and client-centred[11] approaches. On-site supportive services address health needs, education, employment and substance abuse. The Bell is not a 24-hour institutional care model and participation in programming is not a condition of tenancy. Rather, supportive programing supports independence and helps tenants build successful tenancies and address the underlying causes of their homelessness (e.g. mental health, addictions, trauma, poor rental histories or lack of life skills). On-site staff and tenants meet weekly to set goals. Once stable, tenants are supported to move to other community housing if they identify they have outgrown the need for support and wish for more independence. Tenants have lease-based rights and responsibilities – an unusual feature in congregate housing first settings where providers or programs own the buildings. Tenants pay rent-to-income; rent supplement is available for all units over a 15-year period. Units are self-contained bachelor suites that contain a kitchenette and bathroom; six are fully accessible.

In order to be considered eligible for tenancy at The Bell, persons have to be chronic or chronically episodic users of emergency shelters. Chronic is defined in one of two ways: use of emergency shelter for over 90 days in the past six months with high service needs and poor housing history *or* long-term shelter use (i.e. continuous shelter utilization for six months or more). Chronically episodic is defined as repeated admissions over the course of six months or more, regardless of length of stay.

9. An approach that centres on moving people experiencing homelessness into independent housing where on-site tenant-related supports are available but are not a requirement of tenancy.

10. An approach aimed at reducing the risks and harmful effects associated with substance use and addictive behaviours for the individual, the community and society as a whole.

11. An approach supporting the client to take an active role in his or her decision making and focusing on the clients' definition of success.

The Bell Tenants: Socio-demographic Profile

The majority of the tenants in the first 13 month period were male (70%). Tenants ranged in age from 25 to 77 years (average 46.3); three quarters were in their prime working years (25–54 years old), one fifth was approaching retirement (55–64) and a small portion was of retirement age (65+). Most were of aboriginal ancestry, were unattached to mental health or substance abuse supports and were in receipt of general or disability benefits from Employment and Income Assistance; a few were employed or collected Canada Pension Plan disability pension. The tenants are reflective of Winnipeg's shelter population (Gessler & Maes, 2011; Homelessness in Winnipeg; Hwang, 2001).

Tenant's Housing History

Immediately prior to moving into The Bell, almost all tenants (95%) had been housed in a shelter – in either transitional or emergency housing. One tenant had been housed in a single-room residency (SRO) hotel unit and another had been in a substance abuse treatment facility. Length of residency in the housing immediately prior to The Bell ranged from one to 61 months, with the average length of residency 10 months (for those in transitional housing in a shelter) and 14 months (for those in emergency housing in a shelter). The majority of tenants had moved one to four times in the year leading up to residency at the Bell – typically moving back and forth between shelters and social housing/private market housing. One female tenant, for example, had the following 13-month housing history pre-Bell: transitional housing in a shelter (two months), SRO hotel (two months), emergency housing in a second shelter (one month), back to transitional housing in the first shelter (four months) and finally transitional housing in a third shelter (one month). One male tenant had lived in private market housing (two months), transitional housing in a shelter (one month), short-term transitional housing at an agency for persons working on recovery from substance abuse (five months), emergency housing in a second shelter (two months) and transitional housing in the first shelter (three months).

Of the 43 chronically homeless persons who moved in to The Bell during the start-up period, 35 continued to reside at The Bell 13 months later – a retention rate of 81%.

Of the 43 chronically homeless persons who moved in to The Bell during the start-up period, 35 continued to reside at The Bell 13 months later – a retention rate of 81%. Of the eight tenants who were discharged, two were evicted and three abandoned their units. The other three discharges were due to a death, a transfer to a personal care home and a tenant decision to leave The Bell to find accommodations closer to the tenant's place of employment.

TENANT INVOLVEMENT WITH POLICE SERVICES: PRE- AND POST-TENANCY AT THE BELL

In the 13 month post-tenancy period, 40% of tenants experienced reduced involvement with Winnipeg Police Services. As a group, contact hours declined 82% – from 13 hours/month to two hours/month. The number of contacts specifically related to intoxicated persons declined 71%. Some reductions were particularly dramatic: among the three tenants who had the highest involvement with police prior to tenancy at The Bell, contact hours declined by 90%, 60% and 100%. For one quarter of the tenants, involvement was constant: zero hours of involvement pre- and post-tenancy.

Some reductions were particularly dramatic: among the three tenants who had the highest involvement with police prior to tenancy at The Bell, contact hours declined by 90%, 60% and 100%.

The remaining quarter had more hours of police involvement after moving into The Bell. In terms of police call types (categories used by the Winnipeg Police Services that describe the nature of the police involvement), tenants who were previously police-involved had more of the same types of calls – intoxication, involved in a dispute or creating a disturbance. Among those who previously had zero contact hours with police, calls were for accused theft, loss of property, involvement in a dispute or victim of robbery.

Exterior view of The Bell Hotel before transformation

Photo credit: Bryan Scott

TENANT VISITS TO HOSPITAL EMERGENCY DEPARTMENTS: PRE- AND POST-TENANCY AT THE BELL

Exterior view of The Bell Hotel after transformation

Photo credit: CentreVenture Development Corporation

For the group of 35 tenants who had resided at The Bell for 13 months, a dramatic drop in emergency department (ED) use was evident: from 251 visits for the group in the 13 month pre-tenancy period to 118 visits for the group during 13 months of tenancy – a decline of 53%. The average number of visits per tenant in the 13 month pre- and post-tenancy period was 7.2 and 3.4 respectively.

Reductions in ED use were even more dramatic when comparing pre- and post-tenancy ED use among the top five ED users in the pre-tenancy period – frequent users who accounted for over 70% of all ED use among the group in the period prior to moving into The Bell. Reduction in ED use among these five users was 63%, 66%, 78%, 80%, and 100%.

As was the case with involvement with police services, there was substantial variation in hospital ED use and change in use between the pre-tenancy and post-tenancy period among the 35 individual tenants. While half visited the ED less, approximately one quarter visited the same (having a low number of visits pre-and post-tenancy at The Bell) and one quarter visited more.

With regards to the scale of emergency of the ED visit (i.e. CTAS level[12]) for the group of 35 tenants as a whole, Level 1– the most urgent – increased slightly (from zero to two percent) while Levels 2 through 5 decreased (19%, 33%, 52%, 81% respectively). The number of ambulance mode-of-arrivals decreased by 75% and the proportion that left without being seen by a doctor decreased by 30%.

12. Canadian Emergency Department Triage and Acuity Scale (CTAS): Level 1 – resuscitation; Level 2 – emergent; Level 3 –urgent; Level 4 – semi-urgent; Level 5 – non-urgent.

SUCCESSES AND CHALLENGES AROUND THE PARTNERSHIP MODEL

In addition to securing stable and supportive housing for tenants and reducing their use of emergency services, the partnership model was powerfully successful in terms of the impacts it had on partner organizations and systems. Partners resolved differences in philosophies, approaches and deeply ingrained system and sector practices to converge on a solution. The partnership would not have been possible without partners' willingness to shift their scope of practice beyond their own sector (i.e. housing, health, business) and find new and different ways to practice their respective business in non-traditional delivery models.

Nonetheless, the never-before-tried partnership experienced significant challenges – particularly around establishing roles and protocols, reaching consensus on the project principles (housing first, harm reduction and client centred), operationalizing the service provision approach (i.e. supporting independence or autonomy – in contrast to the 'doing for' approach often undertaken by the shelter sector), navigating organizational silos and integrating and coordination services in ways previously untested. Also especially challenging was managing differences in practices and expectations around tenant privacy and consent (e.g. how much information about tenants the service provider would share with the property manager) – an issue that was resolved with the establishment of operational procedures that were informed by all partners around the collection and sharing of tenant information that supported key functions but respected confidentiality within the Personal Health Information Act. Tenants signed confidentiality releases but information was shared only on a 'need to know' basis to maintain appropriate confidentiality while respecting key areas that partners required for their business functions.

Other key themes arising from the interviews with project partners and other stakeholders were: the project's success has made an impact on political leaders, funders, decision makers and the corporate community; the concept of harm reduction is not well understood and/or remains an undesirable model for many; visitors pose significant risk to tenants' tenancy; visitor management impacts heavily on staff resources; and aspects of the physical building design are integral to project security and safety.

Also arising were factors critical in supporting the success of inter-sectoral collaboration for supportive housing solutions that address the needs of a chronically homelessness high needs population:

- A **champion** who voluntarily takes extraordinary interest in and commitment to the adoption, implementation and success of the project.
- Ongoing **communication of the project approach/vision** (i.e. harm reduction, housing first, supported independence) by the project champion to all partners and stakeholders through informal and formal communication mechanisms.
- Ongoing **communication between project partners** – especially between: the service provider and the property manager; the service provider and the service funder; the Department of Housing and the Department of Health.
- Ensuring the **project approach/vision is front and centre** of planning and decision making.

- **Leadership by the health sector** in coordinating and integrating health services and working with other partners around complex housing/health issues.
- Adequate and stable project **funding.**
- An accountability framework where the **sectors are mutually accountable to one another,** not just to the funder.
- **Flexible and creative policy and service delivery approaches** including an adapted scope of practice specific to the needs of the chronically homeless population.
- **Adopting a culture of learning** whereby the project partners and stakeholders build on achieved successes, are not discouraged by challenges that arise within a unique partnership structure and are continuously interlinking their knowledge and experience gained around the project into moving the project forward.
- **Significant time commitments** on the part of partners that far exceed initial expectations.
- Having **mental health and education expertise on site** to facilitate integration and coordination of services across multiple providers.
- Ensuring **staff skills match the project service approach and client needs,** and providing appropriate levels of **staff training and support.**
- Recognizing it takes **time to build trust and relationships** with tenants; having **patience with tenants' progress.**

DISCUSSION

The Bell's first 13 months of data demonstrate that community housing stability in supportive housing can be achieved by long-term chronically homeless adults even among those with high and complex needs. The Bell's retention rate of 81% is comparable to rates for the supportive Pathways to Housing model in the United States (Pathways to Housing) and higher than similar supportive housing projects in other Canadian jurisdictions (Bell Project Team, 2013). It is important to note that, while The Bell provides assertive interventions within a high tolerance environment, a number of the tenancies were not sustainable. Tenants who were unsustainable at The Bell were supported to transition without an eviction on record (supported transitions in place of a recorded eviction aims to result in a rental history that is not a barrier to secure future housing).

Consistent with other studies on how supportive housing impacts the use of health services (Aubry, Ecker & Jette, 2014; Martinez & Burt, 2006), dramatic quantifiable reductions in visits to hospital EDs and ambulance use were experienced by The Bell tenants who had been frequent users of the health system prior to The Bell tenancy. Service arrangements that facilitated reductions included: block-based versus appointment-based Home Care (Home Care available on site during a block of time to tenants who want service, no appointment necessary); linking nearly all tenants to a primary care physician; flexible scheduling of medical appointments at a nearby primary care access centre as supported by the centre's nurse practitioners (tenants are called if they miss an appointment and are rescheduled); twice weekly visits at The Bell by the Health Authority's mobile public health service that promotes healthy sexuality and harm reduction; and weekly in-suite meetings with tenants. That mental health on-site supports connect tenants to appropriate mental health services may also be reflected in decreases in CTAS Levels 4 and 5 (which are the levels often used for triaging mental health presentations). While the reduction of patients leaving the ED without being seen is at least in part reflecting the proportional increase in higher acuity ED visits, it may also be reflecting that on-site supports at The Bell are encouraging tenants to have more trust in and interaction with the health service system. On-site health supports accompany tenants to appointments with health care providers, educate tenants and health care providers on what to expect at appointments to support more positive interactions and use a non-judgmental approach. An embedded on-site clinical support during The Bell's first year (that led to a permanent, full-time on-site nurse in year two) engendered significant trust through relationship building that translated to health service connection. Currently, The Bell nurse provides early identification and intervention so health issues are addressed and resolved.

That stable tenancies are accompanied by decreases in police interactions among persons with former high levels of police contact has been demonstrated in other studies (Dennis, Culhane, Metraux & Hadley, 2002; Somers, Rezansoff, Moniruzzaman, Palepu & Patterson, 2013). However, with respect to *increased* contact with police among some tenants after establishing stable tenancy, at least some of the increase is accounted for by changes in data collection for calls relating to intoxication (during The Bell's first year, calls of this type were included in the Winnipeg Police data; formerly, these data rested with a different Winnipeg organization). Second, as The Bell tenants are supported to self-advocate and report victimization, some of the increases may be due to increased reporting rather than increased incidents. Third, service providers report that as stable tenancies shift tenants' focus away from the securement of basic needs (shelter and food), issues that tenants may be struggling with (e.g. trauma) become more prominent and sometimes manifest in disruptive tenant behavior.

...early learnings have facilitated positive discourse around homelessness in Winnipeg. ...media attention around The Bell overall has been positive.

The finding that one quarter of the tenants had no involvement with Winnipeg Police Services before or after their tenancy at The Bell challenges common public perception that all chronically homeless persons are heavy consumers of emergency services. This and other early learnings have facilitated positive discourse around homelessness in Winnipeg. The Bell staff have been asked to speak at events; media attention around The Bell overall has been positive.

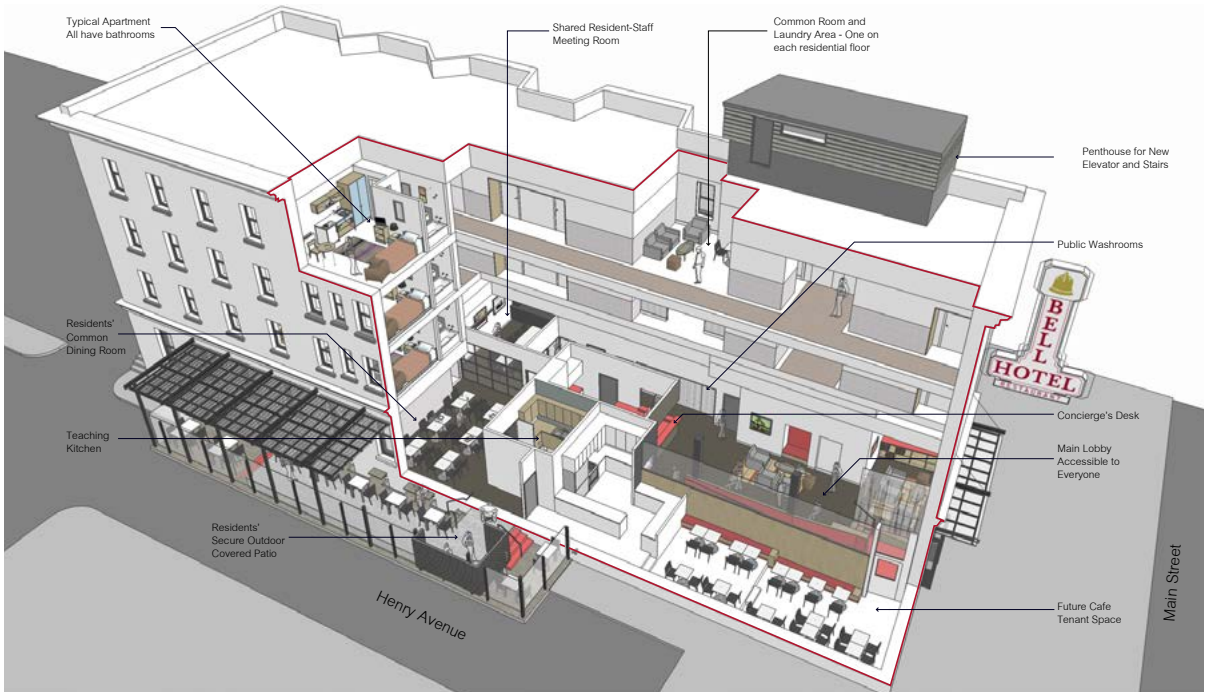
Project partners did not always agree on the project's service approach ('supported independence' vs. 'doing for'). While the project model was designed to be independence-based, elements of both approaches were beneficial to the success of the project. For example, providing meal support on site was not part of the original project design; however, it became evident that tenants lacked basic food skills and needed support acquiring groceries and preparing meals. Adapting the service approach not only responded to the needs of tenants, it also facilitated staff buy-in to the independence-based approach.

A number of the critical success factors noted by The Bell partnership – adequate and stable project funding, robust partnerships with service agencies, a strong match between staff skills and project need and on-site access to nutrition – match those identified by others delivering supportive housing to high-needs chronically homeless in other Canadian jurisdictions (Charette, 2014).

This chapter has outlined the early leanings and outcomes according to the project's first year of operation. Further and deeper investigation is needed to determine the longer-term impact of The Bell's supportive housing environment on tenants' involvement with public services. Additionally needed is a quantifiable measurement of project outcomes according to tenants' health and quality of life (anecdotal evidence from staff suggests that, in addition to experiencing improvements in self-esteem, independent living skills, life and socialization skills and quality of life, tenants are using substances less, are enrolling in courses to improve employability and are reconnecting with family). As well, an analysis of costs and consequences of The Bell in comparison to usual systems of care for the chronically homeless should be undertaken. An additional evaluative framework worthy of consideration is Social Return on Investment, a principles-based approach that values change for people and the environment (Gibson, Jones, Travers & Hunter, 2011; Leck, Upton & Evans, 2014).

CONCLUSION

Solutions involving collaboration, partnership and integration across sectors and systems focused on health, housing and business are powerfully successful in achieving community housing stability among long-term chronically homeless adults even among those with high and complex needs and in reducing use of emergency, health and police services. While The Bell is addressing the needs of a select group, there is a need for more inter-sectoral solutions employing innovative partnerships across multiple sectors to address both the needs of others similar to The Bell's population as well as more specific segments of the Winnipeg's homeless population (e.g. women, families and those committed to a non-addiction lifestyle). The Bell's positive early outcomes have made an impact on project partners who now feel more secure in supporting further inter-sectoral ventures.



Cut away view after transformation

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A Project Partner's Words

The words by one project partner perhaps best sum up the first year outcomes and learnings of The Bell Hotel Supportive Housing Project:

Things really changed for people who needed them to change most importantly. They changed in significant and positive ways and that's what we did, that's what we were able to do. And yes there are ways to do it better in the future. There are ways to do it differently if not better. But you can't ignore the fact that we got a lot of it right. We got a lot of it right because the findings say so. That's because of Winnipeg Housing and because of Main Street Project and because of the Health Authority and because of the Province and because of CentreVenture and every other partner that was involved. It would not have gone the way it did for the tenants if we hadn't done it the way that we did. So at the end of all of it, this is the most important piece, what happened for tenants – and it's the piece we should be holding onto and it should encourage us to continue the work.

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Sharon has a unique role with the Winnipeg Regional Health Authority combining the Director of Housing, Supports and Service Integration with the Community Area Director for Downtown-Point Douglas - focusing on strengthening and integrating health, housing and social service responses to the target population. Working closely with community, agencies, programs, service providers and government sectors, Sharon supports a skilled and dedicated leadership team to build partnerships and practices that prioritize health equity and community capacity.

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Joanne is currently the Senior Director, CEO Implementation & Transformation Unit with the WRHA and has held a series of leadership roles within the provincial government and health region.

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Réal is Vice President and Chief Operating Officer with the Winnipeg Regional Health Authority. He has worked in various leadership roles in the Winnipeg health care system for 28 years. His focus in the health care system in Winnipeg is: to ensure better integration of the Region's health care system; to work closely with other levels of government to improve policy and coordination of services; and to work with community stakeholders to address health equity issues.

Program and Service-level Collaboration

1.6

VIGNETTE:
1011 LANSDOWNE: TURNING AROUND A BUILDING, TURNING AROUND LIVES

Elise HUG

At 1011 Lansdowne Avenue in Toronto, a public/private/non-profit partnership model of housing and supports turned around both a once notorious apartment building and the lives of many vulnerable persons. This approach is primarily focused on addressing the needs of single persons with chronic mental health issues and low incomes by offering a wide range of supports. This case study looks at the necessary ingredients of the partnership, the key elements that facilitated the collaboration, success factors and available evaluation measures.

THE PROBLEM(S)

Residents with mental health issues present a unique set of challenges. For residents with chronic mental health issues and low incomes, finding and keeping safe, decent, affordable housing is difficult. Within the health care system, hospitals are concerned about discharging clients into homelessness as well as the impact of housing instability on health outcomes resulting in re-admission to hospital. Many property managers are wary of accepting mental health patients as tenants. Property managers who do accept residents with significant mental health challenges may deal with regular incidents of tenants becoming disruptive and/or dangerous to staff and other residents. This was the case at 1011 Lansdowne Avenue. At this building, while the property manager knew that many residents had chronic mental health and/or addiction issues, staff's only intervention option was to call the police.

THE PARTNERSHIP

This is an example of not one public/private/not-for-profit housing partnership, but rather a constellation of partnerships between multiple not-for-profit agencies, the property manager and the public sector. At 1011 Lansdowne, over 110 residents have been housed at the building by mental health agencies and are provided with supports. Supports depend on the level of individual need and the referring agency, ranging from simple referrals and case management to rent supplements and a high-support housing program (Image 1). Most agencies involved partner with the property manager through a form of head lease, whereby units are reserved by each agency for clients.

THE BUILDING & RESIDENTS

1011 Lansdowne Avenue (Images 2 and 3) is a privately owned, mid-century high-rise rental apartment building. The building has a unique unit mix, including 85% bachelor units, including bathroom and kitchenette, similar to student residences. Residents of the building are primarily single adults, with a history of one or more of the following:

1. chronic or acute mental health challenges;
2. addictions;
3. recurring or lengthy hospitalization; and/or
4. homelessness.

Approximately 28% of building residents were referred via one of the agencies.

1011 Lansdowne Avenue in Toronto, Ontario, Canada is a 353 unit mid-century high-rise rental apartment building located in the west end of the city, within walking distance of the subway.

Photo credit: *Courtney Evers, Madison Community Services*

THE MAIN PLAYERS

The main players at 1011 Lansdowne Avenue come from the private sector, the non-profit sector and the public sector. LPM Inc. is a private sector property management firm that operates 1011 Lansdowne on behalf of the owner. The property manager is Roslyn Brown. Sixteen non-profit health agencies are involved at 1011 Lansdowne as of January 2015 (Table 1), including The Centre for Addiction and Mental Health (CAMH)—Canada's largest mental health and addiction hospital—which referred over 30 of the building's approximately 390 residents and Madison Community Services (MCS), a mental health agency that operates an on-site program to provide a high level of support to 20 CAMH patients transitioning from the hospital into the community. Various provincial government sources provide rent supplements via the non-profit sector partners. The City of Toronto, through its Affordable Housing Office and Tower Renewal Office, provided $1.3M in funding for major capital repairs as well as ongoing advice on building retrofits to reduce monthly utility costs, extend the life of the building and improve building operations.

TABLE 1 *Unit breakdown by tenancy model at 1011 Lansdowne Avenue, as of January 2015*

PARTNERING/REFERRING AGENCY	NUMBER OF RESIDENTS
HOUSING + ON-SITE RECOVERY SUPPORTS	**59**
Mainstay Housing	36
Madison Community Services / Centre for Addiction and Mental Health (MCS/CAMH) High Support Program	20
COTA	3
HOUSING + LIMITED SUPPORT	**52**
Centre for Addiction and Mental Health	12
Streets to Homes	11
Archway (CAMH)	10
Fred Victor	5
Housing Connections	4
University Health Network (UHN)	4
WoodGreen	4
Seaton House	4
Regeneration Community Services	2
Reconnect Mental Health Services	2
Good Shepherd Homes	1
Central Neighbourhood House	1
The Salvation Army	1
Dixon Hall	1
STANDARD MARKET TENANTS	**278**
Direct payment via income support program	
Ontario Disability Support Program (ODSP)	190
Canada Pension Plan / Old Age Security (CPP/OAS)	29
Social Assistance / Ontario Works	25
Public Guardian and Trustee	4
No direct payment from an income support program	30 (approx.)
TOTAL[1]	388

1. Total number of residents (388) exceeds total number of units (353) due to multiple residents sharing 1 bedroom and 2 bedroom units.

Key Partnership Elements

The key elements of the partnership at 1011 Lansdowne include:

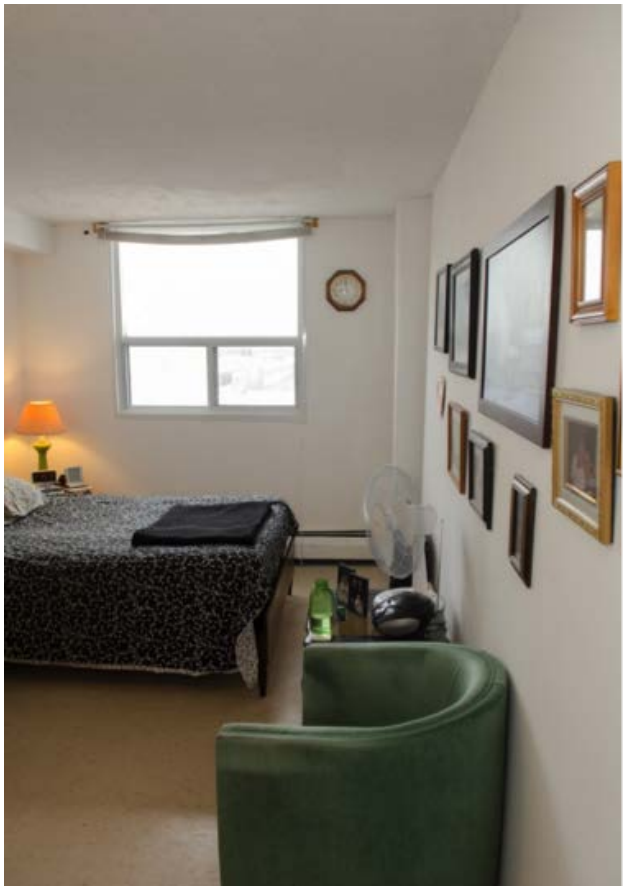
1. Government funding for major capital repairs;
2. In-suite improvements;
3. Securing affordable rents for the long term; and
4. Combining small affordable units with rent supplements.

Government funding through both the Rental Rehabilitation Assistance Program (RRAP) and the Investing in Affordable Housing program (IAH) was used to make substantial repairs to major building components, bringing the building into a state of good repair. A total of $1.3M over two funding cycles (2010 and 2011) and an investment by the owner combined to pay for roof replacement, a new boiler, new windows, new elevators, insulated cladding on external walls and improving building accessibility, such as a ramp at the building entrance and wheel-in showers in several units.

Systematic improvements were also made to the suites. LPM Inc. upgraded individual units at the company's cost upon unit turnover to new residents. Depending on unit condition, this could include upgrading the kitchenette, renovating the bathroom and/or refinishing the walls and floors.

The RRAP and IAH funding is set up as a forgivable loan, with conditions to ensure long-term affordability. If the owner maintains the units at affordable rents for 15 years (as per CMHC average rents for the City of Toronto, by unit type), the loan is forgiven. If the owner does not maintain the rents at affordable levels, a pro-rated share of the loan must be paid back.

Due to the small unit sizes (220 sq.ft.), rents are $650/month per bachelor unit. However, on a per square foot basis, the rents are $2.95/sq.ft./month, meeting standard industry targets. Some rent supplements are secured by agencies to bridge the gap between the rents and what residents are able to pay, usually through the housing allowance of the Ontario Disability Support Program (currently $479/month). The resident pays his or her portion of the rent by direct deposit to the property manager and the agency pays the rent supplement directly to the property manager via a head lease.



A resident of the CAMH/MCS High Support Program in a typical bachelor unit. Units are 220 sq.ft with own bathroom and kitchenette, similar to a student residence.

Photo Credit: Courtney Evers, Madison Community Services

Partnership Components

Key components of the public/private/non-profit partnership at 1011 Lansdowne include:

1. The use of head leases and partnership agreements;
2. Modifications to building operations and staffing, including enhanced security;
3. Renovations to create on-site program spaces; and
4. On-site supports.

Rather than accepting residents on an individual basis, head leases are used to reserve units for specific agencies for a certain number of residents that meet qualifying criteria. Partnership agreements outline roles, responsibilities and expectations for the building manager and referring agency, including how to share information while respecting privacy, protocols for eviction avoidance and minimum building maintenance standards.

Building operations were modified to meet the needs of the building's residents. Building staff are selected based on their ability to de-escalate situations and work with residents with mental health challenges. The property manager pays for 24-hour security staff, a higher level of security than would normally be provided for a rental building but necessary in this case because of the high percentage of residents experiencing mental health and/or addiction challenges. By engaging in regular conversation with residents, building staff serve as the first level of resident well-being monitoring.

Renovated program spaces are a key component of the success of the program, but there are few available funding sources. In order to make the initial CAMH/MCS On-Site High Support Collaboration work, LPM Inc. converted an underutilized basement locker area into an open concept space. This space includes a kitchen for communal cooking, a lounge area with sofas and gaming consoles, a computer and internet centre and an administrative office. Due to growing

demand, LPM Inc. also created a second space consisting of a seminar room and administrative offices for other agencies to use. Later, a boardroom, community room and outdoor terrace were created to offer space for other activities. Overall, LPM Inc. provides over 2,000 sq.ft. of space rent-free and paid for the renovations.

On-site supports vary based on individual need, the person's referring agency (if any) and resource availability. At the high end, the CAMH/MCS On-Site High Support Collaboration is designed to support patients being discharged from the hospital into housing with recovery supports to reduce re-hospitalization rates. It offers extensive supports from 8 a.m. to 8 p.m. for 20 high-need residents, including supervised activities, recovery supports, a meal program and daily community excursions. Mainstay and COTA operate part-time programs for 40 residents.

Success Factors

The success of the partnership hinges on several key factors. These include the strengths and resources of the various partners (including an anchor agency); the on-going collaboration and communication between the property manager, City and various partners; and an incremental and flexible approach.

This partnership leverages the strengths and resources of each of the partners: the property owner's capital asset (the apartment building); the non-profit sector's ability to offer recovery supports outside of a hospital; and available public sector funding to extend the life of existing affordable housing.

The City of Toronto and the property owner engaged in an ongoing partnership to improve the building, including identifying and prioritizing building improvements and securing funding. First, the City's Tower Renewal Office worked with the property manager to assess the building's performance and develop a multi-year action plan, including cost estimates for capital repairs and efficiency retrofits. Then the City's Affordable Housing Office worked with the Canada Mortgage and Housing Corporation to streamline the RRAP program to make it easier for property managers to apply for and secure funding for high-rise rental buildings. Together, the City and owner were able to accelerate repairs, lower operating costs and achieve rapid improvements to building conditions at a relatively low level of funding ($3,654 per unit). They also secured affordable long-term rents, increased unit accessibility and reduced environmental impacts.

In 2009, after the owner made initial investments in the building, more residents began choosing to live at 1011 Lansdowne due to the improvements in building conditions and management. This was due to the low rents, self-contained units, and the property manager's openness to accepting residents with mental health challenges. Very high vacancy rates began to steadily decrease.

In 2011, CAMH and MCS established the first formal partnership with LPM Inc. They acted as an anchor partner, attracting other agencies to the building. The CAMH/MCS partnership agreement was then used as a template from which the property manager and subsequent agencies could create customized agreements. Agreements are scalable, allowing agencies to incrementally increase the number of units as funding and units become available.

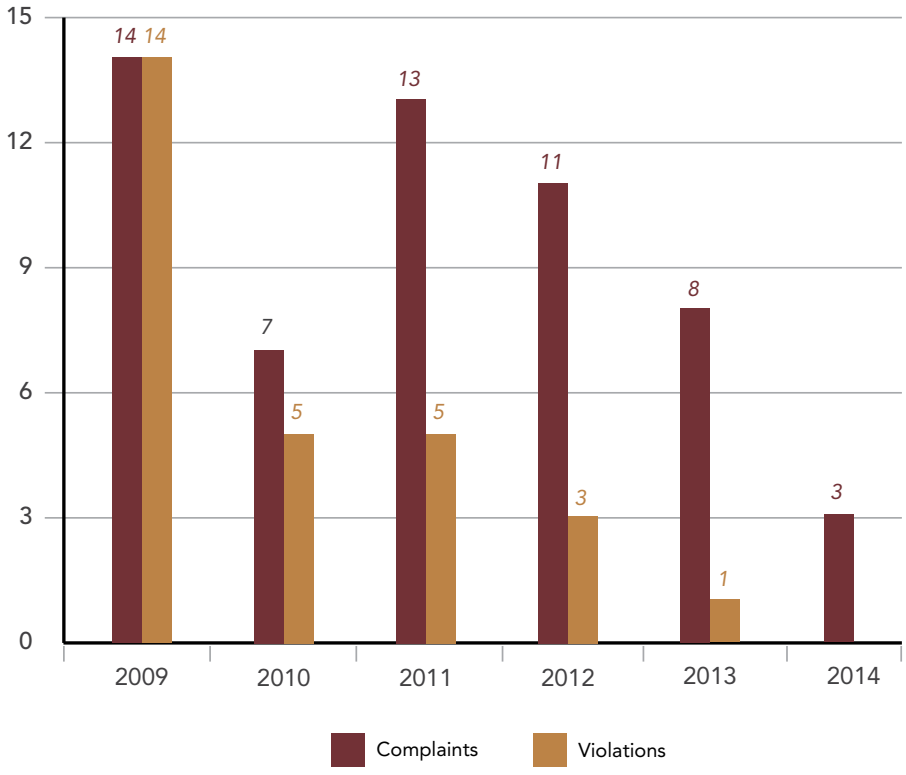
Establishing a framework for on-going communications was essential. The property manager and CAMH/MCS set up an advisory steering committee to deal with issues that arose. This committee was identified as a "critical mechanism" to proactively "address emerging challenges and make positive changes to the program" (CAMH, 2014, Executive Summary, para.8). Staff from various agencies also continue to connect informally.

MEASURING OUTCOMES

Three evaluation methods were used to assess outcomes using different lenses. A formal evaluation framework was set up for the CAMH/MCS partnership, in addition to self-reporting by the property manager and a review of municipal property standards records. Several positive outcomes have been identified in terms of building conditions, the business model and health outcomes.

This apartment building has been turned around, both in terms of living conditions and in terms of its business model. Based on municipal data, there was a marked decrease in both the number of municipal property standards violations and complaints between 2009 and 2014 (Chart 1) (City of Toronto, 2015), indicating improvements in building conditions. There was also a marked change in vacancies. The property manager reports that vacancy rates in the mid to late 2000s were as high as 75%. There is now a waiting list. Based on the success at 1011 Lansdowne, the property manager has expanded the partnership model to other apartment buildings and is seeking to expand to other Canadian cities in partnership with local agencies.

CHART 1 *Complaints and Violations with respect to Municipal Property Standards at 1011 Lansdowne Avenue, Toronto.*



An internal review of the CAMH/MCS On-site High Support Collaboration led by Dr. Sean Kidd and Nick Kerman (CAMH, 2014) revealed the following significant successes related to health outcomes:

- Since the program started in 2011, 70% of clients continue to reside and participate in the program, while 13.3% have moved on to private housing, 6.6% have moved to other supported housing and 10% have returned to hospital (Madison Community Services, 2014).
- The majority of clients had a history of repeated and/or lengthy hospitalizations, and many had also experienced periods of homelessness. Madison Community Services indicates that clients have been able to experience stability in their housing situation, reduce their use of emergency services and increase their participation in social settings.
- "Residents reported higher levels of satisfaction with their lives than is commonly found in samples of people with schizophrenia; and clinicians' ratings of functioning gradually increased over the course of the evaluation" (CAMH, 2014, Executive Summary, para.10).
- The cost of the On-site High Support Collaboration is between $178.25 and $192.55 per day, depending on whether the program is full or not. This compares to $665.47 per day per client in hospital at CAMH (CAMH, 2014, Executive Summary, para.8).

HOUSING FIRST PRINCIPLES

Overall, the partnerships at 1011 Lansdowne Avenue adhere to Housing First principles of immediate access without housing readiness requirements, consumer choice and self-determination, recovery orientation, individualized and person-driven supports, and social and community integration. However, because of the diversity of supportive housing models available in response to the diversity of client-resident needs and funding provided, there is variability between programs and the protocols of the different referring agencies. For instance, the agency offering the highest levels of support (CAMH/MCS) has criteria for program eligibility based on the levels of support the program is funded to provide.

SUMMARY

The public/private/non-profit partnership model at 1011 Lansdowne is a highly effective approach to addressing homelessness for persons with low incomes and mental health challenges. Each sector brings its strengths and resources to the partnership. Expansion and replication should be explored with other property managers and agencies in Toronto and in other cities.

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As Project Manager in the City of Toronto's Tower Renewal Office, Elise brought together property owners and managers, City Divisions, major funders and non-government organizations to improve Toronto's older high-rise apartment communities, including at 1011 Lansdowne. She is currently working in the City Planning Division, facilitating development review and area-wide plans.

2.0

Systems Planning for Targeted Groups

2.1

WOMEN FIRST — AN ANALYSIS OF A TRAUMA-INFORMED, WOMEN-CENTERED, HARM REDUCTION HOUSING MODEL FOR WOMEN WITH COMPLEX SUBSTANCE USE AND MENTAL HEALTH ISSUES

Chelsea KIRKBY & Kathryn METTLER

INTRODUCTION

While estimating homelessness in Canada has been difficult, it is believed at least 200,000 Canadians experience homelessness each year (Gaetz, Donaldson, Richter, & Gulliver, 2013). What is often missing from research into homelessness in Canada is identification of the specific situations and needs of women experiencing homelessness. This paper identifies the complexity and specific issues for women experiencing homelessness, and presents two different supportive housing models offered by the Jean Tweed Centre in Toronto as responsive models to the needs of women. The two housing models discussed serve women experiencing homelessness and concurrent mental health, and/or substance use concerns.

Women and Homelessness

Women experiencing homelessness are often hidden from the public realm: A recent study by Sistering in Toronto has shown that women's homelessness is underestimated due to a lack of understanding of the ways in which women experience homelessness, which may include couch-surfing, trading shelter for sex, remaining in violent situations for housing, and other tenuous housing circumstances that take place outside of the public realm (2002). While male homelessness is often more visible in urban areas where men are more likely to sleep on the streets or in public spaces, women are less likely to be seen in public places when homeless due to the significant threats of physical and sexual violence they experience. Many women will therefore stay with dangerous and violent partners rather than submit to the incredible risk of violence and exploitation on the streets (Gaetz, Donaldson, Richter, & Gulliver, 2013). The risks of violence associated with homelessness even extend into the shelter system for many women, which may also explain their avoidance of accessing these spaces and contribute to the relative invisibility of their condition. There is also a disincentive for many women to access shelters because their needs simply go unmet – the most recent Toronto Report Card on housing and homelessness found that women with substance use and/or mental health issues are not sufficiently supported by the shelter system (Toronto, 2003). For these reasons, homelessness for women is often more hidden than it is for men (Klassen& Spring, 2015; Novac, Brown, & Bourbonnais, 1996).

Not only is homelessness often more hidden for women than it is for men, but the experiences of women facing homelessness are also different than those facing men. For women in particular, domestic violence remains a leading cause of homelessness. In 2002 the World Health Organization found that 29% of Canadian women reported physical violence by an intimate partner, and in a study by Baker, Cook and Norris (2003), 38% of women reported becoming homeless immediately after separating from their partners, and up to 50% identified other housing difficulties, including loss of ability to pay their rent. Not only is violence a leading cause of homelessness for women, but it also continues when on the streets: when women become homeless, they are at increased risk of violence and assault, sexual exploitation and abuse (Gaetz, et al., 2010).

To add complexity to the issue, many women who are homeless are also struggling with mental health and substance use concerns – issues which affect women of all statuses, but which can compound the challenges faced by women at risk of homelessness. Each year, one in five Canadians experiences a mental health or substance use issue (CAMH, 2012). It is estimated that about two-thirds of women with substance use problems have co-occurring mental health problems (Finnegan, 2013) and more than 50% of women in shelters experience major depression (Helfrich, Fujiura, &Rutkowski-Kmitta, 2008). Mental health and substance use concerns can increase for women who experience homelessness, and they can also be precipitators to homelessness - women experiencing these difficulties often face challenges in maintaining employment, which can affect their ability to afford their housing, and maintaining tenancy can be difficult when experiencing significant mental health and/or substance use concerns, requiring treatment.

Women who are pregnant or parenting can also face increased barriers to maintaining housing. Women with children have been found to be at higher risk of living in substandard housing, and families have been identified as one of the fastest-growing homeless populations in Canada (Ritcher&Chaw-Kent, 2008, Zabkiewicz et al., 2014). Women with children remain particularly vulnerable to homelessness as violence and poverty are identified as "the leading cause of homelessness for families" (Gaetz et al., 2013). Parenting women are not only at high risk of being precariously housed, but those who experience homelessness also report being scared to access emergency shelters and supports due to fear of apprehension of their children by child protection authorities (Cooper, Walsh, & Smith, 2009; Jones & Smith, 2011; YWCA, 2006). To add complexity to this issue, pregnant women who are homeless can experience increased vulnerability to substance abuse: the Canadian Perinatal Health Report found that 11% of pregnant women consumed alcohol in the past month and up to 5% reported using illicit drugs during pregnancy (Public Health Agency of Canada, 2008).

Not only is homelessness for women often hidden and under-estimated in the public realm and shelter system, there is also a paucity of research that specifically examines women's experiences of homelessness. Therefore, for members of the public, social service workers, and academic communities the prevalence and nature of women's homelessness is obscured.

With the causes and actual experiences of homelessness being different for men and women, policies and programs tailored to meet women's needs are required, lest efforts to address homelessness fail to serve many women who are most severely affected. Given the barriers for women, there is a particular need for safe, affordable housing specific to women, and women with children, which is responsive to their needs. Stable, supportive housing has been linked to positive outcomes for those with mental health and/or substance use problems, including reduced substance use, improved mental health, and reduced use of costly services (i.e. hospital emergency departments) (Padgett et el., 2009). In addition, providing stable housing for families is crucial to promote well-being as it has been found that child homelessness is associated with poor health outcomes for children, and longer periods of homelessness among children is associated with worse health outcomes" (Sandal et al., 2015).

A GENDERED APPROACH TO ADDRESSING HOMELESSNESS

The Jean Tweed Centre (JTC) is a not for profit agency funded by the Ontario Ministry of Health and Long Term Care to provide services to women (and their families) across the province who are experiencing problems related to mental health, substance use and/or gambling. JTC offers a range of services including day and residential programming, out-patient counselling, trauma counselling, family support and continuing care. Outreach services are available in Toronto for pregnant and parenting women, as well as women with concurrent disorders and current involvement in the criminal justice system. Safe, affordable, permanent housing is also included in the range of services offered by the JTC.

In partnership with two housing agencies (Mainstay Housing and the YWCA Toronto), the JTC has tailored supportive housing programs for women experiencing homelessness, problematic substance use and/or mental health concerns. These programs serve women who identify experiencing homelessness in keeping with the definitions of the Canadian Observatory on Homelessness, defined as: being unsheltered (e.g. living in public spaces or make-shift shelters), emergency sheltered, provisionally accommodated (e.g. couch surfing, trading sex for shelter), and at imminent risk of homelessness (e.g. experiencing violence in the home, unable to afford rent) (Canadian Observatory on Homelessness, 2012). The supportive housing programs described in detail below provide a stable place from which women can anchor themselves while engaging in supports to achieve their goals related to housing stability, substance use and mental health, thus increasing overall wellbeing.

Frameworks For Supportive Housing For Women

The JTC supportive housing programs are grounded in frameworks that take into consideration the context of a woman's life, the impact of her life experiences on her current situation, her strengths and coping skills, and her desire and readiness for change. Women-centered, trauma-informed, and harm reduction approaches are central to the services offered to women through these programs.

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Women-centred Frameworks

Recognizing that women's experiences with homelessness, mental health, and substance use can be different than those of men, a women-centred approach has been incorporated into these supportive housing models. This approach takes into consideration the context of women's lives and how all areas are interconnected and contribute to her well-being. Women-centred care also emphasizes the importance of women's relationships, and supports connectedness among women. (Ontario Ministry of Health and Long Term Care, 2005). As described by Barnett, White, & Horne (2002) and based on the *Framework for Women-centred Health* (Vancouver/Richmond Health Board, 2001) the core of women-centred care is:

- a focus on women
- involvement and participation of women
- empowerment
- respect and safety

In addition, Barnett, White, & Horne (2002) describe how women-centred services:

- address the complexities of women's lives
- are inclusive of diversity
- have integrated service delivery
- respond to women's forms of communication and interaction
- provide information and education

In the context of supportive housing for women with mental health and/or substance use concerns, a women-centred approach means creating safe spaces for women to reside, providing women's only spaces, encouraging women to participate in community-building and housing related activities, supporting women to live with increasing independence, and addressing all areas of women's lives that impact their well-being. Another important aspect of women-centred housing is to ensure that the woman is the lease-holder for her own apartment unit, which ultimately gives her choice and control over her own living space.

Another important aspect of women-centred housing is to ensure that the woman is the lease-holder for her own apartment unit, which ultimately gives her choice and control over her own living space.

Trauma-Informed Approaches

A trauma-informed approach is also essential when working with women with mental health and/or substance use concerns. A number of studies have shown the connection between mental health and/or substance use and a history of trauma: a recent Canadian study looking at the pervasiveness of trauma among Canadian women in treatment for problematic alcohol use found that of the women interviewed, 90% reported childhood or adult histories of abuse (Brown et al., 2009). Experiences of trauma among women with substance use issues are linked to a range of mental health outcomes, including suicide and low self-esteem (Finnegan, 2013). One study has found that more than half of the women who report experiencing domestic violence also identify some form of mental health concern (Roberts, Lawrence, Williams, and Raphael, 1998).

Similar numbers have been found in large studies in the United States, including one that interviewed over 1,500 women and found that trauma was reported by over 95% of women who utilized both substance use and mental health services (Newmann & Sallmann, 2004, cited in Sturm, 2012). Likewise, the 2005 *Women, Co-Occurring Disorders and Violence Study*

The supportive housing models follow these core principles of Trauma-Informed Practice, as described in ***Trauma Matters: Guidelines for Trauma-Informed Practice in Women's Substance Use Services***

1. acknowledgment of the prevalence of trauma
2. safety
3. trustworthiness
4. choice and control
5. relational and collaborative approaches
6. strengths-based empowerment modalities

found that of over 2,500 women who identified as having substance use and/or mental health issues, more than 91% reported a history of physical abuse and 90% reported sexual abuse at some point in their lives (Becker et al., 2005, cited in Sturm, 2012).

Traumatic experiences also have a negative impact on physical health and those with trauma histories commonly report such symptoms as chronic pain, central nervous system changes, sleep disorders, cardiovascular problems, gastrointestinal and genito-urinary problems, among others (BC Centre of Excellence for Women's Health, 2009). These physical symptoms can have a detrimental affect on a woman's well being, particularly if she is also facing a mental health and/or substance use issue, is under-housed, un-/under-employed, and/or living in poverty. It has been well documented that those living with these issues have a difficult time accessing health care for a number of reasons including, lack of transportation and systemic barriers (e.g. not having an address to register with Ontario Health Insurance (OHIP), stigma related to mental health, etc.) (Canadian Mental Health Association, 2008).

Considering the significant impact and prevalence of trauma for women with mental health and substance use concerns, the JTC supportive housing programs have incorporated a trauma-informed approach to care.

Considering the significant impact and prevalence of trauma for women with mental health and substance use concerns, the JTC supportive housing programs have incorporated a trauma-informed approach to care. With this approach in mind, the support service providers work with women in a way that acknowledges how common trauma is and the wide impact it has, including the interrelationship between trauma, substance use and mental health concerns. This understanding is foundational in all aspects of women-centered service delivery. It also recognizes a wide range of physical, psychological and emotional responses that women may experience as a result of trauma and view these not as 'problematic behaviours' but as responses to difficult life experiences, which may reflect coping strategies that are (or were) survival strategies. It is acknowledged that these responses may help or hinder her in achieving her health-related goals. Service providers also develop safe spaces to support women with the challenges they experience, and seek to maintain safe therapeutic relationships with clients. They collaborate with women in non-judgmental ways to support them in identifying their own goals, and steps to achieve them. One concrete way this is done is by developing individual service plans with each woman, ensuring women experience choice and control in the development of their own care plan. In addition, service providers seek feedback in how services are being delivered, and are responsive to this feedback.

Harm Reduction Frameworks

Harm reduction is another approach central to the JTC supportive housing models. The Canadian Harm Reduction Network defines this approach as "policies, programs and practices that aim to reduce the negative health, social and economic consequences that may ensue from the use of legal and illegal psychoactive drugs, without necessarily reducing drug use" (Canadian Harm Reduction Network, 2014). In practice, this means that goals related to substance use (i.e. reduction, abstinence, and/or no change) are respected, and women are supported with respect to their choices and where they might fit on the abstinence/active use spectrum. As this housing is not contingent on abstinence, there is flexibility in supporting women to reach the goals they have set for themselves. Counselling approaches are also flexible and women are offered support (including referral to community resources) to ensure that their goals match external expectations that women may be facing (e.g. parole conditions, child welfare conditions, etc.).

Within these supportive housing programs, harm-reduction extends beyond substance use and takes into consideration all areas of a woman's life. The women participating in the supportive housing programs are often confronted with the challenges of living in poverty, violence and trauma, pregnancy, mothering, single-parenting, discrimination, oppression, stigma, involvement in sex trade work, involvement with the criminal justice system, and involvement with child protection authorities. The BC Centre of Excellence's 2009 discussion guide titled *Women Centred Harm Reduction* describes the inter-sectionality of this approach:

> *In the context of women's substance use, harm reduction cannot simply be about the intersection of one health determinant with the use of substances; it is instead about how many health determinants interact, and in turn amplify or influence the experience of women's substance use (BC Centre of Excellence, 2009).*

Harm reduction approaches are therefore also used to address mental health concerns, including medication management and referrals for on-going psychiatric care. Furthermore, the use of harm reduction approaches help women maintain their housing by addressing issues such as hoarding and interpersonal conflict with neighbours. In each of these instances, the counsellors seek to support women to identify their own goals in relation to their well-being, and facilitate mechanisms to increase safety and support. In many instances, referrals to other community services are made, with the intention of creating wrap-around support systems for women and their families.

PROGRAM MODELS

The JTC has partnered with two agencies to create two different supportive housing models, the Addictions Supportive Housing (ASH) model and the Elm model. Both of these housing programs offer low-threshold access to housing, in that entry into housing does not require women to provide housing references from previous tenancies, or to abstain from substance use. This is in keeping with housing-first philosophies which identify housing as a fundamental human right, and a cornerstone of overall health and well-being. As support from case managers/counsellors is integral to these models, a willingness to work with staff to address mental health, substance use, and other health concerns is required.

This is in keeping with housing-first philosophies which identify housing as a fundamental human right, and a cornerstone of overall health and well-being.

Common Components to Jean Tweed Centre Supportive Housing Models

In addition to working from women-centred, trauma-informed, and harm reduction frameworks, another key component of both housing models is the provision of housing support for women who have historically experienced difficulties maintaining their housing. The JTC's housing partners (Mainstay Housing and the YWCA Toronto) employ housing support staff dedicated to helping women to identify and solve tenancy issues, which if left unattended, may lead to eviction. Examples of this work include discussions about tenant rights and responsibilities, payment plans for tenants who are in rental arrears, and mediated agreements between tenants and the landlord to address disruptive behaviours. The housing support is provided in tandem with counselling and case management support, however these roles are separated by workers and agencies to allow women safe spaces to discuss their personal concerns independent of issues related to their tenancy. If a woman loses her tenancy, the JTC counsellor remains connected to her and provides support to obtain other housing and access to other appropriate resources.

Finally, another important aspect of these housing models is the integration with larger social and health care systems. Women entering the housing programs often present with a range of challenges that include mental health and substance use, physical health needs, criminal justice concerns, lack of food security, lack of transportation and income instability. Clients are able to connect with a Nurse Practitioner who provides weekly on-site support to clients in the housing programs, and is also available via the Ontario Telemedicine Network. Women are also often connected with other health care providers, therapeutic groups, food banks, residential programming, and government assistance.

Addiction Supportive Housing for Women

The Jean Tweed Centre's Addiction Supportive Housing (ASH) model is delivered in partnership with Mainstay Housing - a non-profit agency which provides housing for mental health consumer-survivors through government funded rent-geared-to-income subsidies. This model, which first began operating in the spring of 2011, hosts 32 self-contained apartment units, mostly located in the west-end of Toronto. This model originally had all 32 units in one residential building, with the staff located on-site. In recent years this model has been modified to 16 units being located in the same building (clustered housing model), and the remaining 16 units distributed throughout the city (scattered housing model).

This model is considered to be an "intensive-support" model with one support staff per eight tenants. The JTC employs three counsellor/case managers to assist clients with accessing appropriate health care, navigating the service system, and additional support in the areas of criminal justice, family law, etc. Mainstay Housing employs one housing support worker to assist clients with maintaining their tenancy. Staff hours are extended to provide support to tenants between 9am and 8pm. The counsellors also offer group sessions in the areas of relapse prevention, health and well-being, and mindfulness practice. A breakfast group is offered once a week to offer nourishment and opportunity for social interaction, and seasonal lunch celebrations are offered on a quarterly basis.

This housing program is intended to serve women with complex health care needs, including high use of emergency department and/or withdrawal management services. All tenants entering the program identify being homeless at the point of intake, and also identify "severe and active" substance use concerns. In the four years of operation, this program has served 56 women. Ages of women in the program average 35 years old, with the youngest being 18 years old and the oldest 59 years old. Primary substances of concern are, in descending order of prevalence: crack, alcohol, cannabis, cocaine, heroin, and opioids. A high number of the women identify poly-substance use and/or high-risk behaviour associated with their use, with over 30% of women identifying a history of injection drug use. Over 30% of women also identify co-occurring mental health concerns, including anxiety, depression, and suicidality. Of the participants, 18% identify other physical health concerns, 14% identify criminal justice involvement, and 32% identify Children's Aid Society (CAS) involvement with their children at the point of intake. The primary income sources for women in this program are Ontario Works (43%) and the Ontario Disability Support Program (39%).

Elm Housing

The YWCA Toronto Elm residential complex is a congregate housing model, with 300 units for women and their families, and is located in the downtown Toronto core. Of these 300 units, 150 are affordable units for women with low incomes, 100 are dedicated to women experiencing homelessness who also identify "severe and persistent" mental health concerns, and 50 units are dedicated to women of Aboriginal descent.

The JTC employs five counsellors/case managers to provide on-site support services to the 100 women living with mental health and concurrent substance use concerns, and two Aboriginal counsellors offering services to the 50 women of Aboriginal descent. The YWCA employs three community engagement staff for the Elm community, as well as a mental health specialist and an occupational therapist. Two housing support workers are also employed to help women maintain stable housing, and break the cycle of homelessness.

The 100 units that make up the supportive portion of this housing program are dedicated for women with significant mental health concerns, who also identify being homeless at the point of intake. The average age for JTC clients in this program is 43, with the youngest being 20 years old and the oldest 69 years old. While all of these women identify mental health concerns, 45% of women also identify co-occurring substance use, with the primary substances of choice being alcohol, crack, cannabis, and heroin.

While all of these women identify mental health concerns, 45% of women also identify co-occurring substance use, with the primary substances of choice being alcohol, crack, cannabis, and heroin.

EVALUATION METHODOLOGY

The evaluation of these programs described in this section have been drawn from two main sources described below: 1) The Supportive Housing Performance Indicator Reporting, and 2) The Jean Tweed Centre Supportive Housing Evaluation. As these two sources are used for evaluative purposes and to monitor program quality and improvement, Research Ethics Board approval was not sought prior to data collection. This is in line with the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* that states in Chapter 1, Section 2.5 that program evaluation does not fall within the scope of Research Ethics Board review, even with the presentation of the results in this Chapter, the anonymity of the information presented ensures the confidentiality of all participants (Government of Canada, 2015).

1. JTC Supportive Housing Performance Indicator Reporting

Performance Indicator Reporting is program-based data collection (used for both ASH and Elm Supportive Housing programs) with the purpose of demonstrating program successes and challenges by monitoring targeted goals. Program counsellors are responsible for collecting the data through discussion with clients (self-report) and observation, and report monthly on such indicators as Emergency Department (ED) visits, Withdrawal Management System (WMS) use, length of time housed, and a range of determinants of health such as income, housing, connection to primary care and community resources.

2. The Jean Tweed Centre Addiction Supportive Housing Evaluation

Recruitment

In 2012, all women in the ASH Program were invited to participate in either a focus group or an individual interview to explore the benefits and challenges they have experienced through their participation in the Supportive Housing Program. Recruitment was facilitated by face-to-face invitation and through the distribution of invitation/information flyers in residents' mailboxes.

Follow-up phone calls were made by the Evaluator and Counselors to ensure that each woman had the opportunity to participate in an interview or focus group if she was interested. In each recruitment method, it was stressed to participants that participation was voluntary and that their choice not to participate would not have an effect on their support services or housing.

Data Collection

All participants were interviewed on a one-on-one basis. With the aid of an interview guide, in-depth, semi-structured interviews were conducted by an internal evaluator, who was not a program counsellor. The interviewer maintained some structure within the interview while allowing for fluidity and reactivity within the interview process so that the interviewee could freely express her thoughts and feelings. In total, 12 interviews were conducted that ranged from 15 to 45 minutes in length.

Confidentiality Concerns

The evaluation team considered internal confidentiality (when individuals are identifiable to others in research reports) as a primary concern as the evaluation was conducted with a small network of women who know one another or know of one another.

To maintain confidentiality, the following strategies were used throughout the data collection process: individual interviews were offered, the names of participants were not recorded on audio-files or written recordings, consent forms were kept in a locked cabinet which was kept separate from all forms of data collection, all audio-recordings were deleted immediately following transcription, and all written documentation was kept on a password protected computer. Also, the informed consent process outlined to participants how their identity would be protected, how direct quotations and data might be used and the intent to share the findings publically. This process allowed respondents to make informed decisions about what they wished to disclose and who would eventually have access to the findings. Finally, no identifying information was included in the following report.

Analysis

Thematic analysis was used as a method of "identifying, analyzing and reporting" themes co-constructed from the qualitative data (Braun & Clarke, 2006). This involved becoming familiar with the data through transcribing the audio-recordings. Next, inductive analysis was used to code the transcripts whereby particular segments of data were considered meaningful and were given codes that represented their meaning. Relationships between codes were then examined and themes were developed that conceptualized their relationships. Themes were then refined until they were coherent and reflective of the patterns within the data.

This process allowed respondents to make informed decisions about what they wished to disclose and who would eventually have access to the findings.

EVALUATION OUTCOMES

Impact on health system

The ASH model has shown considerable savings to the health care system through significant reduction in hospital Emergency Department (ED) visits and use of Withdrawal Management Services (WMS). Use of emergency services is extremely costly to the system with an average emergency room visit in the central Toronto area being $219 (Dawson & Zinck, 2009). Data collected from participants in the ASH program through performance indicator reporting between July 2011 and March 2015 shows consistently an average quarterly decrease in Emergency Department use by 86% compared to ED use in the three months prior to entry into the program (see Table 1), and decrease in Withdrawal Management Services use by 98% compared to the three months prior to women entering the program. Furthermore, the focus on appropriate health care has led to the vast majority of women (100% in the ASH program, and 99% in the Elm program) now identifying a consistent primary health care provider, which is also cost effective (e.g. can decrease unnecessary visits and duplication of services if also using a walk-in clinic or ED) and improves continuity and coordination of care.

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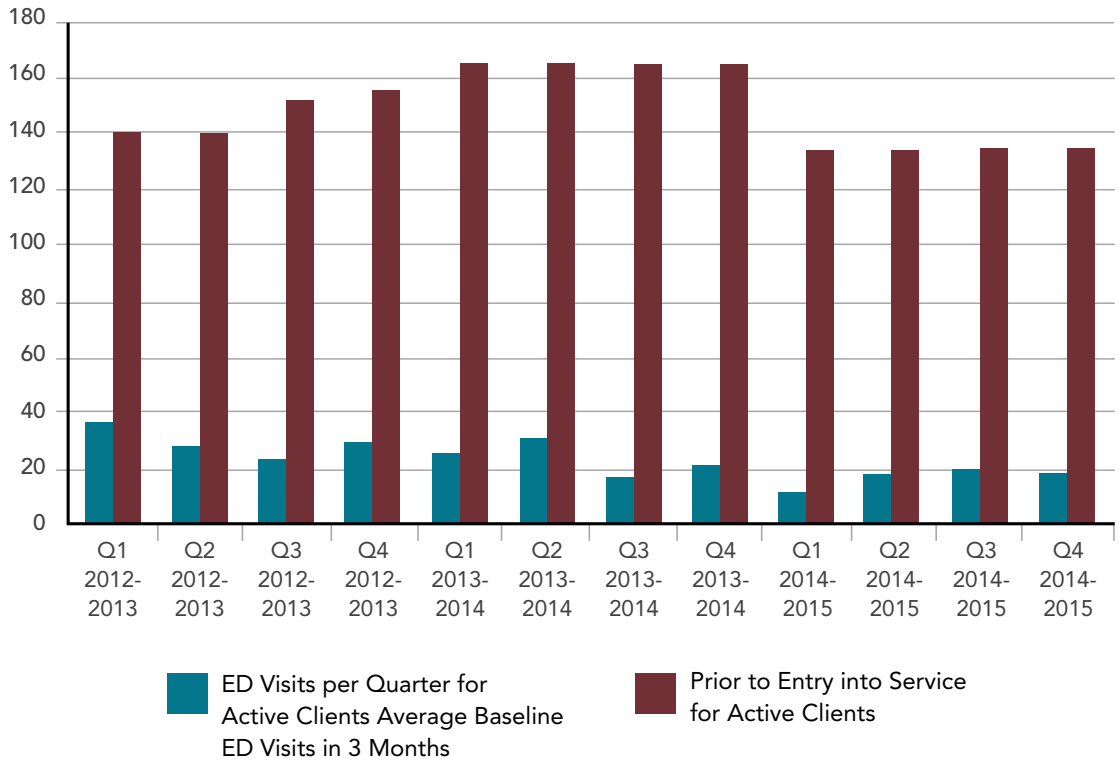
TABLE 1 *Average Baseline Emergency Department Visits in 3 Months Prior to Entry into Service for Active Clients Compared to ED visits per Quarter for Active Clients*



Impact on women's health and well-being

Increased housing stability

Housing has been deemed to be a "fundamental condition and resource for health" by the World Health Organization's Ottawa Charter for Health Promotion (WHO, 1986). Housing support has proven beneficial in helping women maintain their tenancy. Women have reported that the ability to enter into mediated agreements with the landlord to address behavioural concerns, and/or have payment plans to address rental arrears has meant they are able to maintain their tenancy for longer periods of time than ever before. The Performance Indicator Report, which tracks how long women remain housed, shows that the average time for women who are currently housed in the ASH program to have maintained their permanent housing is 3 years and 1 month. These findings are significant in that many women identify this being the longest amount of time they have maintained their housing in one place. In an interview conducted as part of the ASH Supportive Housing Program Evaluation in 2012, one woman shared the following:

"I love my house, it's nice. I am definitely proud of it. Even my daughter called me and said "You're still in the same place?" Like, there is pride. It has given me a lot of self-pride, knowing that I can do it on my own and that I chose to. I could have been one of those girls who got the boot for not paying their rent or whatever circumstance it was, I could have been one of them. And I have, at certain points for sure. So it also shows me that this is what I want, I do want a structured life, I want to be a normal person. I don't want to have a place where it is used and abused and it had just given me that safe place where it's a choice, it's how do I want to live with it. I have had numerous housing where it has just been a party house, where it has been used and abused and then it's gone. But this I've had for over a year because that's what I chose. It's wicked, it feels good"

Improved family life

With 32% of women in the ASH program and 6% of women in the Elm program involved with CAS and many women having become pregnant during their tenancy, reunification with children and apprehension prevention are important goals for many women. Addictions and Mental Health Ontario commissioned a report to help identify client outcomes for Addiction Supportive Housing across the province (Johnston, 2014). The study did not break down results for each program, but found that participants (both men and women) in this type of housing had a slightly increased chance of regaining custody of their child(ren) when participating in this program with 7% having custody of under-age children at admission while twelve percent (12%) had custody at the conclusion of the study (Johnston, 2014).

Women also report increased connection to family and some women who have previously had their children removed by the child protection system are now parenting from home. In data collected as part of the ASH Supportive Housing Program Evaluation, women shared how supportive housing was an important factor in re-establishing contact and care for their children. For one participant, having housing was essential in re-establishing contact with her children. Having the stability of safe and permanent housing was imperative for this to occur and she described her feelings now that she has care of her son,

"And it really is his time, and that's what I am trying to remember as much as possible, it's his time to be here with me and it is his time to really get to know me like I want him to know me. I want an everyday home life with my kids. I have that with my daughter and even though she is big now, she is…[omitted for confidentiality purposes], she is going to be coming this summer too so I am going to spend time with both my kids."

Increased sense of safety and well-being

Women have reported increased ability to stabilize their health care needs, particularly with respect to their experiences of mental health concerns. One participant identified:

"What I have steadily noticed is that the number of my dissociative episodes I've had has severely decreased. And I do have panicked moments and I will come running down and will talk to whoever will listen and that's everybody here who's pretty supportive of me".

Other women have also expressed that their use of substances to cope has also decreased due to the stability offered by permanent housing. One participant described:

"I want to be more sober than I used to. Seeing other women in this building accomplishing things, so for some of the women actually getting their kids back, that has helped. And back in the day, I heard what was said but I wasn't listening and now I am listening and taking everything to heart. And I am taking the advice that I am receiving. Before it was like "Yeah, okay, whatever, I just want to get out of here" but at the same time I wanted to learn but my addiction wasn't allowing me to. I believe that I have changed more than I expected, I didn't expect myself to realize the addiction and the fight and all the ups and downs that comes with it. And I have a desire to stay clean now and I didn't before and I believe that if it wasn't for here I wouldn't be feeling this way".

Women have also described their own increased sense of overall confidence and wellbeing:

"I feel a lot more confident than I used to be. And I understand my feelings a lot more and where they're coming from and I can pinpoint where they're coming from and what made me feel the way I felt. And it's amazing very, very amazing what one place, one little building would do for somebody".

"My self esteem is better now that I am not on the streets, prostitution can kill your heart and your mind and your spirit within. The street killed me, I was on the streets for a long time, and it hurt my body and my feet, so now my body is recuperating from that. The housing is helping me to get my body and my mind and my health back together".

OPPORTUNITIES FOR FURTHER DISCUSSION

Dedicated buildings versus scattered housing models

There remains on-going discussion about the benefits and disadvantages to providing supportive housing in dedicated housing versus scattered models. Women in these programs have identified the dedicated model to have increased their sense of community and safety; on the other hand, women have also identified increased stigma with respect to living in a dedicated supportive housing unit, and have also identified feeling triggered by the substance use of some of their neighbours. One model does not fit all and a women-centred approach would offer choice and provide different options depending on the needs and preferences of women entering the program. As a result of the attrition of units from the landlord, the ASH program shifted from clustered-model housing to a scattered model and when possible has offered scattered units for women who felt they would be better suited to be in a separate market-rent unit.

Staff support models

Another matter for further exploration is the offering of support on-site at the place of residence, versus an off-site support office. Whereas on-site staff support increases accessibility for tenants and provides a high level of responsiveness in times of crisis, questions remain about how best to structure staff responses in order to ensure support needs are being met, while simultaneously empowering women to develop their own coping mechanisms. While some tenants have identified they prefer the accessibility of having staff on-site, others have stated a preference to meet staff away from their place of residence in order to minimize the stigma associated with seeking support, and to maintain some distance between their own home and their counselling spaces.

Additionally, there remain questions about how best to structure support so that it is flexible and responsive to changing client needs. Typically, it has been found that much support is required in the initial move-in phase; however, the longer people remain housed, the more stable they may become, and thus may not identify requiring the same level of support over time. For some, the cyclical nature of mental health and/or substance use leads to variable and changing support needs, and therefore some flexibility to increase and decrease support in response to presenting needs is required.

Intake and Assessment

Given the significant trauma histories, mental health concerns, substance use issues and other health care needs, women referred to the program are not always in a position to care for themselves without a high level of support beyond that of which these programs are able to provide. While both these programs offer low-threshold access for women who are experiencing homelessness, mental health and substance use concerns, an ability to live safely and independently is still required. In instances where there are concerns about a woman's ability to perform daily living tasks, it is the role of the counselors to connect women with additional resources. As part of the assessment process, it is often found that women being referred to the program are not connected to a primary health care provider, and so this is also a key part of the initial support provided to women looking for supportive housing. When women present with complex health care needs and counsellors are trying to assess her ability to live independently, inviting the Nurse Practitioner to be part of the assessment process has been beneficial. While counsellors currently make use of available screening tools to assess each woman's presenting needs upon intake, a mechanism to identify which women may be better served in more structured housing models (e.g. transitional housing and group home models with 24-hr staffing) would be beneficial.

CONCLUSION

Although there are areas that the two supportive housing models discussed above can be improved to better serve participants, it is clear that taking a gendered approach to housing has had a positive impact on women who have accessed these programs. It has offered choice where there is often very little, it has taken into consideration the intersectionality of substance use, mental health, and trauma and adjusted its model to address these issues simultaneously and with great care, and it has taken into consideration the context of women's lives (including experiences of violence, experiences of mothering and pregnancy, etc.). For many women, having a space that is safe and respectful has improved their engagement with services and their sense of security and independence in their own home.

Ideally, more supportive housing specific to women would be beneficial to those women and families who are struggling with the many issues discussed in this chapter, but at a minimum, all supportive housing should be designed with a gender lens and incorporate the trauma-informed and harm-reduction approaches that women have found helpful.

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2.2

SERVICE COORDINATION FOR HOMELESS PREGNANT WOMEN IN TORONTO

Danielle LeMOINE

INTRODUCTION

When pregnancy accompanies the precarious state of homelessness, a normal health condition presents unique challenges to the health and social service systems. Homeless women become pregnant for a number of different reasons including victimization, trading sex for safety or economic survival, lack of access to contraception, uncertain fertility, the need for closeness and intimacy, desire for a family and hope for the future (Killion, 1995; Killion, 1998; Little et al, 2007; Ovrebo et al, 1994; Tuten et al, 2003; Weinreb et al, 1995).

The health and social service needs of homeless pregnant women are unique and complex. The most pressing survival priorities for homeless women such as nutrition, safety, income, shelter and housing are often already competing with health needs such as primary and preventative health care, mental health care and substance use support services (Basrur, 1998; Beal & Redlener, 1995; Mayet et al, 2008). Adding pregnancy to the experience requires prenatal services such as medical care and parenting support. It requires particular attention to rest and good nutrition, and since homelessness and factors such as mental health and substance use can put a mother at risk of losing her baby to child protection agencies, bereavement support may also be required (Beal & Redlener, 1995; Little et al, 2007).

The barriers to accessing health and social services that homeless individuals face are numerous and documented elsewhere (Frankish et al, 2005; Greysen et al, 2012; Holton et al, 2010). There are also several specific barriers that homeless pregnant women face to accessing essential prenatal services. These include: denial of or ambivalence about pregnancy; unknown pregnancy due to irregular menses; developmental delay; history of trauma, social, sexual and physical abuse; mental illness (especially depression); substance use; lack of insight and awareness; past negative, stigmatizing or traumatic experiences with health care providers; lack of identification; precarious status; competing priorities for basic needs such as nutrition and shelter; transportation costs; lack of social support and accompaniment for appointments; previous history of having children apprehended or knowing someone who has; and the transient nature of their lives (Beal & Redlener, 1995; Bloom et al, 2004;

Little et al, 2007; Ovrebo et al, 1994; Paradis, 2012). As a result, babies born to homeless women suffer poor health outcomes including preterm birth and low birth-weight (Beal and Redlener, 1995; Killion, 1995; Little et al, 2005).

With appropriate access to care, these poor health outcomes can be prevented. In fact, pregnancy is frequently referred to as a window of opportunity for empowerment and change by engaging with homeless women who tend to be 'service-shy' (Killion, 1995; Killion, 1998; Mayet et al; 2008; Ovrebo et al, 1994). One important way to facilitate this is through service coordination efforts. A Canadian example of a service coordination program for homeless pregnant women is the Homeless At-Risk Prenatal (HARP) team in Toronto. This chapter presents the findings of a research study that explored service coordination for homeless pregnant women using HARP as a case study.

SERVICE COORDINATION

There is an extensive body of literature that explores the need for service coordination for homeless individuals and other populations whose complex needs span physical health, mental health, housing, disability benefits and other sectors (Fisher & Elnitsky, 2012). Sometimes called 'service integration,' this literature refers to a number of processes that range from coordinating services to restructuring services to consolidating systems (Austin, 1997; Fisher & Elnitskly, 2012; Gregory, 1996; Hassett & Austin, 1997). Terms like 'communication,' 'collaboration' or 'coordination' are often used to describe various activites related to service coordination (Fisher & Elnitsky, 2012).

For the purpose of this chapter, the term 'service coordination' is used to reflect the concept of engaging in different activites with the intention of ensuring that clients have access to the various health and social services that they need in an streamlined manner. Examples of such activities include case management linkages, outreach, providing parallel services, providing multiple services in one location, joint funding and interagency agreements (Austin & Prince, 2003; Hilton et al, 2003; Morrissey et al, 1997; Randolf et al, 1997).

FIGURE 1 *Service Coordination Continuum*

(Austin & Prince, 2003; Fisher & Elitskly, 2012; Hilton et al; 2003).

It is helpful to conceptualize the activities of service coordination along a continuum. This continuum combines concepts described by a number of different authors (Austin & Prince, 2003; Fisher & Elitskly, 2012; Hilton et al, 2003). Some activities fall closer to the individual client level on the left (e.g. case management linkages) and others are closer the administrative level on the right (e.g. interagency agreements) (Figure 1).

It is difficult to discern from the literature which aspects of service coordination are most effective under which circumstances. It can be assumed that this is particularly true for homeless pregnant women who have such unique needs, though this has not been well explored in the literature on homelessness and pregnancy. One exception is Little et al (2007), who outlined some aspects of service coordination and integration that were found to be successful for homeless pregnant youth. These included: networks, community advisory panels, case conferences, consistency of workers and strong cohesion between hospital and community agencies. The current study built upon these findings.

TORONTO PUBLIC HEALTH'S HOMELESS AT-RISK PRENATAL PROGRAM (HARP)

Approximately 300 babies are born to homeless mothers in Toronto each year, a number that has not decreased since 1998 and is likely to be greatly underestimated (Basrur, 1998; City of Toronto, 2012). Since 2007, Toronto Public Health (TPH) has been delivering HARP as part of the Healthy Babies Healthy Children Program to help address this complex public health issue. HARP is a team of specialized public health registered nurses and registered dietitians who work with high-risk homeless pregnant clients during their pregnancy and for a short time after. HARP clients are selected based on an acuity assessment that considers their health and social needs and stability, transiency and complexity (not all homeless pregnant women require such intensive case management; some low-risk homeless pregnant women fall into the 'usual care' Healthy Babies Healthy Children program at TPH). HARP providers meet with their clients on average once per week. HARP's primary goals are: one, improved access to prenatal care; two, connection to community services for health and social needs; and three, better health outcomes for baby and mom. Service coordination is a primary component of the work HARP does to achieve these goals, with HARP service providers acting as case managers to coordinate care for clients. HARP providers make referrals to other agencies to provide services for their clients and HARP providers also rely on other agencies referring homeless pregnant women to them as a way of case finding.

RESEARCH APPROACH

The primary research goal was to explore service coordination as conducted by HARP. Through a collaborative process between the investigator and the HARP team, the following research question was established: What aspects of service coordination serve the unique and complex needs of homeless pregnant women most effectively from the perspective of service providers?

METHODS

Semi-structured interviews were conducted with 27 individuals who were part of the service community for homeless pregnant women. The service community was defined as professionals who work with homeless pregnant women in the City of Toronto either in direct service provision or in agency leadership roles.

Participants were divided into internal and external groups. Seven internal participants represented public health nurses, registered dietitians and supervisors from HARP. Twenty external participants represented registered nurses, social workers, counsellors, outreach workers, parenting specialists, case managers, supervisors and coordinators working outside of HARP. The service sectors represented in the external participant sample included: shelter and housing, pre- and post-natal health, addictions, parenting, child protection, physical health and networking.

External participants were recruited initially through convenience sampling and recruitment continued in a snowball manner. Data were analyzed using an inductive analysis approach, as outlined by Thomas (2006), which facilitated establishing links between the research goals and findings and the development of a conceptual model.

FINDINGS

Two overarching themes emerged from this research that are described below: pregnancy creates a window of opportunity for change, but also a time pressure; and relationships are the key to successful service coordination. Ten activities that facilitate effective service coordination are then presented, followed by a discussion of how the findings demonstrate the value of a service coordination program for homeless pregnant women and the implications for research, policy and practice.

A WINDOW OF OPPORTUNITY FOR CHANGE, BUT ALSO A TIME PRESSURE

Several participants described pregnancy as a window that opens up an opportunity to engage homeless women and 'intervene about something.' It was generally felt that this window, as open or closed as it may be, creates some space to allow for progress toward stabilization and improvement in health for mom and baby.

After the baby is born the momentum created during the pregnancy was described as sometimes 'running dry' and the relationships between the client and her care providers change.

In part, this window of opportunity is related to a sudden determination on behalf of the mother to achieve particular goals in order to provide for her child and herself, often described as hope for the future. Mayet et al (2008) and Ovrebo et al (2008) described this as well and TPH's prenatal care practice guidelines (2010) also reflect this concept.

Another aspect of this window of opportunity is that there is an opening in the system of resource-intensive supports and services available to homeless pregnant women that are not necessarily available to other homeless women because a baby is involved (and many of these resources will again be unavailable to her shortly after the baby is born). Such services include but are not limited to service coordination through HARP, some shelter spaces and associated supports and some mental health and addiction services. This reflects a gap within the system of services for this population, one that several participants described as being problematic. It suggests that perhaps the system of care for homeless women places a higher value on care provision when there is a baby involved, and that pregnant women are more worthy of resource-intensive supports; or, alternatively, that this level of intensity of supports is provided because the system views the perinatal period as one of exceptionally high need, and this level of support is only possible because it is time limited.

Along with the window of opportunity that pregnancy creates, there is the 'pressure of the clock' that is guiding the relationship between the client and their service community. The baby is coming and the service community must do everything possible in a hurry to try to get mom stabilized, whatever this looks like for her. The time frame varies from case to case, as some clients are linked with HARP early in their pregnancy, while others are connected very late. Both internal and external participants described this urgency.

After the baby is born the momentum created during the pregnancy was described as sometimes 'running dry' and the relationships between the client and her care providers change. This was especially true if the mother was not able to parent and the baby was taken into child protective services. Because of this, participants expressed how important it was to use this window of opportunity to get clients connected with as many resources as they may need. Ideally these connections would be with service providers who could continue to be involved after the baby was born wherever possible, because of mandate limitations on how long HARP can work with the mother after the baby is born. However, this was described as challenging given the structure of the system of services for this population.

Other authors have not described this concept of time urgency. It is very relevant to this discussion because it provides more context for why coordinating services for homeless pregnant women is unique compared to coordinating services for other homeless subpopulations. Relationships between service providers and service coordination activities are both highly impacted by this time pressure.

These themes demonstrate that within the context of the current system of services for homeless women, homeless pregnant women are in a unique position. While health and social systems are strained, HARP's model of service coordination works within these constraints and opportunities to improve access to services for homeless pregnant women not by addressing the number of services that exist within the system, but by acknowledging that these high-risk homeless pregnant women need some assistance to use them.

> *The system assumes that clients have the ability to go to appointments, HARP makes sure they get there… it's like a netting to capture people and ensure they get to existing services… It's not like we've created a new response, there was already prenatal care, but this population wasn't accessing it, now they are. (Internal participant)*

In a resource-constrained political and social context, high intensity case management and service coordination through programs like HARP may be the best option for ensuring homeless pregnant women have access to the health and social services they require. On the other hand, the time pressure could be relieved if such intensity of services were available for all high-acuity homeless individuals, creating the potential for the necessary services to already be in place when homeless women do become pregnant and allowing for more consistent care once they are no longer pregnant.

RELATIONSHIPS ARE KEY

Relationships Between Provider and Client

Strong therapeutic relationships between clients and providers were seen as the most important aspect of providing care to homeless pregnant women. In fact, it was seen as an intervention in itself. Building this trust was challenging: it involved a lot of effort in being flexible, persistent, answering phone calls and texts, listening, 'just being there,' taking baby steps and sometimes being 'fired and rehired,' which is consistent with findings in the literature (Little et al, 2007).

The ways in which HARP providers built trust with clients was guided by a number of standards of practice. Some examples include the TPH Prenatal Nursing Standards of Practice (TPH, 2010), Community Health Nurses Association of Canada (CHNC) Standards of Practice (CHNC, 2011) and Harm Reduction Principles (International Harm Reduction Association (IHRA), 2015).

The values from these frameworks that were particularly important for HARP providers to embody when developing trust with clients included a foundation of inclusive, equitable and client-centred care (TPH, 2010). The values and beliefs that all clients have strengths, clients are active partners in service delivery, the therapeutic nurse-client relationship is the centre of practice, harm reduction mitigates the consequences of high-risk behaviours and promotes better health, and that pregnancy provides a unique opportunity for empowerment and change were integral to how HARP providers conducted their work (TPH, 2010). Other important professional values included access and equity; professional responsibility and accountability (CHNC, 2011); dignity and compassion; universality and interdependence of rights; and transparency, accountability and participation (IHRA, 2015).

It doesn't matter how much you teach her about pregnancy, pharmacology, etc., if I can't build this relationship then none of this matters… if she won't see me, it doesn't matter what I know. (Internal participant)

A key facet of these relationships that is important to this discussion is that they are very fragile. Sometimes navigating therapeutic relationships was described as a 'dance,' where providers had to tread carefully because trust could be broken in an instant, and the window of opportunity to engage the client could close. This had to be finely balanced with helping the client get access to as many services as possible to become more healthy and stable in the pregnancy.

Knowing when to introduce topics or interventions depends on where you are on the continuum of the relationship with the client… asking them to do things or discuss certain topics when they are not willing or ready can put you at risk of losing the therapeutic relationship. (Internal participant)

Another commonly described part of this 'relationship dance' was the importance of deciding how to use the provider-client relationship effectively.

You have to use that bond effectively… If I have one shot at it, who do they really need to see? Do they need to see an obstetrician, or a psychiatrist? Sometimes you have to choose. (Internal participant)

This was described repeatedly by participants. It reflected a careful selection of providers that they were willing to introduce their clients to.

Relationships Between Service Providers

The relationships between providers were described as mostly being informal because they were not based on a partnership agreement between service agencies. In reality, while providers viewed these relationships as informal, they existed within an unwritten structure guided by both professional expectations of one another and agency-specific value systems. Internal participants sought relationships with service providers in the external service community who were like-minded, flexible and open to working with the complexities of homelessness and pregnancy compassionately. The external providers that internal providers preferred to work with practiced in a way that embodied the same value systems that guided their own practice (described in the previous section).

The careful selection of relationships with other providers in the service community was essential to the work that HARP providers did, as introducing clients to new service providers could be risky. Internal participants described many occasions when introducing their clients to practitioners who did not share the same value system led to a breakdown of their own therapeutic relationship with the client. In some cases HARP providers were able to slowly rebuild this trust and continue working together on goals; in others, clients went 'underground' and did not resurface in the health and social system until the birth of the baby.

I know [the other practitioner's] views, philosophy, how she works. I know she'll be really good for this client. I know she and I can communicate with this client. I'll tell the client: 'we're going to refer you to [X], I'll get you this [provider] that I really like, you'll like her too.' I'm going to feel good, client's going to feel good, and… all the trust I've built with the client won't be washed away with that one introduction. (Internal participant)

Interestingly, the relationships between service providers were described by a number of participants as being very similar to their relationship with a client: they take time and energy to build; they require persistence, flexibility and trust; and they can be fragile.

> *If you give up too easily, or if you get defensive when they don't give as much as you do, the relationship won't happen. And it's a constant negotiation that requires a lot of work. (Internal participant)*

Once built, the relationships between service providers were guarded very closely. Internal participants described wanting to 'stick with' these service providers when they found them, preferring to spend their energy strengthening these relationships rather than finding new ones. This was because it was generally felt that some service providers did not share the same values and "you just can't budge them" (internal participant).

When HARP providers selected external service providers in this way, the most important values they looked for in individual providers were underpinned by many of the same principles that guide HARP providers' practice that have already been mentioned. Harm reduction principles were particularly important, including: dignity and compassion, demonstrated by accepting people where they are at without judgment; incremental change, demonstrated by acknowledging the significance of any positive change that individuals make; universality and interdependence of rights, by demonstrating that all individuals have the right to health and social services; and transparency, accountability, and participation, by valuing open dialogues and the input of a wide range of stakeholders (most importantly including clients) in decision making (IHRA, 2015). Trust, flexibility, mutual respect, understanding each other's roles and mandates, and supporting each other were also described as essential to these relationships.

In addition to the time commitment required to maintain provider-provider relationships and differences in personal clinical practice values, other challenges to building strong relationships included conflicting value systems at the agency level, or agency mandates.

The value systems that HARP providers embodied and hoped to see from the service providers and agencies they chose to work with reflected an ideology that assumes that what is right for the mother is right for the baby. This emphasis on placing the mother's needs at the centre of care decisions was a primary feature of service coordination within this service community for high-risk homeless pregnant women. When this clashed with the ideologies of service providers or agencies that HARP clients needed to work with challenges arose and the relationship between service providers was described as less effective for the client. The inefficiencies included more time being spent trying to coordinate services for HARP clients, longer wait times for clients to access services, and less communication between service providers. This resulted in an overall less streamlined approach to care and more barriers for the client meeting their goals.

Strategies used within the service community to deal with these challenges included taking the time to learn about each other's agency, being respectful, pointing out the strengths of each partners' contribution to the service community, acknowledging the limitations of what each agency can offer and reaching a common ground.

Informal Relationships

Throughout the interviews it became very apparent that almost all participants valued the informality of their relationships with other service providers. Formal partnership agreements between HARP and the agencies that external providers work for did not exist, with the exception of one agency. The only formal process that was discussed was obtaining consent from clients to allow providers to discuss case details with one another.

Informal relationships between practitioners allowed them to facilitate access to services in a more seamless and timely manner. These processes were described as being important because they allowed agencies to just 'pick up and run' without paperwork or time-consuming referral processes getting in the way. When a client is willing to meet with a particular service provider, the sooner it happens the better.

Overall the majority of both internal and external participants considered the current informal methods to be effective. Myrtle et al (1997) support this; they describe the value of informal partnerships in service coordination for marginalized groups in general, stating that tightly integrated systems may not be as desirable as some argue, and that alternatives to formal arrangements or 'loosely coupled' integration strategies might allow for adaptation to meet clients' needs more effectively.

It is worth noting, however, that although practitioners viewed these relationships at informal, they were guided by a set of values and professional expectations that are described in the previous section. This created an unwritten set of guidelines within the service community.

One challenge to the value placed on informal relationships in the service community that was often described by both internal and external participants is the fact that even once relationships between providers were well established, staff turnover presented an enormous risk to the system of service coordination for clients. When providers in the service community left their position (e.g. they moved on to other jobs, took holidays or got sick), the relationship between care providers was over, and the other party in the relationship was left with a 'gap to fill.' For example, if a HARP provider had one or two contacts in the mental health sector that she knew to be an excellent fit for HARP clients, and one of these providers moved on to a different role, the HARP provider then needed to establish a new relationship within the mental health sector. This was also the case for external providers when a HARP nurse with whom they had a relationship left their position, as sometimes external participants were left not knowing who to refer their homeless pregnant clients to for service coordination. Even if this gap was just temporary, this greatly impacted the client's access to services because of the 'window of opportunity' and 'time pressure' concepts previously described.

It is important to mention that participants were well aware of the risks of building these types of informal working relationships. "We don't do it this way because we're stupid and we don't want things to be sustainable. It's because we are so cautious of who we introduce our patient to" (internal participant), and this was seen as more valuable because the client's needs were always first. This was so important because in the experience of HARP staff, without the trust between them and the client many of these women disappeared altogether and did not access *any* services.

Strategies to ease the transition into the service community for new service providers were noted by some participants, but it was clear that there was no easy answer. Some expressed that it was helpful to have new HARP providers introduce themselves to external service providers. Doing this introduction face-to-face worked far better than over the phone. While introducing new staff to partners did not mean the new relationship picked up where the old one left off, it created space for the development of mutual trust without having to start from a clean slate. Others felt that building the new relationship just happened

organically over time as clients were shared through talking on the phone and eventually meeting in person.

Some of the challenges to service coordination related to relationships described above are consistent with some of the general barriers to service coordination described in the literature (Christian & Gilvarry, 1999; Eisen et al, 1999; Fischer & Elnitsky, 2012).

Significant additions from this study include the exploration of how value systems in this service community at the individual and agency level impact service coordination and the risk that staff turnover presents in the context of a system that values such informal relationships.

ACTIVITIES THAT FACILITATE EFFECTIVE SERVICE COORDINATION

Ten activities were identified during the interviews that made coordinating services for homeless pregnant women effective in the context of this service community. They are listed according to their position on the partnership continuum (Figure 1), starting from individual case level activities on the left, towards more administrative level activities on the right. This is demonstrated more clearly in the Framework for Effective Service Coordination (Figure 2), which is described in more detail in the following section.

Activity 1:
Seamless Pathways for Referrals

Referring a client from one agency to another was usually the first entry to service coordination. Much like informal relationships, informal referral pathways were highly valued. This was mainly described as being able to call a particular service provider directly and get the referral process started right away without having to struggle with navigating formal referral channels such as application forms or general intake telephone lines.

Referring a client from one agency to another was usually the first entry to service coordination. Much like informal relationships, informal referral pathways were highly valued.

As mentioned previously, pregnancy creates a window of opportunity and the need for connection to services is almost always time sensitive. Such streamlined processes for referral allowed for more timely access to services for clients, and were described as resulting in faster, more efficient care. When service providers did not have strong relationships with a provider in a service sector they needed to refer a client to, they had to use the formal referral processes and this was often viewed as a barrier to accessing services for their clients.

Activity 2:
Working Together Regularly

When two service providers who shared clients worked together frequently the working relationship was stronger. Sharing clients regularly created more opportunities for providers to interact with each other and work on important aspects of building relationships.

Working together frequently was something that was facilitated more easily for providers who work in the service sectors that homeless pregnant clients use most often (e.g. HARP, prenatal medical care services and child and family social services). On the other hand, when providers referred clients to services that clients use less often, more time would go by without having a mutual client and the relationship between providers was less likely to be maintained (e.g. housing services).

Activity 3:
Regular Communication Related to Clients

When service providers shared a common client, communicating with each other regularly was generally considered to be critical to service coordination because the lives and needs of these clients can change so quickly. When clients gave service providers consent to communicate with each other about the details of their care, providers could give each other updates on progress, discuss goals and challenges, and strategize about how to address barriers as the client's circumstances changed. This communication took place mainly over the phone and in person. This was viewed by participants as a way of creating a more transparent and effective environment of care for clients.

The frequency of communication required for effective service coordination was identified as being individual to the specific needs of the client. Participants described that these discussions mostly happened on an as-needed basis and when relationships between providers were strong, facilitating these conversations was relatively easy.

Activity 4:
Case Meetings

Case meetings are meetings where two or more service providers and the client are present. These meetings had all the benefits described above with the added benefit of the client being present. During such meetings service providers worked together with the client to establish goals, brainstorm, problem solve, make a plan of action, divide the work and make sure services provided by each agency did not overlap. These meetings were seen as particularly important for agencies that were regularly involved in the client's care provision including HARP, child protection services, prenatal medical services and in some cases shelter and housing services.

As the primary service coordinator, HARP was viewed as being in the unique and important position of having more intimate knowledge of the client, and therefore having more ability than other care providers to advocate for her and identify areas of strength and limitations. External agencies really valued this because it helped them make more informed decisions about care provision.

Another positive outcome of these meetings was that they ensured that the client and all providers involved were on the same page and hearing the same messages. This provided clarity for realistic goal setting. Once goals were established, HARP could continue to reinforce these messages for the client throughout her pregnancy. Some participants described that some homeless pregnant clients fragment their services by using multiple services and sharing different information with each. Participants described that while this is a coping mechanism, fragmentation creates barriers to coordination and it can result in either service duplication or gaps. Case meetings created a safe place where clients could start to build trust with all of their providers and reduce fragmenting behaviours.

The frequency of case meetings to make service coordination most effective depended on the needs of the client and the type of service being provided. In some cases it could be once during the pregnancy (for example, a meeting to establish an appropriate shelter option). In other instances, case meetings might be necessary once every three weeks (for example, case meetings related to parenting where the HARP worker, Children's Aid worker and the client meet regularly to assess achievement of goals that impact the client's ability to parent such as mental health and addiction stability). As was the case with communication between service providers, both internal and external participants indicated if they had a good relationship with the service providers involved, arranging case meetings was fairly easy.

Notably, not all service providers felt that case meetings worked well for them. As with all service coordination activities, the use of case conferences needed to be tailored to the needs of the particular client and the goals the service providers were working towards.

When providers in the service community did not know about each other and the services provided at their various agencies, they could not work together.

Activity 5:
Outreach Activities

When providers in the service community did not know about each other and the services provided at their various agencies, they could not work together. Engaging in outreach activities on an ongoing basis enhanced service coordination by creating opportunities for providers to introduce themselves, engage with one another outside of client care and discuss organizational mandates and values.

Outreach activities that were valued in the service community included care providers in care coordination roles (e.g. HARP) going to agencies and sharing information about their services and how to access them, establishing contacts with providers who work at the client level and ensuring both parties are clear about how to communicate with one another. In some of the external agencies that often work with homeless pregnant clients (e.g. a prenatal clinic), assigning one HARP provider to act as a contact point and representative was described as extremely helpful. Other outreach activities included sending out staff contact updates by email and providing flyers of program and service details during networking events. Participants also described that it is important for all agencies to engage in such outreach activities, not just HARP.

The frequency of such activities required was not clear from the responses. In general, however, participants felt that these outreach activities were not being done often enough. The most commonly discussed challenge to outreach was time, as balancing outreach activities with client activities and other work responsibilities was challenging. Many internal participants expressed having to prioritize their client-related work over outreach activities, and this had an impact on how well care was coordinated for clients.

Activity 6:
Establishing Mutual Goals and Values

It was clear from the interviews that the service providers that had the best relationships and the most effective service coordination were those who shared mutual values because it made working together with clients to establish goals and a plan of care easier.

As previously identified, differences in values occurred on two levels: at the individual level and at the agency level. When differences in values occurred at both levels, relationships and service coordination were particularly difficult. The important value systems for working with high-risk pregnant clients in this service community have been previously discussed. Other factors that influenced these value systems in the context of services for homeless pregnant women include power dynamics, political will, agency priorities and funding structures.

"It makes it hard for HARP... because our [mandate] can be challenging for them at times... We make exceptions sometimes, but our mandate is limiting. We've [had to] work through many frustrations." (External participant)

The most effective service coordination occurred when, despite differences in values and mandates, providers were able meet on a common ground and acknowledge that although they may not offer the same service in the same way, they all have the clients' needs at the core of their work.

"Even though we don't all offer the same service and can't do it in the exact same way, there is a meeting on a common ground." (External participant)

Activity 7:
Communication Outside of Clients

In addition to regular communication about clients, the participants that had the most collaborative relationships had some element of communication outside of client care. This refers to interactions that were not directly discussing a case. An example is discussing aspects of the work at a systems level rather than client-based level. Much of this communication took place during other service coordination activities including outreach, participating in networks and sharing resources.

In addition, a handful of participants discussed how their relationships with a particular contact were so strong that they communicated even outside of these activities. An example is using personal email or text to provide an update on something that was 'heard through the grapevine' that impacted how the service community might provide care to homeless pregnant women such as a bed opening in a supportive housing unit, or impromptu discussions that occurred after case meetings or networking events that help service providers get to know one another on a more personal level.

These interactions, for those who experienced them, were said to improve the relationship and therefore service coordination. Rationale provided was similar to many of the other activities: it helped service providers learn more about each others' values, expertise, styles of work, perspectives and created a working relationship with more mutual respect. While not all participants experienced this type of communication, those who did stated that they thought these working relationships should serve as a model for the 'ideal relationship.'

Activity 8:
Sharing Resources

A handful of the external participants described HARP providers as being 'a part of our team,' meaning that when they came to another agency to see mutual clients they were treated as if they worked there. External providers that experienced this sharing of resources said that the HARP providers knew the staff at their agencies, used shared office and clinical spaces, and were familiar and comfortable with the culture of practice in that setting. Both internal and external participants who experienced this viewed it as positively impacting service coordination, as it helped build mutual trust and goals and facilitated collaboration.

External providers that experienced this sharing of resources said that the HARP providers knew the staff at their agencies, used shared office and clinical spaces, and were familiar and comfortable with the culture of practice in that setting.

Activity 9:
Participation in Networks, Communities of Practice and Educational Events

One specific way that participants were able to communicate outside of client interactions was through participating in networks, communities of practice and educational events.

The two primary examples of these available within this services community were the Young Parents No Fixed Address network which met monthly and the Community Advisory Panel at St. Michael's Hospital, which met quarterly. These networks have been integral to the service community in many ways. Such events provided an opportunity for members of the service community from different sectors and professional backgrounds to come together and discuss issues related to providing care for homeless pregnant women. Participants described them as an opportunity to: interact with colleagues outside of clients, meet service providers they had only interacted with over the phone, learn more about the services offered at other agencies, meet and introduce new staff, work through conflicts, establish shared goals and common ground, share resources and updates on what is happening 'on the ground,' brainstorm and problem solve about challenging client situations and generally strengthen relationships.

Some participants also described a supportive aspect to these events. This was seen as important because of how difficult this type of work can be, particularly because many service providers work in isolation.

Another critical aspect of networking opportunities is that events that were supported by management but led by front line staff were felt to be the most successful. This was because the front line staff lived the experience of working with clients, and therefore they knew the issues best.

The frequency of such networking meetings that was ideal for service coordination could not be determined based on the interviews. However, most participants expressed satisfaction with the frequency of the meetings they attended.

Barriers to service providers attending such meetings were also identified, and these included workload and lack of management support. Having the meeting minutes circulated by email was something that was valued when participants could not attend.

Activity 10:
Management Support

Feeling supported by management is something that was critical to frontline providers working with homeless pregnant women. In particular, feeling supported to engage in the activities of services coordination that did not involve clients such as relationship building activities with other providers and attending networking events and communities of practice. Lastly, it was also considered highly valuable to have the management of different agencies working together on systemic process-related activities such as advocacy or policy work.

THE VALUE OF SERVICE COORDINATION FOR HOMELESS PREGNANT WOMEN

A final important theme that emerged from the interviews is that a specific service that provides flexible service coordination (such as HARP) is extremely valuable. Internal and external participants alike indicated that HARP made unique and essential contributions to the service community for these clients.

"As a result [of HARP], I think these young women have more support, more opportunities to parent, fewer apprehensions, more opportunities for young parents to get some stability in their lives." (External participant)

HARP providers were seen as essential to the service community for homeless pregnant women in Toronto because: they were specialized in providing care exclusively to high-risk homeless pregnant women; they followed their clients anywhere in the city regardless of catchment area; they had frequent contact and therefore intimate knowledge of their client; and they had a unique ability to engage with this complex population. HARP providers were specifically valued for their expertise in the following areas: building and maintaining therapeutic relationships with clients who are typically difficult to engage; medical prenatal needs, because this allowed other care providers to focus on their own specialties; health literacy and education, because they were able to translate and continuously reinforce messages from other service providers for clients; and mental health care, specifically referring to their skills in crisis intervention which was something that many service providers expressed feeling uncomfortable with.

HARP providers were seen as essential to the service community for homeless pregnant women in Toronto because: they were specialized in providing care exclusively to high-risk homeless pregnant women;

SUMMARY OF FINDINGS

This section has clearly demonstrated that relationships were the most important aspect of service coordination, and that while informal processes for communication were highly valued, this can sometimes be risky and needed to be integrated with activities that facilitate effective service coordination. These concepts are summarized in Table 1, and are further explored in the following section using the Framework for Effective Service Coordination in Figure 2.

TABLE 1 *Effective Relationships Between Providers: Challenges and Strategies*

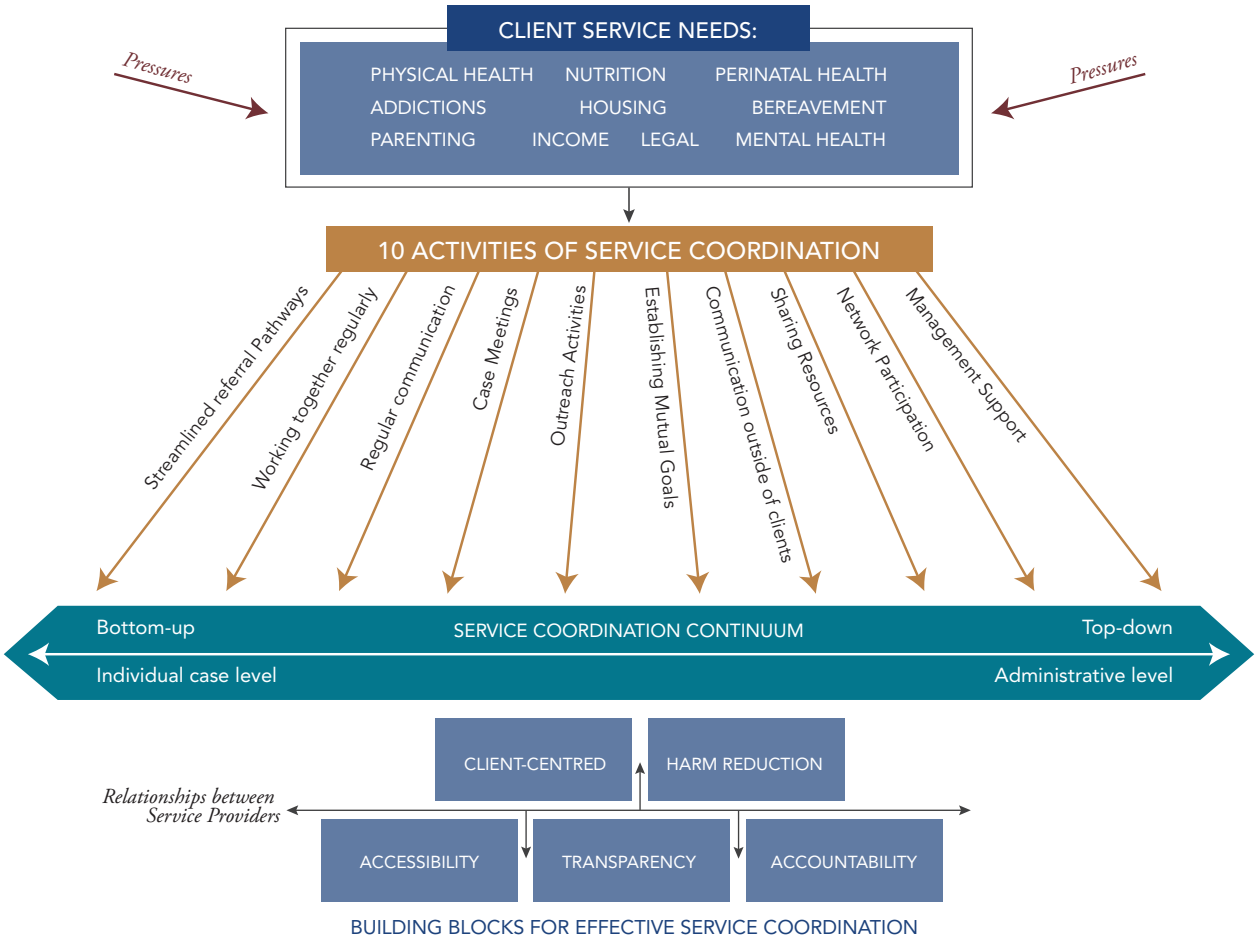
CHALLENGES	STRATEGIES
Conflicting mandates, goals and values	Taking the time to learn about each other's agency and value systems
Inconsistent understanding of roles	Being respectful
Infrequent mutual clients	Acknowledging the strengths and limitations of each partner and agency
Time consuming	Reaching a common ground
Workload and clinical priorities	Management support
Staff turnover	Outreach activities
	Participating in networking, communities of practice, and education events

FRAMEWORK FOR EFFECTIVE SERVICE COORDINATION

The Framework for Effective Service Coordination in Figure 2 brings together the findings of the research. The Framework is applicable to all service providers working in the service community for homeless pregnant women, their leadership teams and other health service delivery decision makers.

At the top of the Framework, the Client Needs Arch presents the unique and complex service needs of homeless pregnant women as described by participants. These are integral to the conceptualization of service coordination for homeless pregnant women because their needs are different than those of other homeless and marginalized populations (Basrur, 1998; Beal & Redlener, 1995; Mayet et al, 2008).

FIGURE 2 *Framework for Effective Service Coordination*



Service coordination is at the centre, and the 10 Activities of Service Coordination are presented as arrows to indicate their position along the Service Coordination Continuum (presented in Figure 1). In general, the more activities partners engage in the better the relationships are and service coordination is more effective for clients.

Below the Service Coordination Continuum are the Building Blocks of Service Coordination, which reflect the values that service providers need to embody to effectively work with this population. Most important is the glue that holds the Building Blocks together: the relationships between service providers. The Activities of Service Coordination help strengthen the relationships between providers in the service community, which in turn holds the whole system together.

There are also External Pressures on service coordination, depicted as flashes over the Client Needs Arch. These pressures include the time crunch due to the pregnancy window of opportunity being open for only a short period of time, limited resources that are sensitive to this population's unique needs, the transiency of this population, staff turnover, and the fragility of relationships between clients and providers and between providers.

IMPLICATIONS

The Framework for Service Coordination for Homeless Pregnant Women ties the themes of this research together, and can be applied in at least three important ways. First, individual service providers can use it to guide their practice. Second, it can be used at the organizational level as a guide when designing service models or reallocating resources in order to better serve the clients. Staffing models should allow client caseloads to be light enough so providers have enough time to engage in service coordination activities. Third, it can be used to validate the efforts already being made within organizations to engage in service coordination by demonstrating that each effort providers make for building relationships and coordinating services has an impact on the client (e.g. in program evaluation or quality control endeavors).

Thinking more broadly, this research highlighted some opportunities for system responses to the way care is currently provided to homeless pregnant women. The primary themes that informal, carefully selected, one-on-one relationships are 'the key' to service coordination efforts is really challenged by the fact that these relationships can fall apart if a service provider leaves an organization or gets sick. This presents an imperative for agencies to engage in more outreach activities across the service community and create some contingency plans for when this occurs in the hopes of creating a more streamlined process for service coordination in the sector as a whole.

The primary themes that informal, carefully selected, one-on-one relationships are 'the key' to service coordination efforts is really challenged by the fact that these relationships can fall apart if a service provider leaves an organization or gets sick.

The higher availability of resources available to homeless women during pregnancy compared to other times has an important implication for services to homeless pregnant women. The discussion highlights an opportunity to consider the questions: Would making intensive service coordination services available to all homeless women improve overall outcomes and reduce the time pressure that exists when pregnancy is involved? What would it take for the system to demonstrate that all homeless women deserve the level of high-intensity resources that homeless pregnant women have access to?

This study contributes to the body of evidence that exists to support HARP's service coordination intervention as a promising practice for high-risk homeless pregnant women by providing an understanding of the contextual factors that influence the intervention in the Toronto service community (Canadian Homelessness Research Network, 2013). It also initiates the work for creating a promising practice in service coordination in general that could potentially be implemented more broadly across the system of homelessness services. Further research such as a realist evaluation would strengthen the case for the activities of service coordination as a promising practice.

CONCLUSIONS

This research has explored the specific aspects of service coordination that are most effective for homeless pregnant women. The experience of being homeless complicates a normal health condition into a precarious event in a woman's life. Without the appropriate support, a woman who is homeless and pregnant, who is already experiencing an incredible amount of barriers to accessing appropriate health and social services, faces the possibility of having a baby with poor health outcomes and the potential for being unable to parent her child. HARP provides a unique service that uses a number of strategies to effectively coordinate services for this population in Toronto, creating an example of an effective response to a complex health issue that could serve as a model for other Canadian cities.

The key features of effective service coordination for homeless pregnant women are: relationships between clients and providers, the relationships between providers, informal relationships, seamless pathways for referrals, working together regularly, case meetings, mutual goals and trust, communication outside of clients, sharing resources, participating in networks and communities of practice and management support.

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2.3

COMMUNITIES OF PRACTICE AS LOCATIONS FOR FACILITATING SERVICE SYSTEMS IMPROVEMENT FOR NORTHERN HOMELESS WOMEN

Judie BOPP, Nancy POOLE
& Rose SCHMIDT

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INTRODUCTION

Attention to the gender-specific needs of homeless women in Canada's North is crucial. The complexity of the issues involved warrants a whole system shift in social policy and service delivery, as well as in the way that many individual programs and professionals work. This chapter describes a participatory action research project involving service providers, policy advocates and researchers in the three northern territories who had the goal of catalyzing health system improvement to respond to the needs of northern women with mental health concerns and who are homeless or at risk of being homeless. The first section of the chapter presents the context of women's homelessness in the North. Then the community of practice (CoP) approach employed in the Repairing the Holes in the Net project is described. The CoPs held in the three northern territories supported shared reflective practice space, where literature, women's identified needs and ideas for repairing the net of women-serving agencies and policies could be collectively considered. The chapter concludes with an assessment of successes and challenges associated with system change in the context of the North and the potential of CoPs in supporting relational and programmatic system change.

THE CONTEXT OF WOMEN'S HOMELESSNESS IN THE NORTH

The vast majority of northern homeless women do not fit the profile of women 'living rough' on the streets of Canada's southern cities. Rather, homelessness in this population is more likely to be 'hidden'[1] or 'relative'[2] in that they are 'couch surfing' or living in unstable or unacceptable housing (Bopp et al., November 2007). *You Just Blink and It Can Happen* concluded that:

> *In the North, all women can be considered at risk of homelessness because a small change in their circumstances can jeopardize the fragile structure of their lives that allows them to meet their basic needs. (Bopp et al., 2007: 1)*

All across Canada's North there is an absolute shortage of available housing, particularly affordable and adequate housing, which is a critical factor in the incidence of homelessness (Bopp et al., 2007). In 2012 the vacancy rate for rental accommodation was only 1.5% in Whitehorse, 3.6% in Yellowknife and 2.7% in Iqaluit (Canada Mortage and Housing Corporation, 2013). The physical environment of low-cost housing is largely sub-standard and mould, leaky windows, dirt, mice, thin walls, inadequate heating and poor maintenance are common (Bopp et al., 2007). Overcrowding is also a significant issue that can increase social distress and family dysfunction, including domestic violence (Abele, Falvo & Hache, 2010; Tester, 2009).

There are high labour and material costs associated with increasing northern housing stock and construction does not meet population growth rates (Webster, 2006). Specific northern considerations such as a short building season, permafrost, communities that are not connected by roads, the absence of trees in Nunavut for lumber and the need to ship or fly in most or all materials increase building costs (Bopp et al., 2007; Webster, 2006). Because of the unique circumstances in the North, creating new housing is almost entirely dependent on government initiatives.

Historical and political contexts have also shaped the long-standing housing crisis in the North. Shortly after World War II, during a period of welfare state reform, there was a "deliberate effort to centralize previously nomadic populations across Northern Canada" (Christensen, 2012: 421). However, these policies increased demand for social housing as it increased reliance for shelter by Aboriginal people on the federal and territorial governments. In 1993 the federal government withdrew funding for public housing, stopped its off-reserve Aboriginal-specific housing assistance and assigned the construction and acquisition of social housing to territorial governments (Bopp et al., 2007; Tester, 2009; Webster, 2006). When federal funds have been made available to the territories, such as a $300 million public housing allotment in 2006, these funds did not result in an increase in the number of public housing units and were instead used to replace aging public housing stock (Falvo, 2011).

Currently, Territorial Crown corporations own most of the existing housing stock and these units are managed

1. Which includes women who are temporarily staying with friends or family or are staying with a man only in order to obtain shelter, and those living in households where they are subject to family conflict or violence (Kappel Ramji Consulting Group, 2002)

2. Which applies to those living in spaces that do not meet basic health and safety standards, including protection from the elements, security of tenure, personal safety and affordability (Petit, Tester & Kellypalik, 2005)

by local housing authorities (Abele et al., 2010; Stern, 2005). The policies of housing authorities can mean that many women do not qualify for subsidized housing because they have rental arrears or debts for damages to their former housing, often as a result of a partner's behaviour (Bopp et al., 2007).

There are a complex constellation of factors that go well beyond the shortage of housing stock that conspire to keep thousands of women and their children in a condition of absolute or hidden homelessness. Rates of violence, trauma, sexual assault and abuse that are significantly higher than Canadian averages contribute to homelessness among northern women. Most women who are homeless or at risk have experienced violence, have mental health concerns and substance use problems or addictions (Bopp et al., 2007).

*It has been reported that up to **90–95%** of the homeless women in the North are Aboriginal (Bopp et al., 2007; Christensen, 2011).*

It has been reported that up to 90–95% of the homeless women in the North are Aboriginal (Bopp et al., 2007; Christensen, 2011). The historical and current social policy in Canada has had the effect of disrupting Indigenous families in Canada, and the legacy of colonialism and subsequent intergenerational trauma is central to discussing Aboriginal homelessness (Patrick, 2014; Yellow Horse Brave Heart, 2003). With the passing of the Indian Act in 1867, much of Canada's Aboriginal population was relocated onto reserves, while Aboriginal children were placed in residential schools run by churches and funded by the Federal Department of Indian Affairs (Bopp et al., 2007; Patrick, 2014). These forced resettlement policies limited movement and participation in trading, while the residential school system "not only resulted in the loss of language, culture and community for Aboriginal children, but also established spaces in which rampant physical, sexual and psychological abuse took place at the hands of school and church officials" (Patrick, 2014: 59). Residential schools had a devastating effect on First Nation cultures and people and the resulting intergenerational trauma has an enormous impact on the pathways of homelessness in the North (Bopp et al., 2007; Christensen, 2013; Patrick, 2014).

In a thought-provoking argument for why homelessness among Canada's northern Aboriginal people can best be understood as rooted in a "spiritual homelessness" rather than fundamentally as a lack of housing, Christensen elaborates on the "multiple scales of homelessness: social and material exclusion, breakdowns in family and community, detachment from cultural identity, intergenerational trauma and institutionalisation" (2013: 804).

Many of the homeless women in the three capital cities have migrated from rural communities to seek social, economic and employment opportunities or institutional resources (such as mental health or addiction services) or to leave difficult family relationships (such as domestic violence) (Bruce, 2006; Christensen, 2012). However, once in the city, many women are faced with a lack of economic, social and cultural resources (Christensen, 2012). Women also migrate to the capital cities believing that there will be better housing options (Christensen, 2011); however, even in urban centres, housing unaffordability, limited public housing units for single individuals and the low-vacancy private rental housing market present significant barriers to people at risk of homelessness (Christensen, 2011). Relocating to a different community can also leave women in a jurisdictional "no man's [sic] land" where they lose the support of their own Bands but do not qualify for support from the Band government in their new community (Bopp et al., 2007). The high cost of travel within the North makes it very difficult for women who leave their communities to return home.

The few emergency shelters that exist in the North are overcrowded, understaffed and not always gender specific. Due to the limited transitional and second stage housing in the North, many emergency shelters

become permanent housing (Bopp et al., 2007; Falvo, 2011). For example, the Salvation Army in Whitehorse only has 10 emergency shelter beds which are offered on a first come, first serve basis and none are specifically available for women or children (Yukon Anti-Poverty Coalition, 2011).

In addition to limited emergency shelter services, there is a drastic shortage of mental health and addiction treatment services for women in the North, even in the larger city centres (Bopp, et al., 2007; Christensen, 2012). If women leave their territory to attend residential addiction treatment they are ineligible for income support. This policy makes it impossible to maintain a household to which they can return on completion of treatment (Bopp et al., 2007). Most of the homeless women in Canada's three northern territories who access housing or other types of services report experiencing mental health challenges of some kind, and homeless women and the service providers who work with them identify that these mental health issues are invariably both a cause and an impact of homelessness (Bopp, 2009; Bopp et al., 2007).

In the territories, particularly in communities that were not formed around a sustainable economic base, there is also a crucial shortage of formal sector employment opportunities (Stern, 2005; Tester, 2009). Women are also impacted by the very low minimum wage in the North and most cannot afford even a small apartment at market rental rates without holding several jobs (Bopp et al., 2007). These problems are exacerbated by the seasonal part-time nature of available service and tourism jobs that are without benefits, pensions and security, and the "dependence on self-generated, insecure sources of income related to arts, crafts, expediting, guiding and other activities" (Tester, 2009: 141). Many northern women must depend on income support (Christensen, 2013), but the low levels of support make it impossible for women to break the cycle of homelessness. Women described income support rules as "punitive, onerous and opaque" with long waiting times and low levels of benefits to sufficiently cover the high costs of basic living expenses in the North (Bopp et al., 2007). There are also policies in place whereby women living in shelters cannot receive income support and may face a waiting period after leaving; and women in social housing cannot obtain wage-based employment without having their rent subsidies dramatically decreased (Bopp et al., 2007)

The incidence of women's homelessness in the North has continued to grow despite the attention it has recently received in territorial governmental and voluntary sector planning processes, and despite the array of service options that have been created to respond to this troubling social problem. The slow progress toward solving women's homelessness in the North has not been the result of a lack of good will on the part of service providers, program managers and policy makers. The three territorial governments lack the ability to raise significant revenues and are highly dependent on federal transfers, and while they have "provincial-like" powers and responsibilities, "their weak economic positions mean a limited ability to implement robust measures to address the homelessness problems that they face" (Webster, 2006: 17).

Because of the complexity of the issues involved and the need for innovations to reflect the specific context of these Northern communities, it is clear that progress will not result from the mandated implementation of some type of 'silver bullet' solution. This is the type of complex[3] problem that will require a shift in the whole system of service delivery, as well as in the way that many individual programs and professionals (whether in the government or voluntary sector) work. Such a shift will not occur because of a new policy or program framework. Since there are no recipes for solving complex problems, undertaking collaborative learning journeys can be important steps. As Myles Horton and Paulo Freire (1990) remind us, in situations like this we have to make the path by walking it.

3. In their stimulating work entitled "Getting to Maybe: How the world is changed," Westley, Zimmerman and Patton (2006) argue that we can think about problems as being of three types: simple (such as baking a cake – a problem for which a recipe can be devised); complicated (such as sending a rocket to the moon – a problem that requires a number of technical steps that may be complicated but are still a kind of recipe); and complex (such as raising a child or ending AIDS in South Africa – problems for which no off-the-shelf answers exist).

THE REPAIRING THE HOLES IN THE NET PROJECT

This was the challenge taken on by Repairing the Holes in the Net, a two-year multi-level action research project aimed to inform the development of culturally appropriate and gender-specific services for Northern women experiencing homelessness as well as mental health and substance use concerns. This applied health services study was funded by the Canadian Institutes of Health Research (CIHR), in partnership with the Mental Health Commission of Canada (MHCC), through the Partnerships for Health System Improvement (PHSI) Program. The British Columbia Centre of Excellence for Women's Health was asked by northern women's groups in the three territories to be the lead research agency for the project, and the Four Worlds Centre for Development Learning provided pan-territorial research coordination. Territorial partners were the Yukon Status of Women Council and the Council of Yukon First Nations Health and Social Development Department (Yukon), YWCA Yellowknife and the Centre for Northern Families (Northwest Territories), and YWCA Agvvik and the Qulliit Nunavut Status of Women Council (Nunavut).

Repairing the Holes in the Net chose a CoP approach as its key methodology for creating a shared reflective practice space that could stimulate a shift in the system or 'net' of services aimed at addressing the needs of homeless women with mental health and/or addiction issues.

Repairing the Holes in the Net chose a CoP approach as its key methodology for creating a shared reflective practice space that could stimulate a shift in the system or 'net' of services aimed at addressing the needs of homeless women with mental health and/or addiction issues. The project's scope was largely confined to the more limited concept of homeless shaped by the urgent need of service clients for safe and consistent shelter and for support for the many health, justice and income issues with which they struggle to cope on a daily basis. This approach in no way denies the larger context of colonisation and institutionalization that must be understood as the very root of the current situation. Repairing the Holes in the Net chose, however, to take on a smaller piece of this complex web for the sake of demonstrating an approach to co-learning that can stimulate change within a larger system. For this reason, the project invited participation from government departments and service agencies from such diverse sectors as addictions, mental health, primary health care, justice, housing, police, income support, child protection, shelters and women's advocacy.

With a focus on a common practice improvement goals, over the course of meetings held approximately monthly for two years, participants engaged in discussion and action in five key areas:

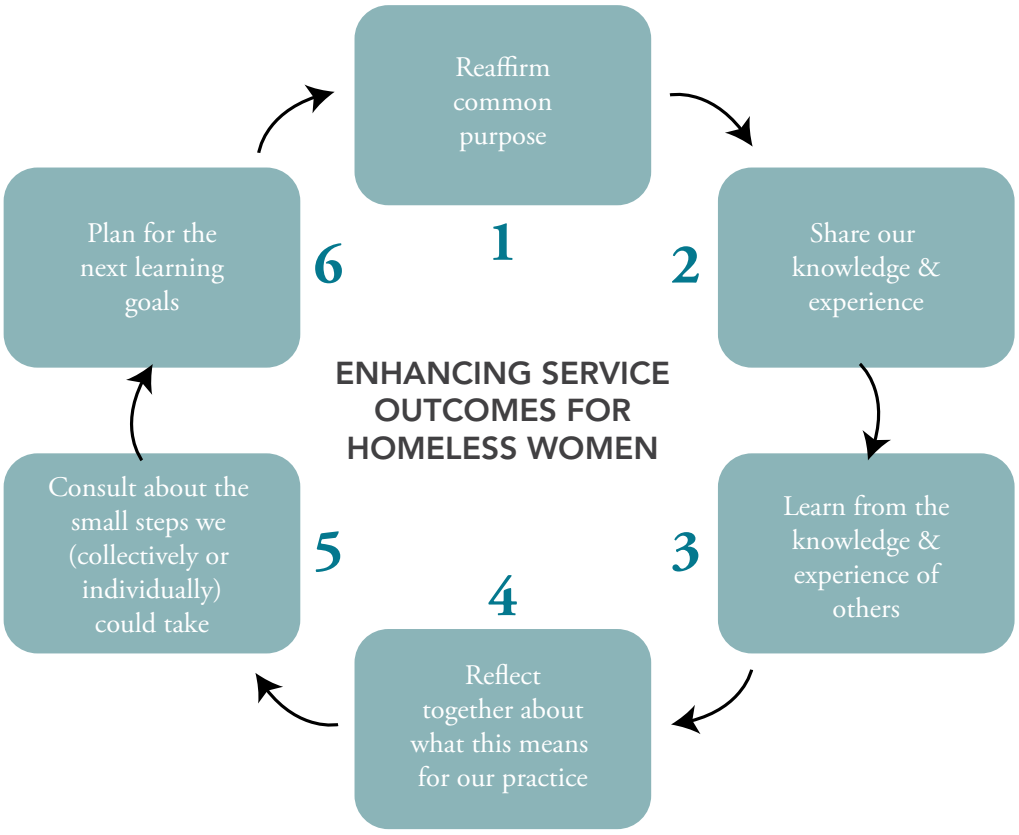
- They considered the relevance of conceptual models from the literature as well as practical examples of service delivery approaches that have demonstrated promise elsewhere;
- They learned from each other as they shared the challenges and successes of the work being done by their own agencies and programs;
- They reflected deeply on the implications for their own individual and collective practice of the data collected from the interviews and focus groups with service users and service providers carried out as part of the Repairing the Holes in the Net project;

- They designed and implemented a service innovation initiative that they could take on to test what they learned about pathways for achieving better outcomes for homeless women with mental health/addiction issues; and
- They continuously set new learning and practice goals.

These steps were incorporated into this simple graphic that served as a model for structuring the community of practice process in each of the three Northern territories.

This chapter describes the CoP model and how it supported this range of collective activities underlying system change: learning from best practice literature; mapping/appreciating services and policy strategies already in place; reviewing and synthesizing the perspectives of homeless women and service providers (derived from interviews) about trajectories of service access and ideas for service improvement; and identifying and piloting some initial actions designed to address the need for improvement in the response to northern homeless women.

FIGURE 1 *The CoP Process*



COMMUNITIES OF PRACTICE AS LOCATIONS FOR STIMULATING SYSTEMS CHANGE

In choosing a CoP approach, the Repairing the Holes in the Net project drew on the rich experience from the field. Perhaps the most commonly cited definition of a community practice reads as follows:

> *Communities of practice are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis (Wenger, McDermott, & Snyder, 2002).*

The primary purpose of a CoP is to "deepen knowledge and expertise" or, in other words, to improve practice. Individuals participate in a CoP to share skills and information with others and, in turn, to learn from the experience and knowledge of their colleagues. Because the Repairing the Holes in the Net CoPs deliberately brought together researchers, key decision and policy makers as well as frontline service providers from the entire service system that has a mandate to address the issues of northern homeless women with mental health and addiction challenges, they became a strategic tool for stimulating system change.

An important first step for the CoPs was for the participants to learn more about and to gain confidence in the CoP process as a tool for shifting their own practice as well as the collective impact of the net or system of services that they represent. Most of those participating in the CoPs had experience with cross-departmental committees or working groups as strategies for attempting to address challenges that overlap typical government jurisdictions. These types of bodies tend to be somewhat formal groups with a delegated authority and clear mandates related to developing policies or plans. CoPs differ from these structures in several important ways. Denscombe (2008) clearly describes this difference. Compared with formal groups created within organizations whose structure, tasks, and identity are established through functional lines and status hierarchies, CoPs hinge on the fact that they can and do transcend boundaries of departments, organizations, locations and seniority. It is crucial to the whole idea of CoPs that they come into existence through the need to collaborate with those who face similar problems or issues for which new knowledge is required.

Taking these important distinctions into account, the CoPs facilitated in the three territories enacted the following features:

1. The CoPs were voluntary and encouraged individuals to participate from a commitment to learning from and with their colleagues about how to improve their own practice and how to create synergies within the whole system of services.
2. Members participated as individuals not as representatives of their agencies, allowing them to speak freely and work together as peers.
3. The CoPs were facilitated, out of a recognition that the busyness of the daily work life for most people in non-mandated activities will not be sustained, unless someone is paying attention to calling the group together regularly and catalyzing the rich and purposeful dialogue that characterizes successful CoPs.

4. The CoPs paid attention to relationships. They were designed to foster relationships characterized by openness, trust, respect and authenticity, to be deliberately non-hierarchical and to become safe spaces for all members to share their experiences, concerns and ideas in an atmosphere of mutual support. In this way it was recognized that change comes from paying attention to how we relate to each other in a system of services, as much as it does from what we do.
5. A key dynamic of the CoPs was learning based both in reflection on practice (i.e. things that the members have tried or are trying to do to achieve their goals) and effective practice and concepts from the literature or from resource people. The CoPs were geared to stimulate change using a highly dynamic iterative process that creates a collaborative platform for reflecting on past actions, learning, considering options for change and trying out innovations. The collaborative relationships and deepened understanding that CoP participants gain were brought back into their own organizations, and in some cases sparked innovations within these agencies.

Collective learning processes with these features are novel approaches for those who have studied and worked in largely hierarchical relationships. In creating a voluntary relational learning community, it was possible to honour experiential wisdom, practice wisdom, policy wisdom, research evidence and traditional Indigenous ways of knowing. In this way the CoP model had the potential to redress exploitative research processes and bridge north/south isolation.

In enacting the research process, the CoPs undertook a number of collective activities that involved engagement in learning from each other, and from existing literature and policy and practice contexts:

A. Examining promising practices from the literature: Applying gendered, cultural and trauma lenses for deepening understanding

The Repairing the Holes in the Net territorial CoPs began their work by immersing themselves in effective practice literature. Three critical themes emerged from this early collaborative study, and they became lenses through which later work on systems change was viewed.

1. The gendered nature of the experience of northern homeless women with mental health and addiction issues. Service systems are often blind to the gendered nature of the experience of mental illness and substance use problems, and do not incorporate gender-informed responses (Greaves & Poole, 2007). The communities discussed how trauma arising from interpersonal violence such as childhood abuse, intimate partner violence and sexual abuse is generally greater for women than for men, and how women exposed to violence develop post-traumatic stress disorder approximately twice as frequently as men (Ad Hoc Working Group on Women Mental Health Mental Illness and Addictions, 2006). Women are also more likely to be disadvantaged relative to many of the social determinants that contribute to mental ill health (e.g. poverty, social marginalization, lack of agency) (Benoit & Shumka, 2009; Spitzer, 2005). Gender affects the response to women with mental health concerns. There are discernible differences in the diagnoses and treatments offered to women as compared with men; for example, women are more often prescribed psychotropic medications such as benzodiazepines (Currie, 2003; Salmon, 2006). The CoPs also found and examined program examples where homeless women were being offered holistic gender- and trauma-informed support (Paradis et al, 2012).

2. The importance of incorporating First Nations and Inuit cultural perspectives and approaches to understanding mental health concerns and supporting women who struggle to remain housed and living well. The community participants shared and discussed key features of Aboriginal perspectives on colonization, reconciliation, wellness and approaches to healing. A key theme in these discussions was that mental health or wellness cannot be separated from a holistic understanding of the interrelationship between all the dimensions (mental, emotional, physical and spiritual) of an individual's life (Vicary & Bishop, 2005). The health of individuals, of families and communities are interconnected, and it is impossible to conceive of healthy individuals apart from healthy communities and vice versa (Royal Commission on Aboriginal Peoples, 1996). Mental health issues in Aboriginal communities cannot be separated from the colonial history of those communities (Maar et al., 2009). The many faces of mental ill health, such as substance abuse, violence, psychiatric disorders and suicide, are not separate problems, but rather manifestations of the same underlying social context (Lavallee & Poole, 2010). Cultural safety and responsiveness to the identity and wellness of Aboriginal women need to characterize the response to women's homelessness, mental illness and substance use problems (Acoose et al, 2009; Ball, 2009; Brascoupé & Waters, 2009).

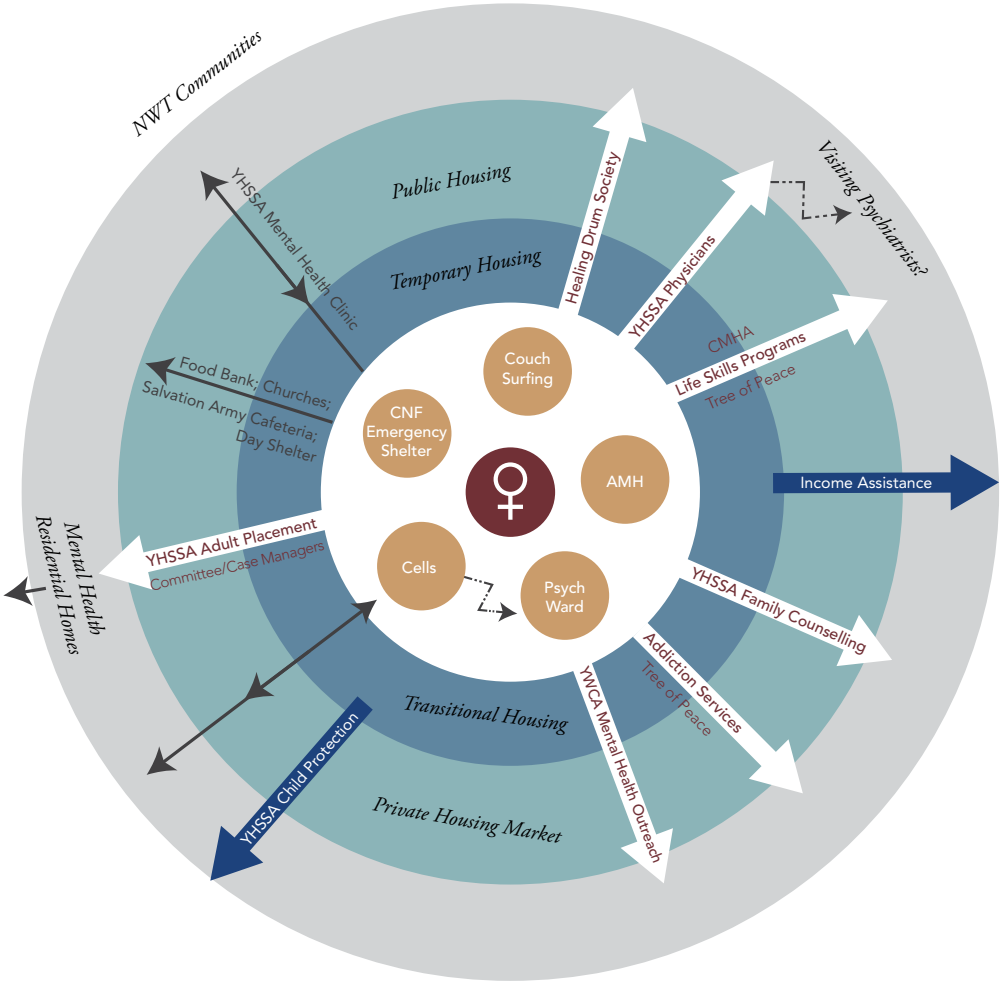
Northern women face overwhelming life circumstances such as interpersonal violence, poverty, hunger and cold, the legacy of adverse early childhood experiences, unresolved grief, persistent exposure to discrimination and racism from many segments of the dominant society and lack of access to real education and employment opportunities (Bopp et al., 2007).

3. The role of trauma as an underlying factor in the mental health and addictions concerns of northern women. The participants spent considerable time learning about the effects of trauma, trauma-informed approaches and healing. Northern women face overwhelming life circumstances such as interpersonal violence, poverty, hunger and cold, the legacy of adverse early childhood experiences, unresolved grief, persistent exposure to discrimination and racism from many segments of the dominant society and lack of access to real education and employment opportunities (Bopp et al., 2007). Most women are also impacted by the legacy of intergenerational trauma that derives from the historical experience of Aboriginal peoples of missionization, residential schooling, the discriminatory and punitive policies and practices of federal and territorial governments and economic exploitation (Aguiar & Halseth, 2015; Royal Commission on Aboriginal Peoples, 1996). Trauma-informed approaches to service delivery that do not require disclosure of trauma or pathologize people's experiences are increasingly being applied (Jean Tweed Centre, 2013; Poole et al, 2013). Trauma-informed approaches focus on creating safe, welcoming services that do not retraumatize (Greaves & Poole, 2012; Prescott et al, 2008).

B. Creating service maps as tools to begin creating a common understanding

A concurrent task taken on by the participants of the territorial CoPs was to map the existing service system for homeless and at-risk women. The map produced in Yellowknife is presented here as an example.

FIGURE 2 *Map of services for homeless women identified in Yellowknife*



A key observation that emerged from this work was: the pieces all seem to be there so why is this service system not producing better outcomes? This question was especially striking for government and non-government representatives in Whitehorse, where the service map that emerged contained the names of several dozen service options. The situation in Nunavut is strikingly different from that in the other two territories in that far fewer services exist, but yet the same observation was made – we should be able to do better with what we have.

To understand the opportunities and barriers that could become keys to answering the question about why service outcomes fall so far short of the needs it was clearly necessary to look more deeply at the experiences of northern homeless and at-risk women as they try to navigate the service system whose aim it is to assist them to meet their basic needs with dignity and purpose.

C. Learning from the experience of northern homeless and at-risk women

In reviewing the rich narratives of the women who shared their experiences with the territorial researchers, what emerged was a description of a number of vicious cycles that reinforce each other and are challenging indeed to transform into patterns of life that include stable housing, adequate income, satisfying interpersonal relations, the ability to cope constructively with everyday challenges and an enduring capacity for balance. These vicious cycles describe the trajectory of the struggle of northern women to overcome such barriers as: one, unresolved trauma; two, poverty and social exclusion; three, an inability to find and maintain housing; and four, ineffective services. Each of these themes can be depicted as a type of vicious cycle in which each element reinforces the others and makes the achievement of a different life pattern difficult. All four of these cycles also support each other. Below these four cycles are described and a visual representation of them is captured in Figure 3.

Thought of in this way, it is easy to see why the stories shared by the northern women who participated in this research project are so common and why it is so difficult to break the cycle. And yet, as the members of the territorial CoPs reflected on this material, they found it a rich source of valuable insights into a way forward. In discussions of the CoPs it could be seen that each element of the vicious cycles represents a barrier but also offers an entry point for transformative change.

1. Unresolved trauma

The women who participated in this research project by offering to share their struggles, their resilience and their hopes and dreams spoke graphically about the traumatic events in their lives that contributed to a vicious cycle of homelessness and mental health challenges. In doing so, they were recognizing the importance of understanding the dynamics and impacts of trauma in a way that will enable them to move into a pattern of life that allows them to more fully realize their personal aspirations.

a. Underlying causes - Although the specifics of their life stories varied, there are a number of experiences that were widely shared among these women and that they described as contributing to a kind of deep well of pain that continues to shape their lives in profound ways. After losing parents, siblings, children and other members of their extended families without the means to come to terms with their grief, women spoke about submerging their pain through the use of addictive substances and other strategies to distance themselves from circumstances over which they feel they have no control. More than three-quarters of the women spoke about abusive relationships with intimate partners. For some women, this abuse has occurred many times throughout their lives and often with multiple partners. Women spoke about the agony of undiagnosed and untreated mental health issues during childhood or adolescence that left them feeling alone, frightened and worthless. The effects of the systemic physical, sexual and emotional abuse experienced in residential schools affects virtually every family in the North and cannot be underestimated.

b. Living with unresolved trauma -Northern women attribute many of the mental health issues with which they struggle to their attempts to cope with core traumatic issues such as those described above. In describing their daily life, the women commonly mentioned mental health states such as depression (including longstanding postpartum depression), anxiety (including overwhelming panic attacks). insomnia, anger, debilitating sadness,

grief, despair, loneliness, agoraphobia and claustrophobia. Two thirds of the women interviewed described their ongoing struggles with addictions. While they acknowledged that their use of alcohol and other drugs contributed to many of their daily life challenges, they also recognized their substance use as a way to deal with pain and trauma. Women spoke about the shame they felt about some of their behaviour that contributed to the loss of their children to Child Protection Services or to criminal charges and eviction from public and private market housing. They also spoke about how difficult it is to follow through on the treatment or court-ordered conditions that are part of what is expected of them in order to regain custody of their children or avoid other legal consequences when they struggle daily with significant mental health challenges.

c. **Lack of trauma-informed services -** Several women commented that they would like to have had access to trauma-informed counseling services that recognized the role of experiences such as those described above, as well as the impact of dislocation from their families and communities in creating their mental health challenges. They felt that this option would have been a very helpful addition to their treatment programs, and might well have been more effective than the medication that they had been prescribed, which they felt sometimes just masked their suffering.

2. Poverty and social exclusion

The second theme, or vicious cycle, about which the women interviewed spoke in considerable detail is their experience of poverty and social exclusion. As shown in Figure 3, there are a number of factors that often conspired to keep them locked into their current circumstances.

a. **Inadequate income -** Poverty can be the outcome of some type of catastrophic life changing event, such as illness, an accident, the death of a loved one, a divorce or separation, fleeing an abusive partner or the loss of a job. Such circumstances often precipitate a downward spiral and domino effect that erodes any resources you may have had – a home, a car, furniture or pets. Once these resources are lost, they are very difficult to regain when you are just scraping by from hand to mouth.

b. **Physical health issues and FASD -** Chronic diseases and pain and lack of access to timely and effective health care have a big impact on the capacity of homeless women to be integrated into the society around them; that is, to be employed, to participate in social and recreational activities and to maintain a network of friends. Some women also report suffering from fetal alcohol spectrum disorder (FASD), which further exacerbates the challenge of participating in society.

c. **Racism, discrimination, stigmatization and marginalization -** Many of the women interviewed spoke about their feelings of being viewed as second-class citizens. First Nations and immigrant women experienced the double forces of sexism and racism. Being homeless and having a mental health challenge worsen these feelings of marginalization. Low levels of literacy and education are another reason why women feel marginalized.

3. An inability to find and maintain housing

A safe and stable home is a precondition for breaking the cycle of poverty and despair. It is very challenging to find and maintain employment without both an address and a home base at which to rest and keep yourself and your clothing clean. Being homeless is such a cause of stress that if you didn't have mental health challenges before losing your home, you certainly have them as a result of not knowing where you can be safe and get out of the cold, where you can have some privacy and your things will be not be stolen. Yet, finding and maintaining housing remains beyond the reach of many. Some of the reasons for this are shown in Figure 3 and the description below.

Almost all communities in the North have an absolute shortage of housing, especially housing that is affordable, safe, in reasonable repair and free of mould. Unless a woman is currently fleeing an abusive relationship and is therefore eligible for shelter services, there is really no place for her to go that will provide the type of intensive support she requires to stabilize her life and deal with her mental health issues. Although couch surfing is a common practice, it often places women at significant risk of sexual exploitation and physical abuse. Many of the women interviewed lost their housing because of rental arrears or were unable to secure housing because of their lack of capacity to pay a damage deposit. Once a woman has been evicted and lost her damage deposit, she is not only responsible for repaying arrears but may also not be eligible for a second damage deposit from Income Support.

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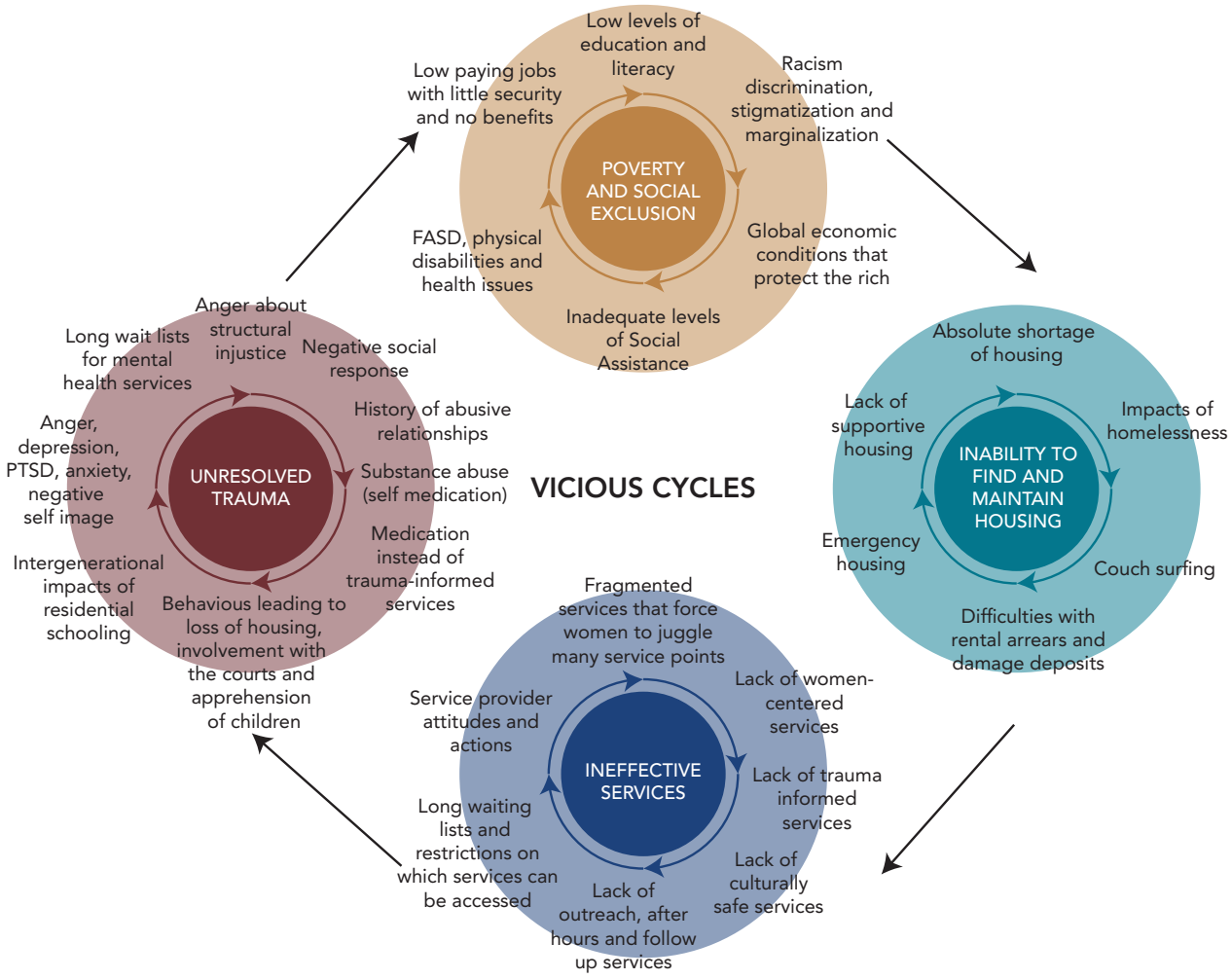
4. Ineffective services

The barriers depicted in Figure 3 related to access to relevant and timely services as reported by northern homeless women were also echoed by services providers in interviews about their own observations: long waiting lists and restrictions on which services can be accessed; lack of outreach, after-hours and follow-up services; lack of culturally safe services and those that are offered in the first language of the user; services that address symptoms rather than underlying causes; lack of services that operate in a trauma-informed manner (i.e. recognizing and operating from an awareness of the adaptations people with trauma histories make to cope; being strengths based rather than deficit oriented; creating a safe, welcoming, non-judgmental environments with low-access thresholds; and offering choice rather than asking women to comply with numerous bureaucratic procedures); fragmented services that force women to juggle many service points in order to meet their needs; service provider attitudes that stigmatize and punish rather than support and empower; and the lack of capacity to respond to needs rather than to follow standardized, unresponsive policies and procedures.

FIGURE 3 *The vicious cycles underlying women's homelessness in the North*



The four "vicious cycles" that conspire to trap women in homelessness and poor mental health can be visualized as a complex, interacting dynamic as pictured in Figure 3 (above).

D. Scanning contextual policies and strategies which have previously been enacted

Another focus for stimulating dialogue and system shift through the CoP process was the compilation of a program and policy scan for each territory. The purpose of this step was to situate service and system shift in a shared understanding of existing instruments that have been created, largely by government, to address the many issues that are part of the tangled web of women's homelessness, mental health and addictions. A collaborative review of existing policies and service options provides insights related to opportunities for leveraging existing political will and policy directives for more effective service outcomes. This work was also seen as an important step for creating synergy rather than having service providers feel that they are going over the information and creating similar frameworks and work plans again and again without seeing any real change.

One key common issue was the need for integration and collaboration among various health and social care services to offer a continuum of culturally relevant services and supports.

Members of the CoP discussed key strategies, plans and reports linked to the study's topics such as overall health and social care status reports and strategies (e.g. *Tamapta: Building Our Future Together – The Government of Nunavut's Action Plan 2009 – 2013* (The Government of Nunavut, 2009)); mental health and addictions plans (e.g. *Alianait Inuit Mental Wellness: Action Plan* (Alianait Inuit-specific Mental Wellness Task Group, 2007)); anti poverty strategies (e.g. *Building on the Strengths of Northerners: A Strategic Framework toward the Elimination of Poverty in the NWT* (Green et al, 2013); *The Makimaniq Plan: A Shared Approach to Poverty Reduction* (Poverty Summit, 2011)); reports on frameworks and strategies to address homelessness and housing (e.g. *A Home For Everyone: A Housing Action Plan For Whitehorse* (Yukon Anti-Poverty Coalition, 2011); *Igluliuqatigiilauqta: "Let's Build a Home Together"* (Nunavut Housing Corporation, 2012)); reports on community programs, assets, and needs (e.g. *What We Have: Our Community Assets* (Sustainable Iqaluit, 2012)). These reports and strategies identified social determinants of health, emphasized the importance of collaboration, acknowledged cultural values and identified guiding principles and priorities. The findings, principles and priorities identified in these policy documents aligned with many of the perspectives and recommendations of the service providers, service users and CoP members involved in this project. One key common issue was the need for integration and collaboration among various health and social care services to offer a continuum of culturally relevant services and supports. Such a continuum of supports would include prevention, intervention, treatment and after care programs and services for women experiencing mental illness, addiction and housing insecurity; link mental health and housing services with Aboriginal and Inuit specific economic empowerment programs; and involve culturally competent providers in delivering Inuit-specific approaches. A second common theme was the lack of safe and affordable housing for women and children and the need to link housing supports with supports related to violence and trauma and community wellness programs. A third common theme was the need for a variety of approaches for homeless and at-risk women, including: crisis/emergency shelters that can also accommodate children, various levels of subsidized/low income housing options, housing services for individuals with mental illness, transition housing and support services for shelter clients and housing and poverty reduction strategies that are inclusive of women. Finally the need to address the impact of trauma from residential schooling and cultural dislocation and historical and ongoing colonialism was a common theme. These common themes with previous work affirmed the thinking of the CoP members and allowed the community to see how their discussions connected and extended the earlier work.

E. Identifying and piloting a collaborative project

The Repairing the Holes in the Net research project offered each of the territorial CoPs a small grant to stimulate the implementation of a collaborative project that participants felt could prompt a significant system shift. This step was built into the research process on the premise that a visible 'quick win' would consolidate commitment to system shift and would provide a hands-on experience in collaborative work for government and voluntary sector agencies.

The CoPs in both Nunavut and the Northwest Territories chose to sponsor the facilitation of a learning experience and the production of supportive tools related to a more comprehensive adoption of trauma-informed practice approaches within the entire service system for homeless women. As noted in the section below about the impact of the CoP, this small project had a notable impact. Because the individuals who participated in the CoP already had a strong commitment to this system change, they were able to influence their departments/agencies to participate actively and they were able to play prominent roles in the learning event itself. And, since the members of the CoP represented virtually the entire net of services for homeless women, learning could influence not only individual agencies but also the entire system.

The Yukon chose to introduce a new service for homeless women that met a clearly defined need – an after-hours, child-friendly, gender-specific, low threshold and open-ended meeting point for vulnerable women where they could share nutritious food, access daily living supports such as shower and laundry facilities, use computers for their personal or job search needs, speak with a counsellor one-on-one if desired and find refuge from the chaos of their living situations. Since the small grant provided by Repairing the Holes in the Net would not cover the cost of personnel, food and other materials and a meeting space, the project was designed to operate by having existing services share a common access point for some of their own outreach activities. Although this project has struggled to be sustainable, it is still operational more than a year later.

Assessing the Impact of the CoPs

As the Repairing the Holes in the Net project was nearing completion, the CoP participants in each territory were asked to share their observations about their experiences with the process and what they felt was achieved.

Relational system change

The term relational systems change was coined by the Institute for Health and Recovery in Massachusetts as they facilitated systems change to support the delivery of integrated and trauma-informed services for women with substance use, mental health problems and histories of trauma and violence (Markoffet al, 2005). They found that a collaborative, inclusive and facilitated change process can effect services integration within agencies as well as strengthen integration within a regional network of agencies.

Likewise in the Repairing the Holes in the Net project, participants appreciated the involvement of colleagues from sectors such as addictions, mental health, housing, social services, shelters, justice, primary health and law enforcement, and especially the input from service providers and managers who do not usually come to inter-agency meetings. As those who attended CoP sessions learned more about each other – what they are trying to accomplish and the strategies and work plans they are using, the challenges they face and their accomplishments – it became much easier to understand why certain service gaps exist, as well as to see possible connections for supporting each other more. So much of what happens in the day-to-day work of ensuring that services better meet the needs of vulnerable women depends on informal collaboration between agencies and this is much more likely to occur if a service provider in one agency has a collegial relationship with a provider in another.

The CoP reinforced the aspiration that many service providers already had to shift the tendency to function in silos to a more relational and collaborative approach.

The CoP helped participants feel that they were part of a larger, supportive net of service providers and to reflect on ways that this culture of openness could penetrate their own agencies more deeply. Part of this evolving culture was the development among CoP participants of a common, respectful and inclusive language to share experiences, insights and suggestions for moving forward.

Pragmatic learning

The voluntary sector appreciated learning techniques for creating collaborative processes that would allow it to contribute its experiences and perspectives in their interactions with government. CoP participants also commented on the value they gained from the literature review and best practice insights. They appreciated the emphasis on reflective practice and felt more personally engaged and fresh in their jobs as well as more effective in their policy development and service provision work. Participants felt that the cross-fertilization between the three northern territories was especially useful and encouraging.

The CoP reinforced the aspiration that many service providers already had to shift the tendency to function in silos to a more relational and collaborative approach.

The academic literature and best practice review as well as the data generated from interviews with service users and providers was cited as being very helpful for feeding into agency planning and resource allocation processes. Participants saw it as helpful as information to bring to future policy and planning processes.

Action

Participation in the CoP itself was a form of action, as it became a space to share struggles and also to feel some hope that collaboration could bring some positive changes. It is easy for non-government and government service providers to get discouraged in the face of so little progress on the determinants of homelessness such as poverty, access to trauma-informed mental health and addiction services, societal indifference or animosity and punitive social policy. The multi-agency, multi-sectoral discussions, building of relationships and small collaborations were identified forms of action. Shelter and other voluntary sector services need strong partnerships with governmental child protection and income support services for the net result to be better outcomes for homeless/at-risk women with mental health challenges. The CoP discussions on topics such as barriers related to paying prior damage deposits and employment while in shelters became important as small policy changes identified that could make a difference in women's and children's lives, and as places to start in policy advocacy.

The CoP participants were especially enthusiastic about the small service improvement project that they undertook because research and other kinds of inter-agency work too often result only in production of reports. In each location, adopting trauma-informed practice was cited as having significant potential for shifting service provision, and also created an avenue for collaborative work outside the CoP meetings. In Yellowknife, CoP participants from the Salvation Army and the YWCA went on to make tangible service provision changes based on learning about trauma-informed practice. These organizations went on to present their work to a large forum on trauma-informed approaches sponsored by the NWT government to inform change in practice by the health system in that territory.

Interestingly, in keeping with a relational system change model, the CoP participants saw the work to inform each other as central to understanding the benefit of the research project and the CoPs approach. The core principles of safety, trustworthiness and collaboration that form the foundation of trauma-informed practice were seen to have application to CoP members' practice with each other, not only to the women they serve. CoP members claimed that they have now become much more aware about the impact of the way that they interact not only with clients, but also with their co-workers and colleagues in other agencies.

CONCLUSION

The Repairing the Holes in the Net project was designed to fill a glaring gap in evidence that could support a shift in the policy and service environment impacting the wellbeing of northern homeless women. The study built on a previous research project undertaken related to the needs and realities of homeless and vulnerable women in Canada's North. *You Just Blink and it Can Happen* (Bopp et al., 2007) focused on teasing out the determinants of women's homelessness North of 60 and the impact of homelessness on their physical, mental, emotional and spiritual well-being. It also explored the service and policy environment that either mitigated or contributed to this distressing social issue and provided recommendations for greatly reducing the incidence and impacts of homelessness on women and their children.

The Repairing the Holes in the Net project built on the previous research by focusing on the services accessed by northern women who were homeless and had mental health concerns, and the potential for service enhancement and improvement. The study connected local service providers and policy developers in three northern cities with southern researchers to discuss, envision and enact change to improve the lives of homeless women with mental health concerns. The project used a CoP methodology for stimulating system change. In doing so, it brought together, over a two-year period, key decision and policy makers and service providers in a highly participatory process that encouraged them to form deeper relationships built on learning, critical reflection and action processes. The dialogue within the CoP was informed by new research data related to the experiences of homeless women in accessing the net of services aimed at supporting them, and of service providers in working within that net, as well as academic and effective practice literature from elsewhere. The joint research work of the CoP in creating a service map and a policy and program scan was another source of evidence. CoP participants also learned through the collaborative implementation of a small service improvement project. In this way, research dissemination occurred throughout the project in participatory, action-oriented ways.

Although a CoP may offer an approach unfamiliar to many policy makers and direct service providers, the Repairing the Holes in the Net project demonstrated that this way of conducting research can be highly effective in stimulating systems shift by deepening relationships among the many individuals and agencies that shape the service system such that they are able to work together more effectively based on a ground of mutual trust and understanding. CoPs also have the potential to create a stronger knowledge base within the system about the needs, aspirations and experiences of homeless women and the efforts of service providers to make a difference within the parameters of their mandates, jurisdictions and resources. Stronger shared conceptual frameworks and vocabulary are created in CoPs for describing issues, effective practice models and current efforts. CoPs can also offer a shared experience of making a small systems shift through collaborative work.

Although a CoP may offer an approach unfamiliar to many policy makers and direct service providers, the Repairing the Holes in the Net project demonstrated that this way of conducting research can be highly effective

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2.4

VIGNETTE:
NORTHERN HOUSING NETWORKS: COLLABORATIVE EFFORTS TO DEVELOP INNOVATIVE HOUSING PROGRAMS FOR HIGH-NEEDS INDIGENOUS WOMEN IN NORTHERN, REMOTE COMMUNITIES

Jeannette WAEGEMAKERS SCHIFF & Rebecca SCHIFF

Canada's northern and remote regions experience unique challenges related to housing and homelessness. There is a need to understand and develop strategies to address housing-related concerns in the North. The diversity of communities across the North demands the tailoring of specific local-level responses to meet diverse needs (Macgill, 2011; Schiff, 2013; Schiff and Brunger, 2015). Over the past decade, local networks have emerged as a powerful method for governance and development of localized responses to addressing homelessness across Canada and North America. Despite this, there is a paucity of research examining challenges and effective approaches utilized by these local networks or their potential applicability for building housing security in rural, remote and northern communities. The experiences of a unique Northern Canadian housing and homelessness network point to strategies that can lead to successful collaborative approaches aimed at implementing programs to address homelessness in northern and remote communities.

Most of the housing initiatives that have been established throughout Canada have emerged as a result of efforts of local community advisory boards (CABs) which were established by the Homeless Partnering Strategy (HPS) in 61 designated cities. This case study examines the efforts of a rural and remote community in Labrador which was not one of the HPS-designated sites; however, this community used the support of an HPS-designated CAB from the provincial capital, as well as its local partnerships, to foster and evolve a non-designated CAB and develop a significant and innovative housing program.

COMMUNITY CONTEXT

Happy Valley-Goose Bay (HVGB) is a remote town of 7550 residents located in central Labrador. It serves as the administrative centre for the region. HVGB is the only community linked to all communities in Labrador by sea, air or road and, as such, is a hub for those travelling within Labrador and between Labrador and Canada's major urban centres. It is the primary location for offices of the provincial government, Nunatsiavut government, NunatuKavut Community Council and the Labrador-Grenfell Health Regional Authority. The remoteness of the town is emphasized by its location: 500 km by road from any other town its size and 1200 air miles from the provincial capital.

Inuit and many Inuit-descendent communities along Labrador's Atlantic Coast, as well as the Innu First Nation communities of Sheshatshiu and Natuashish, rely on HVGB for essential services. Many residents face significant economic challenges significant economic challenges. In 2011, 38% of the HVGB population reported incomes below the Canadian average (Statistics Canada, 2011). These economic issues are coupled with an acknowledged housing shortage and attendant problems of homelessness in the community (Lee, Budgell & Skinner, 2007; Schiff, Connors, & O'Brien, 2012). Because of its isolation, the town needs to rely on individuals in key service positions to mobilize community responses to local problems and perceived needs.

As with many rural and remote communities which lack resources (Christensen, 2012; Waegemakers Schiff & Turner, 2014), social housing and a rising homeless population had become a critical problem in HVGB by 2007 when it responded to an opportunity for Homeless Partnering Strategy (HPS) funding. That funding supported the creation of a task force to examine problems of homelessness in the community. This task force strategically included main service providers and key municipal leaders, and led to the creation of both a Community Advisory Board on Housing and Homelessness (HVGB CAB) and a Community Plan for Addressing Homelessness and Transitional Housing (Community Plan) (Lee, Budgell, & Skinner, 2007). One outcome of this plan was the recognition that the town lacked a shelter system and a treatment system that could be accessed by those needing stabilization prior to long-term/permanent housing. Included was a statement recognizing housing first as a key philosophy in terms of providing immediate housing without conditions of sobriety or treatment compliance. The overwhelming need for housing by by indigenous residents who represent at least 53% of the population (Statistics Canada, 2011) was also an important factor driving the development of this plan.

COLLABORATIVE COMMUNITY SUPPORT: THE HVGB CAB AND HOUSING FOR INDIGENOUS WOMEN WITH COMPLEX NEEDS

The development of a successful housing program for high-needs Indigenous (primarily Inuit) women in Happy Valley-Goose Bay owes its nascence to the fledgling HVGB CAB and the development of the Community Plan (Lee et al., 2007). In that formative document, one of the first priority actions was to use a housing first approach to provide housing for high-needs and vulnerable people. In the community plan, the top priority was identified as the need for "using a 'housing-first' approach to develop accessible individual housing units for people with multiple and complex needs. Adopting flexible, intensive community supports and service coordination for consumers will be a necessary component of this approach" (Lee et al., 2007, p. 1). With the impetus of the newly developed Community Plan, the HVGB CAB and a newly appointed housing support worker were able to provide instrumental support to the Mokami Status of Women Council to develop a proposal for an innovative housing program. The focus of the housing program would be responding to the priorities identified in the Community Plan with a particular focus on support for high-needs women who were homeless and in need of long-term stable housing.

The Mokami Status of Women Council (MSWC) was uniquely and appropriately positioned to enter into a working alliance with the CAB to develop critically needed housing for high-needs homeless Indigenous women. The MSWC opened as a support services and drop-in centre for women in the town of HVGB in 1979. The CAB encouragement of MSWC as the lead agency to develop a housing program grew from a long-standing presence that the organization had within the community and its well-developed reputation for providing drop-in and support services to the local community. However, MSWC lacked the organizational experience in housing programming to develop the application on its own. Thus, the housing support worker and the CAB became critical supporters in the planning and preparation of the proposal to the Newfoundland and Labrador Housing Corporation and the Canada Mortgage and Housing Corporation, which both became key funders of the project. Thus the development of both the physical plant and its operational structure was fueled by local support and input that emerged from the CAB and its leaders.

The project focused on the construction of a new facility which would house the main offices and programming of the MSWC (the Women's Centre), as well as eight apartments. As with many initiatives in rural communities, the CAB and MSWC used in-kind contributions from community businesses to help complete construction and furnish the eight units in a cost-effective fashion without incurring significant extra financial burdens. The partnerships that led to the formation of the MSWC housing project allowed key members of the CAB, who were also local service providers, to identify and refer the original group of women who would be housed in the apartments.

IMPLEMENTATION CHALLENGES

At the time of its inception, there were no program models for housing high-needs Indigenous women that the program leaders could access to help develop housing guidelines, tenant expectations and staff training. There are only a handful of housing programs for Indigenous women (less for Inuit women) outside of domestic violence shelters in major cities, and none consisted of purpose-built apartments that would include round-the-clock support staffing. While it is widely acknowledged that housing programs for Indigenous people need to have a cultural context and be informed by the historical issues that continue to challenge them, (Schiff, 2010) program models are not available. This includes a lack of staff training models on the roles and functions of women in Indigenous and specifically Inuit society, culturally appropriate activities, trauma-informed care and the issues of abstinence versus harm reduction approaches to substance abuse.

Thus the organization had few resources to guide its formative stages. This lack of resources was complicated by a strong vision within the Newfoundland and Labrador Housing Corporation (NLHC) that the program should operate according to "housing first" principles. However, these guidelines were not well defined by NLHC and largely reflected the experiences of people who have co-occurring mental illnesses and addictions in large urban settings (Schiff & Schiff, 2013). Thus, they were not sensitive to the unique needs of Indigenous women in northern, remote communities. This created confusion and tensions about specific program design components, including questions as to whether alcohol and drug use should be permitted on site and what circumstances could lead to loss of housing.

An additional major challenge was the lack of staff who were trained and experienced in housing programs. This necessitated the development of a staff recruitment and training initiative. The training and recruitment strategies focused on local resources for recruitment and the use of experienced trainers from Newfoundland and other areas to provide preparation for working with high-needs women in a housing context. The staffing model included purposeful hiring of women with an Indigenous heritage as well as those who had lived experiences with addictions and homelessness. This staffing approach provided an added peer component that proved to be instrumental in engaging the residents in the program.

1. This was a one time program, designed through a partnership between Memorial University of Newfoundland, the Labrador Institute of Memorial University, and Nunatsiavut Government.

Serendipitously, the School of Social Work at Memorial University of Newfoundland had completed an initiative to provide Bachelor of Social Work (BSW) training to Inuit women in Labrador, the year prior to the opening of the MSWC housing program.[1] The lead support persons for the BSW students, two Inuit women who had deep connections in the town and coastal communities, were recruited as the program manager and lead social worker. This team was able to provide the instrumental support that staff needed as they began to gain experience in working with deeply troubled and marginalized women. These two leaders were also able to draw on experiences in team and community building to implement a vision of an intentional community within the staffing component as well as within the housing program. Integral to this intentional community in the housing program is a strong presence of traditional culture and values that provided a new sense of identity and belonging for residents. This has resulted in considerable stability in retention of housing for residents who have historically been viewed as the hardest to house.

The results of all of these program development efforts was a unique residential program that serves Inuit women who seek to escape a life of addictions, homelessness, and family violence, learn new independent living skills, and create social relationships and a sense of community among themselves that will act as resiliency factors as they move on to more independent living. Its work has the potential to contribute to new understandings about the delivery of culturally relevant housing programs for indigenous women in remote communities. As a new program, it should be carefully evaluated for lessons learned and for important issues that continue to emerge as women move to more independent living.

Lessons Learned

What lessons in systems-level responses to homelessness can be learned from this local initiative that resulted in the establishment of an innovative housing program for high-needs Indigenous women? Two elements in particular emerge: utilising social capital to mobilise action around important issues and the importance of network and program leadership.

Social Capital

One important dynamic that facilitated the development of this program was the degree to which social capital was used to develop an engaged network in this community, as social capital is an essential component of addressing issues of public concern in rural communities (Wiesinger, 2007). The community of HVGB has historically assembled its collective interests to address issues of local concern, whether it is the misfortune of a house fire that devastates a local family or broader issues of access to needed services. The very visible problem of homelessness and lack of social housing galvanized the community to create an active network that could address these issues. The technical assistance of the NLHC was used to leverage the local willpower to create a CAB in the community and to develop timely and responsive plans to address homelessness in the community.

Skilled Leadership

Local leadership, which is an essential component of any successful rural initiative (Avant & Copeland, 2013), by both committed members of the CAB and the dedication of a housing support worker in a new position to serve this role, provided the impetus to develop the program. There was an element of good fortune in the availability of qualified leadership in the program. Small, remote communities often face challenges recruiting and retaining qualified personnel, especially from within the community itself. The program was fortunate to have been able to recruit women from the community who were qualified and capable of providing sound leadership and management.

The rewards to the local community in mobilising to address homelessness issues and develop a unique, culturally relevant program were multifold. The CAB was able to provide tangible evidence that the community was willing to take action and the newly developed program provided visible evidence of the town's willingness and ability to implement a much needed housing program.

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Systems Planning for Targeted Groups

2.5

CREATING A COMMUNITY STRATEGY TO END YOUTH HOMELESSNESS IN EDMONTON

Giri PULIGANDLA, Naomi GORDON
& Robin WAY

INTRODUCTION

Youth homelessness is a pressing problem that impacts communities at great human and financial cost. Without adequate and individualized supports, vulnerable youth will continue to cycle through systems, emergency services and the street, increasing their likelihood of exposure to exploitation and further marginalization (Gaetz, 2011). Research suggests that effective youth strategies must respond to the specific needs of youth and the underlying causes of youth homelessness, which are distinctly unique from those that define adult homelessness and, as such, require youth-tailored responses (Gaetz, 2014; Gaetz, O'Grady, Buccieri, Karabanow & Marsolais, 2013). Further, system disconnects play a major role in contributing to youth homelessness, including barriers to successfully transitioning from youth to adult supports, challenges within the child welfare system, inadequate discharge planning from systems, challenges to accessing/receiving continuous support around mental health and addictions, the need to adopt harm reduction principles in program/service planning and the need for relationship-based and youth-guided approaches (Felix-Mah, Adair, Abells & Hanson, 2014).

In 2014, Homeward Trust began the process of developing the *Community Strategy to End Youth Homelessness in Edmonton* (Youth Strategy). As a guiding document, it aligns with and draws upon the work of provincial, municipal and community plans, particularly the Government of Alberta's *Supporting Healthy and Successful Transitions to Adulthood: A Plan to Prevent and Reduce Youth Homelessness*, released in 2015. Edmonton's Youth Strategy aims to foster innovation and ways forward for strategic cross-systems and integrated planning with community stakeholders, especially the youth themselves. Ultimately, the intent is to achieve the goal of ensuring youth have access to safe, secure, stable housing; long-term connections to supports; improved social, physical and emotional well-being; and access to and successful outcomes in education and employment.

Edmonton's Youth Strategy serves as a roadmap toward developing a clear Housing First-based agenda for youth. Modeled upon Gaetz's (2014) strategic framework[1], it lays out recommendations within three broad strategic areas: enhance systems integration, prioritize prevention and sustainability and identify clear strategies for housing and support options.

FIGURE 1 *Recommendations Under Each Strategy Area*

STRATEGY ONE: Integrated System of Care	**STRATEGY TWO:** Prevention & Sustainability	**STRATEGY THREE:** Housing & Supports
1.1 Coordination of activities of youth-serving agencies and systems partners	2.1 Education on pathways into homelessness and mental health and addictions	3.1 Re-envisioning emergency services
1.2 Establish collective principles and values	2.2 Youth engagement and resiliency strategies	3.2 Increase the amount of housing options available
1.3 Establish a coordinated access and assessment strategy	2.3 Education and awareness campaigns	3.3 Availability of affordable housing
1.4 Coordinated research, data collection, information sharing and evaluation	2.4 Promotion of family reunification and supports	3.4 Housing First for youth
	2.5 Youth employment and education programming	3.5 Continuous support service and case management
	2.6 Effective supports for youth aging out of government care	3.6 Develop and maintain relationship-based approaches to supporting youth
	2.7 Zero discharge into homelessness	3.7 Maintain outreach services to connect youth with supports and housing
	2.8 Aboriginal cultural safety approaches	3.8 Appropriate/adequate services and supports for youth in high-risk situations
	2.9 Cultural competence & connections for immigrants & newcomers	3.9 Enhance services/supports for diverse subpopulations

1. Gaetz' (2014) proposed framework, which assists communities in their efforts to strategically address youth homelessness, is built upon five core components: develop a plan, create an integrated systems response, facilitate strategic stakeholder engagement, adopt a positive youth development approach and incorporate evidence-based practices.

ABOUT HOMEWARD TRUST

Edmonton is a city with strong traditions in planning and collaboration around issues of affordable housing and homelessness, of which Homeward Trust has been an active participant in both its current form and through the work of its predecessor organizations (the Edmonton Joint Planning Committee on Housing and the Edmonton Housing Trust Fund) which merged in 2007. Moreover, the organization was created with a unique structure that ingrains acknowledgement of the disproportionate impact of homelessness on Aboriginal peoples in the city: four of nine board members are selected through an Aboriginal nominating committee with representation from First Nations, Metis and other Aboriginal government and community stakeholders. This proportion reflects the fact that nearly 50% of the homeless population enumerated in Edmonton identifies as Aboriginal (Homeward Trust, 2013; Homeward Trust, 2014). From governance through to administration, Homeward Trust – in structure and in action – embodies a community-based mechanism for attaining the goal of ending homelessness in Edmonton.

Homeward Trust fulfills the role of funder, coordinator and systems planner by leading initiatives and programs that fulfill the mandates of provincial[2], municipal[3] and community plans[4]. In the role of funder, Homeward Trust administers funds on behalf of the three orders of government to support programs, projects and capital investments that are designed to help people find permanent housing and build better lives. As a coordinating organization, Homeward Trust supports local adoption of evidence-based practices, programs and services that help individuals/families find housing and supports that enable them to maintain stability. Homeward Trust manages the Housing First program, which has seen over 5,000 people housed through multiple community-based agencies since the program's inception in 2009 with funding that followed the Government of Alberta's release of *A Plan for Alberta: Ending Homelessness in 10 Years*. In the role of system planner, Homeward Trust brings together stakeholders to change how systems interact with each other and the people the community serves. Within this sphere, Homeward Trust has worked with community partners on multi-stakeholder system planning initiatives addressing homeless pregnant girls with sexually transmitted illnesses, housing and supporting heavy users of police services, engaging homeless people living in parkland areas, reconstructing addiction recovery pathways for homeless people, coordinating a winter warming and emergency response program, moving homeless families from emergency accommodation in hotels to homes and co-creating discharge planning protocols for release from hospital, among numerous others. This expertise in systems and community planning was a key reason why Homeward Trust has played a leadership role in taking action on youth homelessness, including the development of the Youth Strategy and formation of the Youth Systems Committee.

In the role of funder, Homeward Trust administers funds on behalf of the three orders of government to support programs, projects and capital investments that are designed to help people find permanent housing and build better lives.

2. The province of Alberta has developed effective responses to homelessness through legislation of the Social Policy Framework and Children First, through the implementation of A Plan for Alberta: Ending Homelessness in 10 Years, and the provincial youth plan: Supporting Healthy and Successful Transitions to Adulthood: A Plan to Prevent and Reduce Youth Homelessness.
3. At the municipal level, homelessness responses are guided by A Place to Call Home: Edmonton's 10 Year Plan to End Homelessness.
4. At the community level, responses are guided by Edmonton's Community Plan on Housing and Supports: 2011– 2015.

HOMELESSNESS IN EDMONTON

Local contextual factors that influence the realities of homelessness include the major role Edmonton plays in the provincial and national economy: according to City of Edmonton Chief Economist John Rose, Alberta accounted for 80% of new jobs in Canada between 2013 and 2014, with approximately half of them created in the Edmonton region ("Edmonton Generated 40 Per Cent," 2014). This has resulted in high rates of in-migration given the upward trend of employment growth linked to the oil and gas sector. Overall net migration to Alberta remains higher than any other province, though Alberta has experienced a 21% decrease from 2013 (Alberta Ministry of Innovation and Advanced Education, 2014). In Edmonton, there has been a seven percent increase in population growth (approximately 60,000 in-migrants) over the ast two years (City of Edmonton, 2014). Between 2013 and 2014, the vacancy rate in the province remained low, around 1.8%, with Edmonton's vacancy rate sitting at 1.4% and an increase of six percent for average rental rates in the city over the same time period (Canadian Mortgage and Housing Corporation, 2014). Although the time series is too short to make definitive conclusions, there appears to be a strong link between the change in rent and the number of homeless individuals counted in the city during Homeward Trust's biennial homeless counts (Homeward Trust, 2014).

Overall net migration to Alberta remains higher than any other province, though Alberta has experienced a 21% decrease from 2013 (Alberta Ministry of Innovation and Advanced Education, 2014). In Edmonton, there has been a seven percent increase in population growth (approximately 60,000 in-migrants) over the past two years (City of Edmonton, 2014).

Edmonton's population has a median age of 36, four years below the national average, making it the youngest of Canada's major cities (Edmonton Community Foundation, 2014). Census data from 2011 show that 40% of the population is below the age of 30, with half of this group between the ages of 18 and 29 (Statistics Canada, 2013). This proportion mirrors findings from the October 2014 homeless count, with 20% of homeless people counted falling within the 18–30 age range (Homeward Trust, 2014). In the 2014 homeless count, 549 children and youth (under the age of 25) were without permanent stable housing (Homeward Trust, 2014). Of this number, 240 were independent youth between the ages of 13 and 24. In terms of demographics, similarly as in 2012, there remained an over representation of Aboriginal youth (55%) and a larger percentage overall of homeless male youth (57%). The homeless count survey did not include a question around LGBTQ2S identity and therefore the percentage of LGBTQ2S youth experiencing homelessness in Edmonton remains unknown despite growing anecdotal evidence of unmet needs for this subpopulation expressed by community and system stakeholders alike.

Data is also collected twice per year in October and April at the Homeless Connect events that provide free services to people experiencing homelessness or at risk of becoming homeless. Coordinated by Homeward Trust and hosted by the Edmonton Shaw Conference Centre, Homeless Connect has occurred every year for the past seven years. Approximately 1,500 participants who were homeless or at risk of homelessness attended each event in the past few years, receiving generally inaccessible services such as haircuts, eye check-ups and glasses, dental work, family portraits, legal assistance and others offered by community-minded businesses and organizations. Guests provide data as part of the registration process, which incorporates a survey with questions that align with those used in Edmonton's homeless count. Of the 101 youth who attended the October 2014 Homeless Connect, 64% were Aboriginal, 93% were born in Canada, 49.5% were female, 59.4% had no permanent residence and 56.7% reported being homeless more than once in their life. Among Homeless Connect youth participants who indicated that they did not have a permanent residence (n=56), they had experienced on average almost two years of homelessness and two episodes of homelessness in the past three years. The average age at which these youth became homeless was just over 17. Most of these youth used shelters; however, one in four youth couch surfed and another 14% slept rough. Over half were renting prior to becoming homeless; 25% lived with family or friends and 14% were in foster care or a group home. Over 60% had completed some secondary education but 55% could not find employment and were actively seeking it.

Among Homeless Connect youth participants who indicated that they did not have a permanent residence (n=56), they had experienced on average almost two years of homelessness and two episodes of homelessness in the past three years.

In April 2014, Edmonton's youth sector and agencies implementing the Homeward Trust-funded Winter Emergency Response Program began raising concerns that homeless youth who are high risk and have complex needs are encountering serious gaps at the systems level and misconnections at the community level and, in the end, are accessing programs and services not equipped to address their specific needs and conditions. The most immediate concerns were the barriers to accessing mental health and addictions supports, lack of information sharing between systems and homeless serving agencies, insufficient safe spaces for youth to access services to assist with basic needs and lack of appropriate housing options for youth. It was clear that while great work was being done across the youth serving sector, there was still a need for enhanced coordination and integration amongst providers. Given Homeward Trust's role as systems planner, the organization began engaging Edmonton's youth homelessness sector and systems stakeholders to exchange information, identify gaps and recommend areas to focus resources and planning to address the immediate and long-term needs of homeless youth.

DEVELOPING THE STRATEGY: LITERATURE REVIEW

Given the urgency to ensure that the most vulnerable youth can access services and be guided along clear pathways to permanent housing and support options, Homeward Trust began by exploring how other communities were approaching youth homelessness. A literature review was conducted focusing on the UK, Australia, United States and Canada. Initial explorations focused on understanding the causal factors and conditions of youth homelessness. Drawing upon the extensive literature on youth homelessness, Homeward Trust explored national, regional and international recommendations that best reflected Edmonton's local contexts. For the purpose of supporting strategy development, thematic analysis of the literature centred on three priority areas: integrated systems of care, prevention and sustainability, and housing and supports.

An integrated system of care is defined as a local system that addresses the needs of individuals through the coordination and connection of programs, services and resources from planning through to delivery (Calgary Homeless Foundation, 2014). Importantly, an integrated system of care requires youth to be active participants in the planning, delivery and evaluation of programs and services specific to their needs (North Carolina Families Inc., 2006). Homelessness prevention approaches draw from the public health model of prevention, which is generally understood within three categories: primary, secondary and tertiary prevention (Culhane, Metraux & Byrne, 2010). Gaetz (2014) defines each as follows:

1. Primary prevention includes community-wide interventions that focus on working upstream by looking at the factors that increase the risk for homelessness;
2. Secondary prevention identifies conditions at early stages for those at risk of becoming or newly homeless; and
3. Tertiary prevention refers to ensuring homeless individuals are moved into housing with wraparound supports.

Successful prevention approaches require an integrated and coordinated system amongst youth serving agencies, government and organizations both internal and external to the homeless-serving sector (Gaetz, 2014).

Successful prevention approaches require an integrated and coordinated system amongst youth serving agencies, government and organizations both internal and external to the homeless-serving sector (Gaetz, 2014). The literature is clear on the need for housing solutions to include a range of options across a continuum that matches the diversity of youth needs with suitable and affordable options (Gaetz et al., 2013). Regardless of the model, youth need the flexibility to move across the continuum of housing options according to their needs and as they transition to adulthood (Gaetz, 2013). Successful housing also necessitates available and appropriate supports that focus on the development of life skills, meaningful engagement, access to education and employment, and strengthening social relations (Gaetz, 2013).

DEVELOPING THE STRATEGY: STAKEHOLDER ENGAGEMENT

While Homeward Trust took the lead in drawing up a rudimentary framework for the Youth Strategy that brought together research on youth homelessness as a conceptual starting point, it was ultimately community discussions that framed the development and priorities of the Youth Strategy. The process was an intentionally inclusionary endeavour and facilitative of cross-systems planning. Participants at each stage of consultation were strategically selected to ensure a diversity of perspectives and to foster relationship building and networking, not only between Homeward Trust and stakeholders but also amongst stakeholders themselves. The first consultation stage, a scoping session, focused on frontline engagement to help understand how services are planned and delivered on the ground and the challenges faced by frontline providers. The second stage, the strategy planning session, focused on a wider range of public, private, community and systems stakeholders. Invited participants came from both frontline and leadership positions to ensure system planning knowledge could interact with expertise from on-the-ground operations and direct delivery. The third stage, the youth consultation, was explicitly for youth to share their perspectives on having experienced services and programs first hand and living the daily realities of homelessness. Essential to consulting youth was the establishment of safe spaces for discussion, which was achieved by having the youth define the parameters and boundaries. Also necessary was the provision of incentives, which was pursued as a matter of principle: it was less about an incentive than it was about showing youth that their time and perspectives were valuable.

Initial Scoping Session

While a literature review provided an initial starting point and strong theoretical basis for strategy development, it was imperative to engage Edmonton's youth-serving sector and systems partners to define local contexts, identify gaps and barriers, and prioritize key areas to focus resources and cross-systems planning. Invitations were sent to homeless-serving agencies, youth-serving community agencies and stakeholders from diverse systems including primary health and mental health and addictions systems, corrections and justice, public and catholic schools, police, libraries, employment centres, income support programs and Aboriginal organizations/agencies, among others. The findings from the literature review – and emerging framework for the Youth Strategy – were presented to approximately 30 participants, including both community and government stakeholders. The three-hour meeting was held at the University of Alberta in late August 2014 and aimed to share knowledge, engage in discussions around community-level resourcing and cross-systems planning, and identify clear priorities and approaches to further develop the Youth Strategy. Following a brief presentation by Homeward Trust staff on research and strategic responses from other jurisdictions, the floor was opened for plenary discussions on two questions:

- What are the barriers/gaps at the systems level that are limiting youths' access to appropriate resources and services?
- What does integrated cross-systems planning and coordination of community level resources look like for Edmonton?

These discussions were facilitated by Homeward Trust staff with the purpose of maintaining continuous and inclusive dialogue and facilitating information sharing amongst participants. For a discussion that could have easily been mired in problem orientation and pointing fingers, the feedback was surprisingly focused, solution oriented, honest and collaborative. Most importantly, it signaled a palpable energy and early momentum for tackling the complex issues around youth homelessness at both the systems and community level. In essence, the community badly needed to see change and was ready to make it happen.

Following the scoping session, Homeward Trust-funded youth agencies and Child and Family Services were engaged to tease out more detailed information on areas to prioritize resources and elicit recommendations on housing options for youth. Informal meetings were held separately with each agency to allow for candid conversations on challenges and barriers around service delivery and to solicit ideas for overcoming these disconnects. These conversations were held with both frontline staff and managers to fill in the knowledge gaps from the scoping session. While not intended as an exercise in validating the Youth Strategy framework, information gathered supported adoption of its core components. Aligning with the scoping session, dialogue with agencies highlighted the importance of meeting immediate and long-term needs of youth, centring on facilitating access to housing and supports.

Strategy Planning Session

To build upon the momentum and collaborative spirit around ending youth homelessness, a second larger planning session was held at the end of September 2014 to discuss a proposed framework for Edmonton's Youth Strategy focused on the primary themes generated from the literature review: (1) enhancing coordination and service integration, (2) improving appropriate connections to housing and supports and (3) prioritizing prevention efforts. Drawing upon community recommendations from the scoping session and subsequent agency interviews, Homeward Trust engaged a broader range of stakeholders within mainstream services and outside of the housing and homelessness sector. Youth-serving agencies were also encouraged to recommend and invite youth to the planning session. Approximately 70 participants representing a wide swath of perspectives attended the session held at Bent Arrow Traditional Healing Society. To facilitate an interactive engagement process, a "Fishbowl Process"[5] was used, consisting of a panel of youth-serving agency leaders and key system stakeholders, guided by a member of Homeward Trust's leadership team in discussion around barriers/gaps and priorities/recommendations. Following the panel session, audience members were given the opportunity to respond and share observations on the dialogue, bringing the broader expertise of the community into the discussion.

Drawing upon community recommendations from the scoping session and subsequent agency interviews, Homeward Trust engaged a broader range of stakeholders within mainstream services and outside of the housing and homelessness sector.

Information collected from the strategy planning session was again organized into the three thematic groupings identified within the literature review (integrated system of care, prevention and sustainability, and housing and supports). Across all categories,

5. The Fishbowl Process used in the Strategy Planning Session involves a small group of participants seated in a circle, with a larger group of observers seated around them. The small group is led through a facilitated discussion for a time, while the larger group observes. When the time runs out, the large group has a turn to speak, while the small group observes. In this manner, this method facilitates dialogue when discussing topics within large groups.

recommendations from the participants highlighted the need for acknowledging and strengthening existing collaborative relationships between community and systems partners. With respect to integrated systems of care, recommendations called for streamlining system navigation and enhancing coordinated access for youth. Recommendations highlighted that a system of care necessitates inclusive approaches that are youth centred and strengths/relationship based, including harm reduction and trauma-informed practice. Regarding housing, recommendations indicated the need to develop clear pathways and transitions along the continuum of housing options for youth, including access to long-term and appropriate services and supports based upon the needs and risk level of the youth. Feedback also highlighted key barriers, including the lack of appropriate housing or interim accommodation options, system breakdowns and inadequate mental health and addictions supports. Prevention and sustainability recommendations indicated the need to enhance understanding around Aboriginal perspectives and historical contexts and the adoption of cultural safety and competency practices more generally. There was also a focus on increasing awareness around the pathways and complexities of youth homelessness and its linkage to identity and social relationships, with special attention required for challenges faced by LGBTQ, newcomer, gang-involved and sexually exploited youth.

Youth Consultation

In January 2015, a consultation was held with homeless and at-risk youth to draw on their lived experiences of homelessness and to identify barriers and gaps within Edmonton's housing and support services. Youth serving agencies were once again engaged to identify and recruit youth who were experiencing homelessness or at risk of becoming homeless to attend the consultation. In recognition of their expertise and participation, $25 prepaid Visa cards were provided as honoraria. Approximately 20 homeless or at-risk youth attended the consultation, which was held at Edmonton's downtown public library for accessibility and inclusion. Safe space boundaries were established by the participating youth. To activate discussions, a short presentation was provided outlining key concepts and ideas on how to address the needs of homeless youth. Following the presentation, the larger group was divided into smaller tables to discuss the following questions:

- What has stopped you from getting housing, healthcare, legal aid, school and jobs?
- What has helped you get housing, healthcare, legal aid, school and jobs?
- In a perfect world, what do we need to end youth homelessness?

Youth feedback mirrored many recommendations provided by the community consultations. Considerable priority was given to the need for an integrated system response and streamlined process and pathways to services, explicitly in relation to health, justice and education. Youth felt that there needed to be prioritization of collaboration within the sector, expressly around information sharing and service continuity. Other areas of importance centred on enhancing education and awareness around the pathways into youth homelessness, with a focus on family breakdown, trauma, mental health and addictions and, more broadly, on the daily challenges

that homeless youth encounter. In relation to housing, recommendations called for increased housing options for youth, particularly congregate supportive housing and scattered site housing with supports for daily living and skills development. Recommendations reinforced the need for a more coordinated and accessible continuum of housing and support options for youth. Central to all youth feedback was the need to involve youth in program and service planning. In reference to their vision of 'a perfect world,' recommendations included a lower cost for housing, increased supports, more transitional housing, stronger community engagement and enhanced partnerships across the sector.

ESTABLISHING THE YOUTH SYSTEMS COMMITTEE

Participant feedback across all consultations, including youth, asserted the need for structured relationships and networks to enable streamlined access and navigation of services and coordination of cross-systems and community planning. Central to this idea was the call for the formation of a committee that would work to share and mobilize information, pool resources and maximize inter- and cross-agency collaboration to implement the Youth Strategy. In January 2015, Homeward Trust created the Youth Systems Committee with this purpose in mind. The committee serves in an advisory capacity to Homeward Trust, helping to identify and address systems challenges and opportunities for Edmonton's youth sector, and overseeing the refinement, implementation and monitoring of the Youth Strategy. The involved stakeholders include representatives from both the municipal and provincial governments; mainstream systems including Alberta Health Services, Child and Family Services and financial support programs; the Edmonton Police Service; public and separate school boards; funding bodies; the Edmonton Public Library; youth shelters; youth-serving agencies who are actively involved in addressing youth homelessness; and other community- and government-based providers. Many of these members had been previously involved in the consultation process that helped to develop the Youth Strategy and thus were eager to participate in a committee focused on realizing its goals.

The committee operates under a mandate of improving cross-systems integration and coordination to ensure homeless and at-risk youth have access to appropriate public and community-based supports and services to prevent and end homelessness.

The committee operates under a mandate of improving cross-systems integration and coordination to ensure homeless and at-risk youth have access to appropriate public and community-based supports and services to prevent and end homelessness. In order to achieve this, a clear work plan has been created that aligns with the Youth Strategy, incorporating feedback and input from all committee members and setting out priority areas of focus and actions to be taken. The work plan includes success measures, a delineated timeframe and lead agents for each activity. In creating the work plan, the committee desired a focus on action-oriented outcomes, framed within the values and principles from the Youth Strategy and grounded within the urgency of solving youth homelessness. Within each strategy area, specific implementation activities are identified that have been prioritized into a measured timeframe of six months, one year and two year markers that will allow for continual and cumulative progress.

FROM STRATEGY TO IMPLEMENTATION

With the completion of the development of the Youth Strategy and the creation of the Youth Systems Committee to oversee implementation of its recommendations, focus turned towards determining next steps in operationalizing implementation efforts. On June 10, 2015, Homeward Trust hosted the Youth Services & Access Design Forum, a daylong event aimed at facilitating greater coordination, collaboration and cooperation among multiple agencies and government systems each providing youth-oriented services, in order to ensure youth can access the supports and services they need. Over 50 individuals attended the forum, representing membership from 30 government and agency partners, many of whom sit on the Youth Systems Committee. Homeward Trust staff worked closely with City of Edmonton stakeholders to co-organize and plan the event. During the youth consultation process for the development of the strategy, youth expressed that being able to participate in the planning and decision making process demonstrated that their voices were being included and valued. Given this perspective, there was considerable regret on the part of Homeward Trust and its partners that, despite beginning the process in the spirit of creating a youth-centred system, the youth themselves were not formally included until development of the strategy was in its final stages. As such, it was decided that moving the Youth Strategy from paper into action must start with meaningful engagement of youth with lived experience.

Planning for the forum centred on incorporating a youth-led neighbourhood tour of Edmonton's inner city and Old Strathcona areas. These tours aimed to help ground the subsequent design work within the experiences and points of view of youth themselves. Afternoon sessions delved into community asset mapping to identify what resources are available in each neighbourhood, where they are concentrated and where there are gaps. Following the asset identification exercise, the participants engaged in a detailed group design discussion, focusing on future visioning of what an ideal youth system could look like and what changes, including additional, reallocated or integrated resources, would be needed to realize such a youth system. Although all the youth guides who participated in the neighbourhood tours were invited to participate in the full day, only one was able to stay and participate in the afternoon sessions. The forum ended with a final debriefing and reflection completed through a Socratic Circle method discussion that was captured by a graphic artist in a visual diagram.

Youth-guided Neighbourhood Tour

The intent of the youth-guided neighbourhood tour was based on approaches like Jane's Walk, in which interested people are directly exposed to places and people to help them understand broader contexts and meaning. As youth homelessness is most visible in two areas of the city (Old Strathcona, immediately south of the North Saskatchewan River, and downtown, immediately north of the river), it was important that forum participants witness the realities at street-level in those areas. Homeward Trust committed to engaging homeless youth to shape the tours with their perspectives and lived experience. Given Homeward Trust's recent foray into systems planning for youth homelessness, partnering agencies were solicited to advise on youth engagement approaches and assist with recruitment of youth. Early steps focused on meeting with youth-serving agencies to determine if such an approach

was practically feasible and ethically sound. From these meetings emerged a blueprint for meaningful engagement and a tactical way forward for incubating this youth-led activity. While there were some initial reservations, there was also buy-in, as youth-led tours were a novel experience; they were also viewed as a catalyst for youth empowerment and a unique opportunity for youth to be at the forefront of service planning. To support participating youth, meetings were held four consecutive Friday afternoons over the course of one month to develop the walking routes, personal narratives and ideas of how to address systemic issues and barriers. These meetings also focused on building trust and establishing relationships between Homeward Trust and the youth, and amongst the youth themselves. To reduce barriers to participation, Homeward Trust provided dinner at each meeting and gave each youth transit tickets to get to and from the meetings. Additionally, their time commitment, practical expertise and willingness to engage forum participants were recognized by providing a $125 prepaid Visa card for those who participated in the tour. While the initial meeting brought together 13 youth from diverse backgrounds, many were uncomfortable with the idea of speaking in front of large groups of stakeholders. In the end, five youth participated: three youth led the downtown inner city walk and two youth led the Old Strathcona walk, sharing their stories and lived realities of youth homelessness. The experience was a powerful one for all who participated, elevating the abstract understanding of system disconnects to the gritty reality of life on Edmonton's streets for vulnerable and neglected youth.

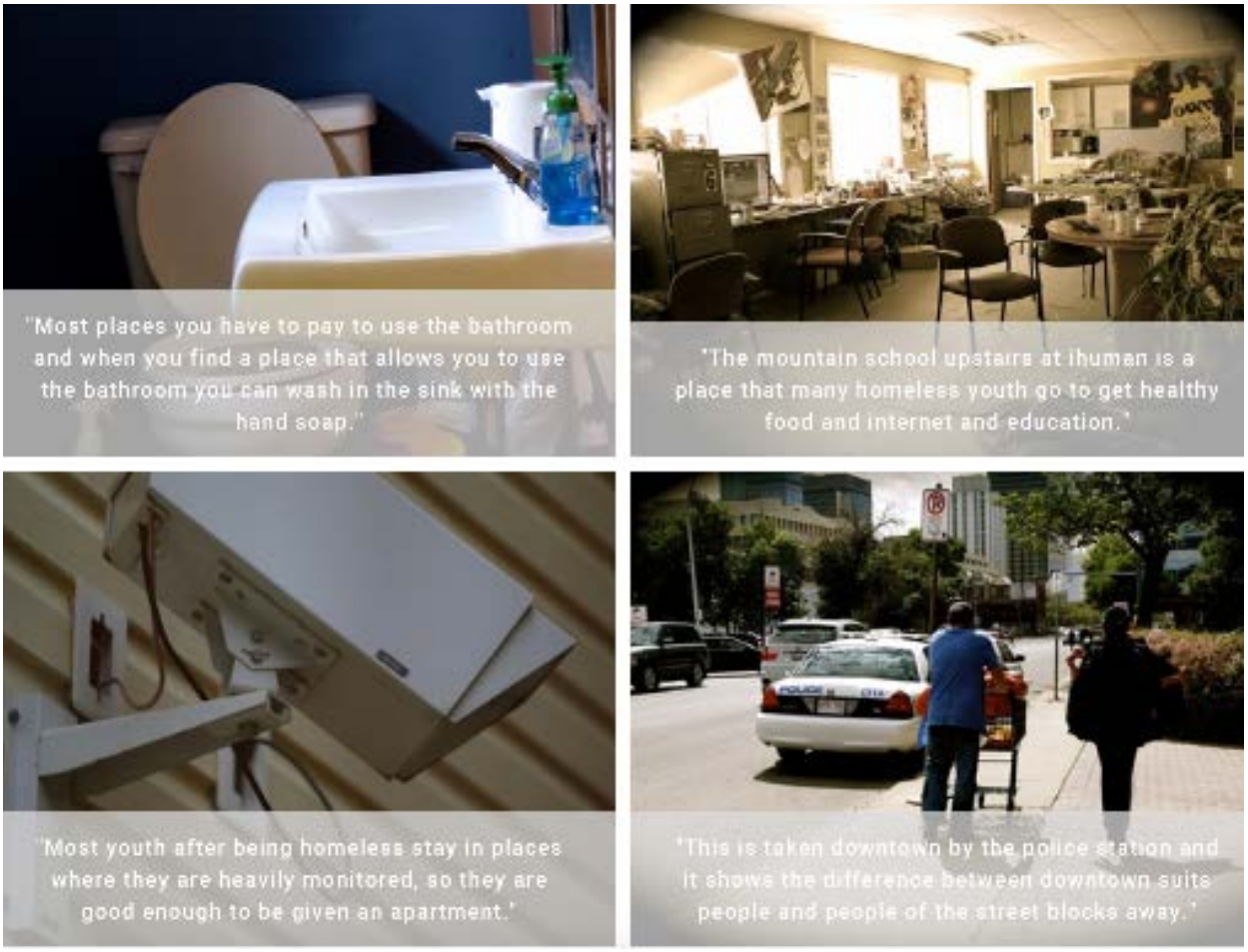
Photovoice

Early in the planning stages of the forum, it became apparent that while the youth-guided tour was a space to express and empower youth, not all youth would be in a position to share their experiences in such a format. To be inclusive of those youth who wanted to participate and share their stories through another medium, Homeward Trust offered the opportunity to share their viewpoints through Photovoice. Photovoice combines photography with community development and social action. Participating youth were asked to represent their perspectives by photographing scenes that highlight barriers and issues that homeless youth face. The purpose of this project was to use photography as a medium of expression to understand youth perspectives and experiences around issues of homelessness, capturing the realities of street life in Edmonton. This project engaged youth to think about their communities and raise issues that are important to them. To help youth frame their story, we asked youth four questions. For each question, the youth took one photo and provided a written response.

1. What places or things have meaning to you and that you think are important to youth around issues of youth homelessness?
2. What are places you feel safe and don't feel safe?
3. What are places and things that you would like to see changed?
4. What does a 'home' mean to you?

Recruiting youth for this project relied solely on partnering agencies, who were contacted via email and in person by Homeward Trust. Community agencies supported participating youth by assisting with transportation to any places youth wanted to document as part of the project, as well as encouraging and helping youth with their written responses. Each youth who participated in the Photovoice project was provided with two transit tickets and a $50 prepaid Visa card for their time and openness in sharing their perspectives and ideas. In total, six youth participated.

FIGURE 2 *Screenshot of Photovoice Contributions posted on yegyouthstrategy.ca*



Community Asset Mapping

In the Community Asset Mapping activity in the afternoon of the forum, the two youth-guided tour groups were divided into smaller groups and given a large printout map of either the downtown/inner city or Old Strathcona/Southside, as well as some translucent Mylar paper upon which they were asked to draw out the resources and assets available in each area. Participants were asked to reflect upon the morning's youth-guided tour and to draw from the knowledge and experience of those in each group to complete their maps. Participants were given markers, coloured dots and a legend of service types they were asked to identify on the map. The aim of this activity was for each participant to gain a better understanding of the current youth system, how and where services are dispersed throughout the city and the challenges and gaps in services that currently exist for homeless youth.

At the end of the session, each small group was able to review the maps of the other groups in their larger breakout, allowing for participants to compare and contrast how others had mapped resources in the same neighbourhood. Through having a clearer understanding of how the current system appears, the participants were then in the right frame of mind to engage in future visioning to determine how an ideal youth-serving system would look.

FIGURE 3 *Youth Design Forum Participants Engage in Community Asset Mapping*

Youth Services and Access Design Discussion

The group design discussions offered stakeholders the opportunity to share their feedback and perspectives on how best to support high-risk and homeless youth in the Old Strathcona/Southside and downtown/inner city areas to access the supports and services they need. The aim for these collaborative discussions was to produce a framework for neighbourhood-specific service and access models, utilizing existing linkages and community supports. Based upon their existing knowledge and the information and experience from the day's activities, participants were asked to envision what the ideal youth system could look like and to engage in 'blue sky' future visioning of how that ideal state could be achieved. Participants were asked to give ideas and suggestions for specific resources, actions or assets that could/should be added, redistributed or reconfigured in order to achieve the goal of a coordinated, integrated and collaborative youth system. Following ample discussion time, the two breakout groups presented back to each other an overview of their discussion and the ideas and suggestions put forth for each neighbourhood. A joint summary discussion, focusing on an overview of suggested ideas, enabled the distillation of several common themes within and between both the downtown/inner city and Old Strathcona/Southside areas. The forum ended with a Socratic Circle method discussion[6], in which participants reflected on the implications of the day for themselves and their organizations and what they felt were the key takeaways from the day. The group's reflections were illustrated by a graphic artist as people spoke, capturing the highlights of the day in a stunning visual representation.

6. The Socratic Circle method is a participant-centred approach to inquiry and discussion between individuals. The method was adapted to incorporate a facilitated discussion in which participants divide into an inner and an outer circle. Each circle of participants is given the opportunity to speak to the issue, then provide highlights of what they heard or ask clarifying questions of each other's conversations.

FIGURE 4 *Graphic Illustration of Sharing Circle Reflections*

FROM IMPLEMENTATION TO INITIAL ACTIONS

Homeward Trust continues to work with the Youth Systems Committee and related stakeholders to mobilize funding and reposition resources to move the community closer to a system design that can end youth homelessness. Moreover, youth who participated in consultation activities have been engaged to form a Youth Advisory Committee to ensure the work remains grounded in their lived experience.

A commitment to providing individualized youth-centred supports requires integrated systems that adopt strategies for information sharing to support the continuity of services and transition planning. As such, a key priority activity for the Youth Systems Committee is to have clarification on provincial legislation and policies so that all stakeholders in the system of care are engaged in reasonable information sharing to better serve youth. This activity will be crucial to accomplishing all further activities related to facilitating coordinated access, intake, service delivery and evaluation. Information sharing will also set the stage for activities within the two year timeframe, such as the use of common assessment protocols and tools and the use of a common data system for monitoring the entire system of care for continuous and responsive quality improvement.

A commitment to providing individualized youth-centred supports requires integrated systems that adopt strategies for information sharing to support the continuity of services and transition planning.

Both within the community consultation events that went into the development of the youth strategy and the discussions to come out of the Youth Forum, a top priority is to develop strategies for high-risk and homeless youth to have easy, coordinated access to co-located and integrated mainstream services needed to prevent and exit homelessness. The objective in creating these 'integrated hubs' lies within the new capacities and efficiencies created from drawing on the untapped collective repository of strengths when multiple agencies are brought together. Integrated hubs can help harmonize multiple mandates and improve information exchange, eliminate competition and ultimately bring agencies closer together (Belanger, 2014). They also can facilitate greater coordination, collaboration and integration among multiple agencies and government systems providing youth-oriented services. Although this is one promising strategy, recommendations that emerged from the Youth Forum also call for ensuring a balance between centralized and decentralized service access and delivery. Incorporating greater integration of system services, such as income support, health and Child and Family Services programs and supports, within community-based service providers across the city would help to ensure that youth can access the services they need wherever they choose to seek assistance.

Additional mobile outreach services were also suggested, to ensure youth are being engaged and reconnected to mainstream services a soon as possible, as well as to target those youth who have become entrenched in the homeless 'street culture.' Social media was suggested as an initial access point for youth and a key engagement tool. Above all else, there was consensus on developing pathways for newly homeless or at-risk youth to be diverted from the shelter system as quickly as possible into alternative forms of interim accommodation and to immediately begin the process of securing appropriate supportive or supported housing options.

CONCLUSION

The Youth Strategy is not the final step, but rather the first giant leap (of faith) towards achieving the goal of ending youth homelessness. The specifics of the strategy will be continuously refined, evolving over time in order to meet the changing needs of youth and adapt to shifting policy environments and service contexts. Effectively, strategies to end homelessness require sustainable, long-term approaches that are supported by integrated systems and community-level resourcing that prioritizes prevention and housing and supports (Belanger, 2014; Bond, 2010; Calgary Homeless Foundation, 2011; CHRA, 2012; CAEH, 2012; CHRN, 2012; CCF, 2010; Culhane, Metraux & Byrne, 2010; Gaetz, 2014, 2011; Gaetz, O'Grady, Bucciri, Karabanow, & Marsolais, 2013; Greenber & Rosenheck, 2010; Hambrick & Rog, 2000; Junek & Thompson, 1999; NAEH, 2013; Quilgars, Fitzpatrick, & Pleace, 2011; Raising the Roof, 2009). Edmonton's homeless-serving sector has historically capitalized on and strengthened the efforts of individual community agents through collaborative partnerships in an ongoing drive to better address the needs of the most vulnerable people in our community, as evidenced by the successes in applying Housing First to house thousands of formerly homeless people over the last six years. In developing the Youth Strategy, Homeward Trust, alongside its community and systems partners, engaged in a series of activities that incited intensive learning about the contexts, disconnects and opportunities for collaborative and coordinated planning and delivery for homeless youth. Throughout the process, the Youth Strategy morphed and evolved, reflecting the experience and expertise within the community, including the youth themselves. While still in the early stages of this work, it is clear that continuing progress will not be defined or limited by constrained ways of thinking or siloed approaches to problem solving. It is no overstatement to say that being able to achieve often repeated but seldom enacted concepts like 'meaningful engagement' and 'collaborative planning' is a laudable accomplishment. Through developing the Youth Strategy and setting the course for its implementation, Homeward Trust and its partners have demonstrated the potential and capacity of Edmonton to engage in collective action aimed at realizing integrated service delivery within the youth homelessness system. Thus, Edmonton has a solid foundation in place on which to build deeper and more complex strategic efforts to make progress towards ending youth homelessness.

In developing the Youth Strategy, Homeward Trust, alongside its community and systems partners, engaged in a series of activities that incited intensive learning about the contexts, disconnects and opportunities for collaborative and coordinated planning and delivery for homeless youth.

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2.6

COORDINATION AT THE SERVICE DELIVERY LEVEL: THE DEVELOPMENT OF A CONTINUUM OF SERVICES FOR STREET-INVOLVED YOUTH

Naomi NICHOLS

Like homelessness in Canada's adult population, youth homelessness is not caused by a single incident, behaviour or action. Homelessness is the result of interrelated structural, personal and inter-personal factors that undermine people's access to stable and appropriate housing (Gaetz, Donaldson, Richter & Gulliver, 2013). Youth who experience homelessness represent a diversity of characteristics and experiences (Gaetz, 2014). Although homelessness cuts across demographic categories and identities, sexual-, gender-, racial- and cultural-minority youth are overrepresented in Canada's homeless population. Structural conditions such as racism, heterosexism, homophobia, transphobia, cissexism, poverty, a lack of safe, accessible and affordable housing for youth and insufficient or ineffective inter-sectoral and inter-agency coordination contribute to exclusion and homelessness among youth (Gaetz, 2004; 2014; Gaetz et al., 2013). For example, experiences of oppression linked to colonization shape an overrepresentation of youth with Aboriginal heritage among homeless populations (Baskin, 2007). Many youth who experience housing instability and homelessness report histories of conflict and/or abuse within the family home. For some youth, familial conflict and instability has shaped interactions with child protection services through childhood and sometimes during adolescence. In Jasinski, Wesely, Wright and Mustaine's (2010) study of women and homelessness, almost half of their study participants were unable to live with their biological families during childhood because of poverty and abuse. Other studies corroborate a link between child welfare involvement and homelessness (Dworsky & Courtney, 2009; Karabanow, 2004; Lemon Osterling & Hines, 2006; Lindsey & Ahmed 1999; Mallon, 1998, Mendes & Moslehuddin, 2006; Nichols, 2013; 2014; Ontario Youth Leaving Care Working Group, 2013). Many homeless youth experience mental health and addictions issues (Baer, Ginzler, & Peterson, 2003; Hughes, Jean R., Clark, Sharon, E., Wood, William, Cakmak, Susan, Cox, Andy, MacInnis, Margie, Warren, Bonnie, Handrahan, Elaine & Broom, Barbara, 2010). Learning disabilities and educational challenges are also common among young people experiencing homelessness (Hyman, Aubry & Klodawsky, 2010; Mawhinney-Rhoads & Stahler, 2006). Like adults who experience homelessness, youth may use a range of services, participating in interventions that "cut across multiple agencies and multiple services systems" (Hambrick & Rog, 2000: 354).

Youth homelessness is a complex problem. It warrants a multi-dimensional response that addresses the circumstances of individual youth as well as the social-structural conditions shaping patterns of exclusion and inequality more broadly. In this chapter, I argue that inter-organizational and inter-professional – or 'joined up' – learning, planning, policy making and working will enable the type of systems-level response that a complex problem like youth homelessness requires. As I see it, an integrated response to youth homelessness requires the following:

1. Conceptual integration (i.e. common terms of reference, goals and frameworks for action);
2. Administrative integration (i.e. via policies and procedures for inter-organizational data collection, accounting and communication as well as methods for distributing leadership and accountability within and across sectors); and
3. The dissolution of traditional sectoral and organizational territories.

This chapter describes the collaborative planning and change process spear-headed by a group of service providers in the city of Hamilton, Ontario:[1] the Street Youth Planning Collaborative (SYPC). The SYPC represents a grassroots-led (or 'bottom-up') effort to collectively identify and address the structural factors and individual circumstances influencing the experiences of street-involved youth in the City of Hamilton. In telling the SYPC's story, I shed a light on the activities of people in Hamilton as they endeavor to create and implement a coordinated system of supports for street-involved youth. As I move through the narrative, I highlight the general implications of this case, teasing out the necessary organizational and behavioural components of a change process that supports a fundamental shift in how people work and think. The case highlights the strategic use of research by a service delivery network to generate a common understanding of a problem and then to identify, plan for and fund a multi-faceted solution. The case also demonstrates the suspension of organizational autonomy that is necessary to joint work. Hamilton's coordinated response to youth homelessness is supported by shared staffing positions and shared funds that support interdependency and shared accountability. As a research case, the SYPC illustrates some of the strengths and limitations of a community-led or bottom-up organizational response to a complex problem like youth homelessness.

1. The third largest municipality in Ontario, the City of Hamilton has a population of approximately 520,000 people. Hamilton has a long history of industrial activity, particularly in steel manufacturing. The dominance of the steel industry in Hamilton continues to exert considerable economic and cultural influence in the region, even as the municipality experiences a decrease in manufacturing and increase in the arts and service industries.

DATA COLLECTION

Data collection for this particular case study began with a review and high-level coding of the SYPC's organizational documents: meeting minutes, terms of reference, evaluation reports and procedural documents. This preliminary review of materials guided the development of case-specific interview prompts and observational foci relative to the standard interview template and observational guide used to construct all of the cases for a larger project. Fieldwork occurred over the span of a single month in 2014.

Observation

The process began with a period of observation and discussion in a number of the organizations that comprise the collaborative[2]. I also observed a meeting of the SYPC Directors Committee, a meeting of the Youth Housing Support Project Members and a meeting of the Frontline Advisory Committee (FLAC).

Interviews and Focus Group Discussions

In addition to the time spent doing site visits, observing meetings and speaking casually with people about their involvement in the SYPC, I conducted three in-depth semi-structured interviews and seven semi-structured focus group discussions. The focus group sizes ranged from four to 15 participants per group. Targeted interview and focus group discussion prompts were developed for each conversation based on early document analysis, site visits and observations as well as the standard set of interview topics used to inform the development of other case studies in this volume (e.g. Doberstein, Chapter 4.4). Throughout this chapter, pseudonyms are used to refer to individual research participants.

FINDINGS – PART ONE

Envisioning a Model for Service Integration

I have organized the findings into two parts. The first part conveys a generalized model for service integration for street-involved youth that is informed by the SYPC's approach. In part one, I use a number of subheadings to articulate distinctive components of the model. In part two, I illuminate a number of persistent challenges that the SYPC member organizations face. Part two outlines key challenges that influence the efficacy of an integrated service-delivery approach to prevent and address youth homelessness.

Build Professional Relationships and Assess Community Needs and Strengths

Prior to the emergence of the SYPC as a formal collaborative structure, people who worked with street youth in Downtown Hamilton communicated with one another on an ad hoc basis, but made no attempt to formally coordinate service provision or communication pathways. In 2000, two youth homelessness organizations identified a significant service gap: "a lack of weekend support for street-involved homeless youth in Hamilton… Street-involved youth couldn't go home on the weekends, nor could they go to any service" (Carrie, SYPC director).

These organizations led to the development of a Street Involved Youth Network. The network emerged as a space for service providers to share information, support one another's work and discuss systemic and service user trends. The goal was to increase collaboration among service providers as a way to eliminate service

2. Social Research and Planning Council, Notre Dame Youth Shelter, Notre Dame School, Brennan House, Wesley Youth Housing, Living Rock, Angela's Place (and the School for Young Mothers), the City of Hamilton and Art Forms, Youth Art Studio.

duplication and repair service delivery gaps. In support of this goal, the network partnered with Hamilton's Social Planning and Research Council (SPRC) to produce a proposal for an assessment of the needs of street-involved youth in Hamilton. The National Crime Prevention Centre funded the proposal, and an individual – Janine – was hired by the SPRC to design and conduct the needs assessment research and ultimately coordinate the activities of the SYPC.

In 2005, the SYPC and the SPRC released the *Addressing the Needs of Street-involved and Homeless Youth in Hamilton* report with 27 recommendations that were developed to support community planning and action processes. Frontline and management staff from street-youth serving organizations were involved in all aspects of the research process. From Janine's perspective, "by the time the recommendations were developed and we tested them [for feasibility] with leadership and frontline staff… people were bought in." Carrie, a member of the SYPC Directors' Committee, corroborates and extends Janine's position: "Those 27 recommendations [from the needs assessment research] have led the work [of the SYPC]." In fact, the emergence of the SYPC as a structure to support collaboration and coordination among street-youth-serving organizations is, itself, a response to one of the central "needs" the research identified: the need for an easy-to-access, well-organized and integrated service delivery model.

Develop a Model: A Continuum of Services for Street-involved Youth

The SYPC represents almost 15 years of collaborative work. Currently, the SYPC consists of seven member organizations. Each of the following organizations performs a distinctive function within the street-youth-serving continuum:

- Alternatives for Youth, which offers addictions and mental health services;
- Good Shepherd Youth Services, which is comprised of the following organizations: Notre Dame Youth Shelter, Brennan Transitional Housing and Brennan ACTs 2nd Stage Transitional Housing, Angela's Place – transitional housing, childcare and a school for young mothers and the Notre Dame Alternative School (in partnership with the school board). Good Shepherd Youth Services collectively offer housing, mental health, childcare, prenatal and parenting resources, education, advocacy, trusteeship and wellness services;
- Hamilton Regional Indian Centre, which offers culturally relevant education, outreach, addictions, wellness, employment, prenatal and parenting resources, and legal supports;
- Living Rock Ministries, which offers employment, wellness, housing support, advocacy and nutrition services;
- SPRC of Hamilton, which offers research, planning, evaluation and community development supports;
- Wesley Urban Ministries, which operates Wesley Youth Housing and oversees the Youth Outreach Worker (YOW) program. Wesley Urban Ministries collectively offer housing, outreach and wellness services; and more recently
- The City of Hamilton offers administrative, governance, and funding support.

Each of these seven member organizations offer a suite of programs and services that contribute to Hamilton's continuum of services and supports for street-involved youth. In some cases, a program is linked to a particular organization, but shared by the system. For example, the Mobile Mental Health Clinician team has an office at Notre Dame Youth Shelter, but the clinicians service all of the Good Shepherd organizations, Wesley Youth Housing and Living Rock Ministries. The Youth Housing Support Project is also comprised of a number of shared housing support worker positions, as is the mobile YOW program.

In addition, the SYPC collaborates with a number of other organizations in Hamilton to ensure a comprehensive continuum of services for distinctive populations of street-involved and homeless youth. For example, St. Martins Manor (Catholic Family Services) and Grace Haven (Salvation Army), two member organizations of the community's Young Parent Network, also offer housing and other supports for pregnant and parenting youth. The relationship between the Young Parent Network and the SYPC is supported by the provision of a full-time housing worker position (funded by Catholic Family Services) that is shared between Grace Haven, St. Martins Manor and Angela's Place. Further supporting the links between the two networks, Angela's Place (a Good Shepherd organization) is a member organization of both networks.

No longer a loosely affiliated network of street-youth-serving organizations, the SYPC is now formally organized to support learning and collaboration within and across three different organizational levels with distinctive mandates:

1. Youth Leaders Committee that offers experiential insights;
2. Frontline Advisory Committee that is responsible for sharing 'on the ground' knowledge and offering advice; and
3. The Directors' Committee that is responsible for making decisions and influencing policy/program directions.

People link the SYPC's three-tiered structure to the collaboration's ability to represent community priorities and concerns: "[it] comes back to that three tier piece… I think it's about youth voice, frontline voice, director voice… other tables that I'm on that don't have all three of those tiers, it's a very different dynamic… [the SYPC] reflects the voice of this community" (Ruby, director). For a change process to "reflect the voice of [the] community," it must begin with – and remain accountable to – local perspectives and concerns.

Identify a Shared Focus and Reorganize the Service Delivery System to Achieve a Shared Goal

Guided by the community-based needs assessment research process, the SYPC identified a shared focus on early intervention and diversion. Their goal is to ensure that young people with no prior street involvement are diverted from the street-involved-youth sector as quickly as possible (within 48 hours) after coming into contact with the system. In support of this outcome, the SYPC has developed a continuum of housing supports that typically begins when a youth enters the system through the Good Shepherd Notre Dame Shelter.

FIGURE 1 *Hamilton's Continuum of Housing Supports*

While very few youth actually progress in a linear way through each housing component, the continuum is organized to provide youth with different levels of supportive housing and other required services wherever they enter the system. The Continuum of Housing Supports is not a staircase model – that is, a young person's access to various housing components is not dependent on demonstrations of 'housing readiness' while participating in any single component; rather, the aim is to provide access to an array of housing options that address the diverse needs of youth in the municipality.

The most common access and comprehensive assessment point is the Good Shepherd emergency shelter, Notre Dame.[3] In addition, the Youth Housing Support Workers and youth outreach workers associated with the various SYPC member organizations ensure multiple other access points, relative to the continuum of services. When youth access the continuum of housing services in Hamilton, they also gain access to the Good Shepherd Mobile Youth Mental Health Clinician team, the City of Hamilton's Mental Health Outreach team, and Alternatives for Youth (AY) Addictions and Mental Health Counselors as needed. This type of structure is often described as a 'no-wrong door' approach to service delivery. The idea is that youth in Hamilton "don't need to jump through A, B, C, and D to get services. You get here; you get services" (Jean, manager).

The other important aspect of the SYPC's early prevention strategy is their effort to work cross-sectorally to prevent institutional discharges from other sectors (e.g. justice, child welfare, mental health) into the Notre Dame Youth Shelter. Transitions between systems increase people's vulnerability to homelessness, particularly among youth transitioning from state care. Given the SYPC's goal to prevent youth homelessness, cross-sector collaboration is an important aspect of its work.

3. Staff at Notre Dame assess incoming youth using a simplified version of the CANS (Child and Adolescent Needs and Strengths) tool. Other organizations across the SYPC are currently being trained to use this adapted assessment tool as well.

Expand the Network: Foster Collaboration Between Sectors

Many of the recommendations from the *Addressing the Needs* report highlight the importance of cross-sector relationships to adequately meet the needs of street-involved youth. To improve cross-sectoral collaboration, the SYPC produced a follow-up report on building collaborative relations between the Child Welfare and Street Youth Service sectors that identified "how well [the two sectors] were or weren't [working] together – and at different levels" (Nicole, current SYPC coordinator). Guided by the two reports, the SYPC has tried to foster cross-sectoral partnerships and/or improve cross-sectoral communication between the street-involved-youth, the mental health and the child welfare sectors.

Cultivate Shared Accountabilities: Joint Work Between the Child Welfare and Youth Homelessness Sectors

In 2009 – in partnership with the Children's Aid Societies (CAS) of Hamilton – the SYPC applied for and received funding from HPS to develop and implement a Youth Housing Support Project Team. This team of seven individuals is shared by and supports the housing needs of youth involved in one or more of the following partner organizations: Catholic-CAS, CAS, Good Shepherd Youth Services (including Notre Dame Youth Shelter, Brennan House, Brennan House ACTS and Angela's Place), Wesley Youth Housing, Living Rock Ministries and St. Martin's Manor. While a single organization is designated as an organizational lead in order to receive and manage the funds, the positions are shared by the partner organizations.

The shared positions are important in two regards. First, they improve the capacity of individual organizations to meet the housing needs of youth. Second, the shared positions provide a formal structure that connects the street-involved-youth sector to the child welfare sector. The organizations meet regularly to discuss the Youth Housing Support Project Team, but the relationship building that has occurred over the course of this five-year partnership has also opened the door to improved communication between sectors on an informal basis:

> *[This project has] solidified relationships and reduced barriers for youth going through systems. Now if things happen, we know we can call Adriano or Mike or Carrie – like we have the relationships... Other than the amazing work of getting kids housed, I think one of the great things that has come out of this is exactly what we wanted, to build a relationship with Child Welfare that wasn't scary for people (Suzanne, member organization director).*

Historically, relations between child protection services and the street-involved-youth sector have been strained – largely because a lack of suitable housing for adolescent youth in care (i.e. Society, Crown, or temporary wards of state) has resulted in the placement of these youth at emergency shelters while more suitable housing arrangements can be established. The Youth Housing Support Project has opened the door for ongoing communication and joint problem solving about this and other persistent issues influencing the housing experiences of youth in care. Now, if a former Society or Crown Ward requests a bed at the Notre Dame shelter, shelter staff are asked to give the (C)CAS staff a call to determine whether the youth might be eligible to enter into a voluntary care agreement with the Society. By working collaboratively, the two sectors endeavour to prevent street entrenchment among transitionally homeless youth.

Inter-sectoral coordination is essential to prevent homelessness. In Hamilton – as in many cities across Ontario – the Children's Aid Societies continue to periodically use the Notre Dame emergency shelter as a 'placement' for hard to house youth in care. Many youth who touch the shelter system in this city report prior involvement with the Child Welfare system. In 2014, 52% of youth seeking admission to the shelter were previously involved with the Child Welfare System (Notre Dame, administrative data). Clearly the implementation of a Youth Housing Support Project does not – in and of itself – redress a lack of suitable permanent placement options for adolescent youth in care or for those transitioning out of care. But, the director of the Notre Dame shelter and the (C)CAS managers I interviewed suggest that their collaborative work has improved inter-organizational and inter-professional relations between the two sectors and enabled a coordinated effort to prevent (C)CAS-involved youth from entering the shelter system wherever possible.

The development and implementation of shared staff positions is one way to leverage limited resources and ensure that young people's diverse housing needs are met no matter where youth enter the continuum of care. The shared staffing model is a key component of the SYPC's collaborative approach and an important driver of sustainable change across the service delivery system. Other important structural and conceptual facilitators of cross-sectoral work are described in the next section on coordinating institutional transitions.

Coordinate Services Across Sectors: Institutional Transitions

Jean, a housing support manager, describes an ideal cross-sectoral response to address the inter-related housing, mental health, youth justice and educational needs of one young man discharging from inpatient psychiatric care. The transition began with a phone call from staff at the inpatient psychiatric ward of the McMaster Children's Hospital to Brennan House, the supportive housing environment for youth. They had a young man – 16 years old – who would soon be discharged and had "nowhere else to go":

> *He was living independently in student housing, [but] really needed to have the support that we offered. A place where he could be monitored, a place where his medication would be offered to him on a regular basis, a place where he would have some support in improving some of the skills he had learned and some harm reduction (Jean, supportive housing manager).*

An ideal cross-sectoral collaboration requires time for transparent communication and planning regarding the needs and expectations of all those involved, including the needs and expectations of the youth:

> *So the ideal process was for… the hospital to bring the youth to us and introduce him to the program, talk about what we offer, talk about the expectations of the house – not only the mental health piece, but also the daily living piece that we would be providing him with… we also need to identify that the youth fits with the group that we have (Jean, supportive housing manager).*

Transparent communication is also necessary to determine and clearly articulate the roles and responsibilities of participants relative to the identified needs and expectations of the youth and collaborating agencies. In this case:

> *The hospital is very forthcoming with us with information… We're doing case conferences. This is not taking one day. It took two weeks or three weeks before that could happen… There was no pressure on us to immediately take the youth. Nor was there pressure on the youth to immediately make a decision to come to Brennan House… Everybody was involved and a decision was made around who was going to follow up with what piece… that is the best-case scenario (Jean, supportive housing manager).*

Sometimes described as a wrap-around or case management model, from Jean's perspective the best-case scenario is characterized by cross-sectoral communication, low-pressure timelines and collaborative decision making processes. The ideal process involves friends and service providers – from across a number of sectors, including education, mental health, corrections and housing – collaborating to ensure youth have access to all of the supports they require to experience wellness and stability in community.

In this case, the original point of collaboration was between the youth housing and mental health sectors, reflecting the SYPC's efforts to prevent homelessness among youth transitioning out of inpatient mental health services. The coordination of discharge planning across sectors represents a single aspect of the SYPC's efforts to collectively address the mental health needs of street-involved youth. The SYPC has also capitalized on opportunities for inter-professional learning and sharing to improve the sector's capacity to identify and address the mental health needs of street-involved youth.

Integrate Key Services: Housing and Mental Health Supports for Youth

In response to recommendations from the *Addressing the Needs* report, the SYPC also created a three-person Mobile Mental Health Clinician team to identify and implement effective mental health treatment supports for youth and increase the capacity among frontline staff to effectively and sensitively address the complex mental health needs of street-involved youth. In so doing, the SYPC hoped to limit the number of 'serious occurrences[4]' documented in Ministry of Children and Youth-funded member organizations (e.g. Brennan House or Wesley Youth Housing). By improving staff capacity to identify and proactively respond to youth mental health issues and improving collaboration between the mental health and street-involved youth sectors, the SYPC has indeed decreased member agency use of emergency services. For example, in 2014, the Notre Dame shelter and Brennen House collectively diverted 154 youth from the hospital by implementing in-house crisis support through the Mobile Mental Health team and the use of consulting psychiatry at the McMaster Children's Hospital. The Notre Dame shelter also diverted 260 youth from accessing emergency services by engaging them in the Youth Substance Abuse program, provided in collaboration with the SYPC member-organization Alternatives for Youth.

As Lynn (a mental health clinician) and Jean (a supportive housing manager) explain, the Mobile Mental Health Clinician team exists to improve the sector's capacity to recognise and support the complex mental health needs of street-involved youth:

> *Lynn: So we know from research, right, that there are many, many homeless kids who have serious mental health difficulties, but we weren't working with them… [a youth's] psychiatric support would come from the hospital… there wasn't the expertise within the program to have those young people living with us.*

4. 'Serious occurrences' are instances where an organization that is funded or licensed by the Ministry of Children and Youth Services (MCYS) is required to notify the Ministry about 'serious' and 'enhanced serious' incidents. For example, an enhanced serious occurrenc" must be reported whenever emergency services are used during a serious incident involving a youth.

Jean: [Now] we are avoiding crises and we are avoiding trips to the hospital, and I think that's what makes the big difference, is that they're not constantly transitioning [into the hospital and then back to the shelter] because we have capacity to support them now.

Rather than simply providing mental health supports to youth themselves, the Mobile Mental Health Clinician team has supported frontline and management-level staff across the SYPC member organizations to identify and proactively respond to mental health issues that have historically undermined a young person's ability to remain housed. They also support staff to collaborate more effectively with mainstream mental health service providers. The Mental Health Clinician team uses a combination of training and professional development, on-site mentorship and the development and implementation of common procedures to enable a proactive, coordinated and collaborative response to the mental health needs of street-involved youth.

The clinicians orient much of their training and capacity building efforts toward improving frontline staff's ability to recognize and proactively respond to young people's mental health needs in-house, while also ensuring that the mental health model used in the street-involved youth sector reflects the approach used by mainstream mental health services: "We started at Brennan House and we got two half-day training sessions from a psychologist at McMaster [Children's Hospital], and that's how it started. We started using some of the basics [of the McMaster approach: Dialectical Behaviour Therapy[5]]" (Lynn, mental health clinician).

As staff across the frontlines of the street-involved youth sector began aligning their approach with the one that the hospital pursued and supporting the development of universal skills among youth across the system of care, they began to see a reduced number of transfers to the hospital. This more therapeutic approach was paired with general harm reduction training, policy and procedures such as regular bag searches by staff:

If there had been a razorblade in any of our buildings five years ago, there would have been one of two responses: 'Ugh, it's a razorblade,' or the alternate response would be, 'Oh my goodness, this kid may self-harm, we need to send him to the hospital right now…' Whereas now our staff go, 'Oh, that young person tends to keep their razorblades here. Let's check that carefully'
(Lynn, mental health clinician).

The Mobile Mental Health team provides formal training opportunities and ongoing coaching to SYPC member organizations' frontline and management staff. These ongoing professional learning and coaching opportunities are designed to change workplace culture and practice across organizations. Professional development and coaching promote changes at the individual staff level. In order to support these changes at an organizational and systems level, policies and procedures were developed and implemented across organizations. In this way, staff's new modes of thinking and acting became standard practices across the sector.

For example, in order to improve frontline capacity to accurately identify the mental health needs of youth, the Mental Health Clinicians – namely Lynn and Esme – developed training and policies for the use of a common assessment tool among all staff who work at the Notre Dame shelter – the main system access point – and a roll-out plan in place to ensure that people are trained to use the tool in member organizations across the SYPC in the immediate future. The shared assessment tool improves conceptual integration and communication across the collaborative:

5. Dialectical Behavioural Therapy (DPT) is an evidence-based cognitive-behavioral treatment approach used with adolescents by staff at the MacMaster Children's Hospital. It focuses on fostering the four skill sets: mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance.

> *Esme: And so when youth transfer from program to program… this little package goes with them that has their CANS and has their [DBT] skills that they've used… [The common tools and process for sharing information is] strengthening the partnership – this intake tool being sort of a common language or a common way of saying, 'What are the young person's needs and what are these young person's strengths?' (Esme, mental health clinician).*

The development and implementation of a standardized inter-organizational communication process ensures that staff have a shared understanding of a young person's history of engagement with other SYPC member organizations as well as an assessment of the youth's needs and strengths.

The activities of the shared Mobile Mental Health Clinician team illuminate several key components of the systems-oriented program of reform in Hamilton's youth homelessness sector. In general, the implementation of a shared staffing model provides a framework for ongoing communication and shared investment in one another's work. Specifically, the Mobile Mental Health team sought to align their intra-sectoral work with the larger mental health system so as to improve continuity of care for youth moving between systems as well as communication and coordination between the two sectors. To ensure that programmatic changes acquired traction among frontline staff, the team developed formal training opportunities, which they supported with ongoing on-the-job coaching and mentorship. This new learning was then reinforced by organizational policies and procedures, including shared assessment tools, to ensure a system for intra- and inter-sectoral communication and coordination.

The implementation of a shared staffing model provides a framework for ongoing communication and shared investment in one another's work

FINDINGS – PART 2

Battling the Headwinds: Barriers to Communication, Collaboration and Coordination

Despite the many gains documented in the sections above, interview participants identify a number of wider systemic influences that continue to make their work difficult. Members of the SYPC agree that they would be unable to do their collaborative work without the organizational and facilitative capacity brought by the SYPC coordinator position. As well as the human resource capacity to support their joint work, fostering collaboration and coordination also requires a sustainable funding base. Partner organizations must be able to share in the economic inputs and outputs of their collaborative work. The loss of economic and organizational autonomy associated with joint working requires flexible and innovative fund distribution, accounting and accountability (e.g. measuring and reporting) mechanisms that support integration at an administrative level.

Funding, Accounting, Administration and Accountability

From the perspective of research respondents in positions of leadership or management, the current funding landscape for non-profit organizations pays lip service to collaboration, that is undermined by the structures that have been developed for distributing and accounting for funds:

> *Most funders are looking for collaboration. But when they say 'collaboration and partnerships,' a lot of funders don't really mean 'collaboration and partnerships.' They mean one agency being the lead, and they just want to have conversations with one committee (Carrie, member organization director).*

There have been times, in the history of the SYPC, where one organization has handed funds across the table to another organization when the collaborative determined that this other organization was better positioned to deliver a particular service. Member organizations share a commitment to positive outcomes for youth that guide all decision-making processes – even decisions about how funds will be distributed between member agencies. In contrast, the reporting and accounting mechanisms put in place by funders anticipate a hierarchical structure between collaborators, with all funds flowing through a single lead agency. This hierarchical structure undermines the distributed approach to leadership and oversight that the SYPC has worked to develop.

The directors of the SYPC observe that government funders might play a role in breaking down funding and other organizational silos, such that productive collaborative relationships between organizations are fostered. It is important that funders do not simply require collaboration at the application stage, but that they enable groups to include a budget line to support the technical and relational work of coordination once funds have been granted. Additionally, if the funding model is going to shift, than the data collection and reporting models will need to change as well:

> *Some of the really good examples where communities have done really high impact work are connected to data. And not just in terms of reporting results... but in terms of really having data that allows you to follow people and follow their progress in really meaningful ways... Especially any group that has multiple partners that touch on multiple systems (Mike, member organization director).*

In order to reap the full benefits of their joint work and to up the ante for the success of cross-sectoral partnerships, the community-led effort spearheaded by the SYPC must be supported by a top-down effort to integrate the administration and oversight of funds and collective outcomes. This change would ensure that the relationship between joint working and shared outcomes is evident and possible to track. In order to prevent youth homelessness, communities need to create and implement systems that sustain cross-sectoral investment in shared outcomes among youth – particularly those youth transitioning between systems of care.

Transitionally Homeless Youth

Young people discharging or aging out of institutional care (e.g. mental health inpatient services or child protection services) and young people being released from youth justice facilities are vulnerable to transitional homelessness – that is, temporary homelessness or shelter use that occurs when discharge planning processes fail to identify and address youth housing needs. Diverting these youth from emergency shelter services is essential to preventing long-term or episodic homelessness. But shelter diversion requires coordinated cross-sectoral communication, decision making and planning processes *as well as* shared accountability for the outcomes of youth transitioning between systems.

In an earlier section, Jean described an ideal discharge planning process coordinated between mental health and street-youth services. Unfortunately, this 'ideal' discharge process remains elusive. Youth continue to be discharged from the hospital into SYPC housing environments without their medication or with insufficient effort to ensure their comfort and readiness: "I was discharged [from psychiatric care into Brennan House], and the next day I was back in the hospital… [The problem] was being rushed into a new place I didn't even know" (Arianne, youth leaders committee). Youth also continue to be discharged into the shelter from inpatient psychiatric care facilities and criminal justice facilities and placed there temporarily by the Child Welfare system. Esme notes that it remains common practice for youth to arrive at the Notre Dame shelter with nothing but a sack of belongings:

> *When a young person or young adult is discharged to the shelter, you're discharging that kid to the streets… And that happens a lot. And then we get to know these kids because they arrive with a sack – I think about that metaphor with a stick and the bag – literally with a sack, and there is [no communication] to precede their arrival.*

Discharging a youth into the shelter system is discharging them into homelessness. The shared goal of diverting youth from the shelter system shapes a continued effort by SYPC and CCAS staff to prevent CCAS-involved youth from becoming involved in the shelter system. By providing former CCAS-involved youth with the option of establishing a voluntary care agreement with the Society, these youth have an opportunity to be quickly transitioned out of emergency shelter services and receive additional housing supports. Even still, Suzanne – a SYPC director – notes that they are seeing more "15 year olds in the shelter and because they're going to be 16 in two months, Child Welfare won't touch them." She adds "[this] is a challenge for us because unless they're involved with Child Welfare, they can't come in [to the shelter] under 16."

The continuous flow of youth into Hamilton's street-involved-youth services from other systems means that no matter how effectively the SYPC organize their service delivery system to identify and respond to the needs of street-involved youth, member organizations will continue to confront youth homelessness and street involvement in their community. Further insight into the effects of these persistent organizational disjunctures in the lives and experiences of street-involved youth are explored in the next and final subsection.

Understanding Cross-sectoral Disjunctures: Youth Perspectives

Of the seven youth that I spoke with, five had used one or more of the SYPC's housing supports. The other two were regular participants (and advisory members) for a street-level youth arts program that operates with sponsorship from Hamilton's Social Planning and Research Council. All five of the housing service users accessed the continuum of housing services through the Notre Dame Youth Shelter. For three of these five youth, access to the Notre Dame shelter was preceded by involvement with residential child protection (Nola), inpatient mental health (Arianne) and a group home (Evan). An additional youth (Camisha) came to the Notre Dame shelter after a conflict with her biological grandparents and another (Sammy) did not describe the circumstances of her initial involvement. Six out of the seven youth I spoke with described struggles with significant mental health concerns – suicidal ideation and self harm, depression, anxiety and oppositional defiance disorder. Their stories illuminate the SYPC's continuum of services in operation and reveal the wider systemic influences shaping the community's efforts to prevent or respond to youth homelessness.

Eight days before his 16th birthday, Evan's parents placed him in a group home for youth who 'weren't suitable for living at home.' While Evan's first point of contact with the SYPC's continuum of services was the main triage and central access point – the Notre Dame Youth Shelter – this was not his first encounter with housing services for youth, more generally. Prior to connecting to "the Dame," he had had accessed street youth services in the same municipality where his group home was located.

"I didn't even last like four days at the shelter there, because there was no way for me to get to school... I was getting cabbed every single day [from the group home in Oakville] all the way to school in Burlington."

One of the consequences for failing to abide by the rules in his group home was to kick a youth out to a local homeless shelter. Evan describes the group home as "very, very structured," and explains that it didn't take long for him to be sent to a youth shelter as a consequencefor failing to follow the rules: "I didn't even last for two months there… in that period of my life I was really hostile and resistant. Like I'm diagnosed with ODD [Oppositional Defiance Disorder]. And so I'm just really resistant to authoritative figures like my parents, teachers, stuff like that."

In Evan's case, being sent to a youth shelter did not result in the behavioural compliance that the group home staff anticipated. As Evan explains, "[When] I got kicked out [of the group home] for the first time. I hadn't been able to have any experience like a normal 16-year-old kid in high school, so I kind of went crazy. I was out partying and I was just doing all that stuff for about three weeks." Instead of following the rules at the shelter so as to earn readmittance to the group home, Evan spent three weeks staying with friends and partying. After living out his welcome at his friend's house, Evan eventually returned to the youth shelter in Oakville where he had originally been placed by group home staff. But, he explains, it was impossible for him to get to school in Burlington while he was staying at the youth shelter in Oakville: "I didn't even last like four days at the shelter there, because there was no way for me to get to school... I was getting cabbed every single day

[from the group home in Oakville] all the way to school in Burlington."Evan eventually returned to the group home after his father: "called me and he told me that if I wanted to go to my little brother's confirmation – my little brother is the most important person in the world to me – I would have to go back to the group home." Upon his return to the group home, Evan quickly learned that his parents and the group home staff would not be upholding their end of this arrangement:

> *And so Friday night – [my brother's] confirmation was on Saturday – I'm inside my room, I'm trying on my suit and stuff like that, like getting ready for tomorrow, and one of the workers comes in and she goes, 'I have bad news. You're grounded because you've been AWOL [absent without leave] for three weeks, so I'm going to have to take away your iPod.' So I gave her my iPod and she's like, 'And also you're not going to be able to go to your little brother's confirmation.' And then I just stopped caring about trying to make that program work.*

At this point, Evan entered into a significant period of housing instability that increased his involvement in street life and undermined his ability to remain connected to school:

> *Within two weeks of finding that out, I got kicked out again [at the end of February]. And so I started couch surfing… I was sleeping on the street and stuff like that… After a while couch surfing, it just gets to point where like you're going to have to leave, right? So from there I went and lived at the Dame [youth shelter in Hamilton]… [I] kept on getting renewals and stuff like that… [Eventually] my ex-girlfriend's stepmom… took me to the Living Rock where I filled out an application for Wesley at the beginning – or mid-April. It took 'til August until there was a spot available.*

Aspects of Evan's story are worth highlighting. The first is that the group home used the local sheltering system as a consequence or punishment for youth who fail to abide by the rules. The second is that the shelter that Evan was 'kicked out to' was located in a different municipality than his school, which meant that he was unable to get to school using public transit. By using a youth shelter as a punishment, the group home increased Evan's contact with street culture and decreased his involvement with school.

The other part of this story that is worth noting is that Evan's first encounter with street-youth services in Hamilton did not – at that time – lead to increased housing stability for him. After accessing shelter services on his own through the Notre Dame Youth Shelter in Hamilton, Evan was unable to secure housing within the period of eligibility (42 days) for emergency shelter use that is funded by Ontario Works (OW) social assistance. As such, he was required to apply for numerous renewals. Other youth – for example those who fail to abide by the rules of the shelter – will be less likely to have their eligibility renewed.

It is important to note that Evan did not access the Wesley Youth Housing Application process until a friend's mother intervened. In other words, the Notre Dame shelter did not, in fact, serve as a point of access for Evan to negotiate a transition to supportive housing. From the time he submitted his application to Wesley Youth Housing, Evan waited almost four months before a spot there became available for him. Four months is considerably longer than the standard length of time an individual is permitted to use emergency shelter services like those offered by the Notre Dame. As Evan's story makes clear, even with efforts to ensure that Hamilton offers a continuum of housing services to street-involved youth, there is insufficient capacity within the system to effectively respond to the housing needs of *all* youth. Significantly, from the perspectives of the service users that I interviewed, youth with the most complex needs have the greatest difficulty getting their needs met through existing channels for service access and use.

The youth I interviewed observed that the roughest and most street-involved youth are less likely to be placed into one of the community's supportive housing environments than more compliant and less street-entrenched youth. While the youth raise important concerns about fairness and access, SYPC members remain committed to prevention and early intervention, which means prioritizing the housing needs of those youth who are new to the system. Additionally, service providers and managers recognize that 'fit' is important for each distinctive housing environment. Jean, a housing services manager, describes the delicate balancing act required to assess the complex needs of applicants to ensure that all the youth in a particular housing environment function well together.

The youth I interviewed observed that the roughest and most street-involved youth are less likely to be placed into one of the community's supportive housing environments than more compliant and less street-entrenched youth.

Without the conceptual commitment to diversion or a full picture of the particular needs and strengths of all the youth in residence in a particular place, youth interpret the housing access process as one that excludes some of the more street-involved young people in Hamilton: "[Service providers] send the people that have potential to Brennan House and make other people wait and use and abuse [drugs and alcohol] at Notre Dame" (Nola, youth leaders committee).

From a continuum of care perspective, Brennan House offers the most hands-on support to youth. Medication usage is monitored, the space is designed to feel like a home and staff directly support residents' successful navigation of other institutional processes (e.g. school enrolment). Camisha – a youth who entered the continuum of housing services through the Notre Dame shelter and was quickly transitioned into Brennan House – explains that the staff at Notre Dame recognised "I wouldn't have made it on my own. I was like a baby… I was only [at the Dame] for two days because they could tell I was not going to be there long… I didn't know what to do" (Camisha). The youth I spoke with interpret this type of response as privileging the housing needs of those youth who are more compliant and less street-entrenched; on the other hand, staff see it is a move to prevent street entrenchment among youth without histories of involvement in street-youth culture. The observation that highly street-involved youth are difficult to place within Hamilton's continuum of housing services (beyond their use of emergency housing supports at the Notre Dame shelter) suggests that the SYPC does not presently have the capacity to support the housing needs of the most street-entrenched youth in their community.

A federal mandate to implement a Housing First approach – and as such prioritize housing those individuals with the most complex needs – may lead to an additional set of housing supports for these youth. In any case, it would be important to explore the specific barriers faced by the hardest to house youth in this community prior to the development of further housing resources targeting their particular needs. More than likely, housing these youth will require innovative partnerships with other sectors, given the particular challenges (e.g. dual diagnosis or Fetal Alcohol Spectrum Disorder) these youth face.

DISCUSSION AND CONCLUSION

Despite the ongoing work that the SYPC will be required to do in order to contribute to the resolution of youth homelessness, there is much to learn from this case. The SYPC suggests a model for how to improve the capacity for cross-sectoral communication, collaboration and coordination:

1. Build relationships across organizations and sectors and design systems for ongoing communication, collaboration and coordination that support and are supported by these relationships (e.g. shared staffing models);
2. Engage all levels of staff in training and professional development as well as ongoing on-site coaching and mentorship; and
3. Support the relational work with clear operational, administrative and accounting policies and procedures that operate across and link organizational contexts.

In order to better meet the needs of street-involved youth in Hamilton, street-youth-serving organizations have had to engage other sectoral players in collaborative or partnership processes. This work – to improve communication, collaboration and coordination across sectors – is ongoing. Ultimately, if the community intends to decrease the number of young people moving into and out of the youth homelessness system from other institutional settings, they will need to engage decision makers at the provincial and federal levels to ensure sufficient coordination of funding and governance to support this aim. They may look to inter-ministerial or inter-agency councils (e.g. those in Alberta) that operate at the state or provincial levels as models for this work.

In order to better meet the needs of street-involved youth in Hamilton, street-youth-serving organizations have had to engage other sectoral players in collaborative or partnership processes.

The SYPC is committed to improving housing stability and reducing street involvement among youth. The continuum of services they have developed is organized to ensure:

1. First-time system shelter users are transitioned out of the emergency shelter within 48 hours of accessing the system;
2. The system offers a single point of access for all necessary services; and
3. Youth experience effective transitions as they move between sectors.

This case offers concrete examples of a community's use of research, planning, capacity building and structural supports (e.g. shared policies and procedures) to improve relations between service delivery organizations that engage with street-involved youth. The case also reveals the limits of a single-sector, community-driven approach to service coordination.

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2.7

VIGNETTE: A TRANSDISCIPLINARY COMMUNITY MENTAL HEALTH PROGRAM PROVIDING CLINICAL CARE TO STREET-INVOLVED YOUTH IN HAMILTON

Chloe FRISINA & Christine EVANS

INTRODUCTION

The Good Shepherd Youth Services Community Mental Health Program operates within a framework that prioritizes partnerships while aiming to provide quality care through a transdisciplinary model. The model focuses on triage, assessment and treatment; providing clinical interventions to disenfranchised youth in Hamilton, Ontario. The program has the following key components, which we will describe in this paper: service delivery approach (i.e. referral process), tailored care pathways, inter-professional collaboration (i.e. with consulting psychiatrists), mental health education, ongoing evaluation and knowledge sharing (i.e. information exchanged with community partners), committed clinicians and contribution from the clients. The following case study identifies and describes an approach to clinical care that can be adapted elsewhere.

HISTORY

In 2004, the Street Involved Youth Managers (currently the Street Youth Planning Collaborative, a committee of street-involved-youth-serving agencies in Hamilton) approached the Social Research and Planning Council of Hamilton to develop a community plan funded by the National Crime Prevention Strategy. The development of a community plan was needed to address the growing population of street-involved youth in Hamilton (Vengris, 2005). The project aimed at developing a profile of street-involved youth, establishing 'best practices' (the maintenance of quality methods that have consistently been demonstrated as superior) and to identify existing gaps in service. One of the recommendations from this needs assessment was for the Children's Service System Table of Hamilton (a committee of Ministry of Children and Youth Services-funded agencies) to increase mental health services available to street-involved youth.

In 2007, the Community Mental Health Program began. Initially a liaison nurse, whose primary role was to advocate for youth and form alliances with health care

providers and frontline social services staff, staffed the program. In 2012, the program expanded to its current form and in 2014 provided services to 140 unique individuals. The Community Mental Health Program provides clinical services to Notre Dame House, an emergency shelter for homeless youth; Brennan House, a residential treatment program for youth over 16; Angela's Place, a young parent centre; and Notre Dame Community Resource Centre, a multi service resource centre for street-involved youth.

The Good Shepherd Youth Services Community Mental Health Program operates within a framework that prioritizes partnerships while aiming to provide quality care through a transdisciplinary model.

MODEL OF CARE

The following seven elements comprise the Community Mental Health Program's model of care.

Service Delivery Approach

From 2012–2014 the Community Mental Health Program received two evaluation grants from the Ontario Centre of Excellence for Child and Youth Mental Health[1]. The purpose of the evaluation was to examine the program's efficacy. This process, which included a logic model and evaluation framework (Appendix A and B) allowed the clinicians to identify and evaluate the different components used within the program. The overall impression of the program aligns with current standards for best practices that emphasize youth-friendly services. Our experience through evaluation has truly allowed the Community Mental Health Program to cultivate an enthusiasm for learning and set a standard for capacity development.

The service delivery approach has a continuum that encompasses the different stages of intervention. They include referral, triage, assessment and treatment. The referral is an internally developed document (Appendix C) designed to capture identifying information and concerns regarding the youth's thoughts, feelings and behaviors. This one-page form is completed with the youth and asks the staff member to rate their concerns (based on the Ministry of Children and Youth Services Rating Scale[2]). The referral form can be completed over several conversations and considers the youth the expert on their own experiences. The referral form informs the program that the youth is interested and in need of services. At the time of referral, the staff member also completes a Child and Adolescent Needs and Strengths Assessment (Praed, 2014) to accompany the referral form. The Child and Adolescent Needs and Strengths Assessment is used to facilitate the design of individual treatment plans.

The triage interview (Appendix D), which is usually the first appointment with a clinician, elaborates on the information collected on the referral form. The clinician has a discussion with the youth, obtains disclosures for collateral information and determines if a mental health assessment is needed. The assessment interview (Appendix E) encourages the youth to expand

1. Evaluation Grant Final Reports can be viewed on the Centre's website, Grants and Awards Index: http://www.excellenceforchildandyouth.ca/resource-hub/grants-and-awards-index

2. Rating Scale:

   Level 1 – All youth and their families.

   Level 2 – Identified as being at risk of experiencing mental health problems.

   Level 3 – Experiencing significant mental health problems or illness (i.e. dual diagnosis, concurrent disorder, taking psychotropic medications) that affects their functioning in some areas.

   Level 4 – Experiencing the most severe, complex, rare or persistent diagnosable mental illness (i.e. hospitalized and/or admitted to an inpatient unit on numerous occasions for a serious mental illness) that significantly impairs functioning.

on mental health history and is a clinician-led process of gathering diagnostic impressions (i.e. evaluative interpretations that shape a diagnosis). The assessment interview includes the completion of a Mental Status Examination (a clinical evaluation tool, completed by a clinician). The assessment may also include standardized assessments completed individually by the youth online: the Children's Depression Inventory 2nd Edition (Kovacs, 2011), the Multidimensional Anxiety Scale for Children 2nd Edition (March, 2013) and the Connors 3rd Edition (Connors, 2013). These standardized assessments identify emotional and behavioral concerns and assist in tracking any changes in these areas throughout treatment.

The Community Mental Health Program offers an individualized approach to treatment, often in consultation with the onsite nurse practitioner, family physician and adolescent psychiatrist. These health care professionals work as a clinical team with the youth to decide the type of therapeutic interventions (including psychotropic medications) that will be used.

Tailored Care Pathways

After the triage appointment youth are assigned to a care pathway that will determine their participation in the program:

Care Pathway One is for youth whose needs are rated a two (a Ministry of Children and Youth Services assigned number categorizing needs for service, refer to endnote two). The clinician meets with the referring staff member and recommends individual Skills for Life education (see Mental Health Education) between a frontline staff member and the youth.

Care Pathway Two is also for the youth whose needs are rated a two. The clinician recommends targeted prevention (skills-based group programming) that takes place at various locations within a 12-week rotation. Group programming is based on the Skills for Life curriculum (for example, the How-To of Sleep – a group designed to assist youth in improving their sleep hygiene). Youth can join the group any time throughout the program.

Care Pathway Three is for the youth whose needs are rated three or four. The clinician conducts an assessment (see Service Delivery Approach) and provides individual treatment that is informed by the youth's point of access (e.g. residential treatment, shelter or transitional housing). Within this care pathway consultation with other health care professionals is common.

What is notable about the care pathways is that there continues to be an appreciation for the youth's precarious lifestyle and transience.

What is notable about the care pathways is that there continues to be an appreciation for the youth's precarious lifestyle and transience. This consideration requires flexibility in treatment times and transitions. For example, if a youth fails to arrive for individual treatment and the file is closed it may be reopened at the request of the youth versus needing to return to the beginning, i.e. referral process, triage interview, etc. Primary means of communication with the youth are in person, via email, by text message and Facebook.

Inter-professional Collaboration

Collaboration is embedded in the culture of the Community Mental Health Program and is crucial in our aim to provide quality care. Interagency consultation is an essential aspect and likely the greatest resource available to the program. In addition to the two-person Good Shepherd Youth Services Clinician Team, a Good Shepherd nurse practitioner and a Hamilton Shelter Health Network family physician are available two days a week for primary care, collaboration and consultation. Three adolescent psychiatrists from children's mental health organizations consult to the program providing five sessions a month. These relationships with other health care providers allow for rich treatment planning, effective transitions and high quality service provision.

Collaboration is embedded in the culture of the Community Mental Health Program and is crucial in our aim to provide quality care. Interagency consultation is an essential aspect and likely the greatest resource available to the program.

Informal collaboration also occurs with frontline staff members within the Street Youth Planning Collaborative, community allies (e.g. addiction counselors), hospital staff from emergency departments and psychiatric units, and school-based social workers. The Board of Directors of Good Shepherd is also a strong supporter of the program's model of care.

Mental Health Education

The Mental Health Team facilitates a comprehensive education program called Skills for Life© which is comprised of 18 skills emphasizing functioning (e.g. sleeping and eating patterns), emotion regulation and shaping behavior (identifying and practicing preferred behaviors). Skills for Life comes from understanding the importance of global functioning (the adequacy of a youth's sleep and eating patterns, their physical health and participation in the activities of daily living, limited criminal involvement, substance use and high-risk behaviors), practice-based evidence (professional knowledge) and principles of Dialectical Behavior Therapy (a form of talk therapy used to help change behaviors) (Linehan, 2014). McCay and Andria (2013) conducted a study using Dialectical Behavior Therapy with street-involved youth and their findings suggest that these interventions increase the youth's capacity to endure challenging situations, manage emotional instability and improve quality of life. More than half of the youth who receive treatment (up to six months) in the program show an improvement in their global functioning. The program's priority of improving youth's global functioning has proven to be consistent for two years. The Skills for Life program is a curriculum designed to be administered by frontline staff members and is the foundation for the program's targeted prevention. Four times a year the clinicians provide training in the Skills for Life program through a one-day workshop available to frontline staff.

Ongoing Evaluation and Knowledge Sharing

Evaluation of the Good Shepherd Youth Services Community Mental Health Program consists of the collection and aggregation of information to support the development of program outcomes. Information is gathered monthly and quarterly using multiple internally developed Microsoft Excel spreadsheets including: self-reported demographic characteristics of the youth (e.g. age, ethnicity, community of origin), primary issues of concern, crisis services provided by the clinicians (e.g. management of self harming behaviors or suicidal gestures), type of participation in the program, other health care accessed and family involvement. Annual outcomes are reported to the Ministry of Children and Youth Services, our funding agent. The program also has internal program outcomes that promote growth (e.g. increase the number of staff trained in Skills for Life) and to evaluate effectiveness (e.g. the measurement of emotional symptoms before and after participation in the program). As of 2014, 93 Youth Services staff members were trained in the Skills for Life curriculum. For youth who receive treatment (up to six months) in the program for singular or concurrent emotional symptoms, 63% experience a decrease in depressive symptoms and 57% experience a decrease in anxiety symptoms.

Knowledge exchange refers to the dialogue between those who create and use information as it relates to professional development (Ministry of Children and Youth Services, 2006). This exchange serves to facilitate the use of evidence in practice. The program takes pride in being community based and aims to create and participate in mental health promotion with the intention of enhancing awareness, improving practices and strengthening relationships. For example, the clinicians presented the results from the program evaluation at the 2014 Children's Mental Health Ontario Conference.

Committed Clinicians

One full-time and one part-time Master's prepared clinicians staff the Community Mental Health Program. Staff are trained as counselors, psychotherapists and social workers. Despite the differences in their academic and professional experiences, one similarity is the committed approach each takes in their provision of care. The shared vision amongst the program's clinicians is to provide the best care to the youth accessing services and challenge each other to ensure this mission is followed. This level of commitment is such an important part of the model because so many of the youth accessing care regard Youth Services as home.

Contribution from the Clients

What is known from the youth accessing services is that their experience of the program determines their participation. Bhui, Shanahan & Harding (2006) found that homeless young people's views of mental illness is more negative with "homeless participants perceiving mental health services as being for 'crazy people' often leading to a denial of their own mental health problems" (152). With this knowledge it became important for the program to consider how it was being experienced and actively integrate this matter into its administration.

Throughout the 2012–2014 program evaluations conducted in partnership with the Ontario Centre of Excellence for Child and Youth Mental Health, the experiences of those who participated in the Community Mental Health Program were explored. Through satisfaction questionnaires, 80% of youth respondents reported overall satisfaction with mental health services offered by the Good Shepherd Youth Services Community Mental Health Program. The experiences of the Community Mental Health Program address the importance of scheduling flexibility, sensitivity to culture, and choice in service agreements, inclusion in treatment planning and services delivered respectfully. Youth have the option to complete satisfaction surveys as they exit the program; this information is aggregated quarterly and informs annual outcomes and the evolution of care pathways.

CONCLUSION

This case study examined Good Shepherd Youth Services Community Mental Health Program's model of care, a dynamic and transdisciplinary approach to care that relies on essential elements and whose main outcome is the engagement and treatment of a historically hard to reach population (Bhui et al., 2006; Karabanow, 2004; Leeuwen, 2004), disenfranchised youth. This model of care reflects partnership, client centered practices and a shared vision. Under a collaborative lens the program is able to effectively utilize resources, consider service responsiveness and demonstrate a commitment to the support of quality care.

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APPENDIX A: LOGIC MODEL

NEED IN THE COMMUNITY: There are a growing number of street-involved youth struggling with mental illness and mental health problems in the Hamilton community

PROGRAM GOAL(S): To increase the global functioning of street-involved youth ages 16–21 with mental illness and mental health problems

RATIONALE(S): The research shows that the use of evidence-informed practice leads to improved global functioning of youth with mental illness and mental health problems

PROGRAM COMPONENTS	Referral & Triage	Assessment	Treatment
ACTIVITIES	• Referral form completed by frontline workers • Collect relevant documentation (consent for prior assessments, staff observations) • Prioritize needs based on functioning, risk behaviors and family functioning using the Child and Adolescent Needs and Strengths Service Sector Assessment • Triage interview • Exchange of information from mental health clinicians to frontline workers about management of youth's specific mental health problems	• Conduct assessment interview • Complete Personal Health Information Protection Act consent form (if applicable) • Complete clinical impression • Complete referral to family physician (if referral to psychiatry needed) • Youth referred to psychiatry attend psychiatric assessment interview	• Individual Therapy (Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Motivational Interviewing, Short-Term Crisis Support, Advocacy, Liaison) • Group Programming • Appointment to consulting Adolescent Psychiatrist • Refer to Barrett Crisis Centre • Conduct staff coaching • Refer to emergency room at hospital for assessment • Skills from Skills for Life curriculum
SHORT-TERM OUTCOMES	↑ in basic functioning (eating, sleeping, physical health, school or work attendance) ↑ awareness of mental illness/ mental health problems	↑ knowledge of needs and strengths related to mental health problems ↑ knowledge of mental health treatment options ↓ in drug and alcohol use	↓ in high risk behaviors (dangerousness, runaway, crime/ delinquency, sexual aggression) ↑ global functioning ↑ ability to regulate emotions ↑ ability to organize time and possessions ↑ ability to regulate behavior ↑ ability to utilize Skills For Life with limited supports
MEDIUM-TERM OUTCOMES			↑ ability to regulate behavior with limited supports ↑ ability to regulate emotions with limited supports ↑ ability to organize time and possessions with limited supports
LONG-TERM OUTCOMES	↑ ability to regulate emotions independently ↑ ability to organize time and possessions independently	↓ anxiety symptoms ↓ depression symptoms	↑ ability to regulate behavior independently ↑ ability to utilize Skills for Life independently
Assumptions:	Youth are committed to participate within mental health program activities Frontline workers are committed to the mental health program		

APPENDIX B: PROCESS EVALUATION FRAMEWORK

EVALUATION QUESTIONS (What do we want to know about this program?)	**LINK TO ACTIVITIES OR TARGET POPULATION IN LOGIC MODEL**	**INDICATOR(S)** (How will we know we have achieved our goal?)	**DATA COLLECTION METHOD(S)** (What data collection method will be used to measure the indicator? e.g. survey, focus group, interview, document review, etc.)	**DATA COLLECTION TOOL(S)** (What specific tool will be used? Specify the name and whether it is a standardized tool or internally developed)	**RESPONDENT(S)** (Who will provide the information needed? For example, parent, child, clinician, teacher, program staff, etc.)	**PERSON(S) RESPONSIBLE FOR DATA COLLECTION** (Who is responsible for ensuring the data are collected?)	**TIMING OF DATA COLLECTION** (When will the data be collected?)
What are the primary issues of concern that are referred to the community mental health program?	Referral & triage	Referral form Previous assessments from other mental health agencies	Document review To be categorized within categories: emotional symptoms, behavioral symptoms, psychosis, risk behaviors	Mental Health Referral Binder (internally developed) Client files	Clinician Program staff	Mental Health Worker	February 2014 Pre data
What are the demographic characteristics of the youth served?	Triage interview	Age, gender, community of origin	Document review	Triage interview form (internally developed)	Clinician Program staff	Mental Health Worker	February 2014 Pre data
What are the youth's and staff's experiences of the community mental health program?	Program delivery Skills for Life	Rating of satisfaction	Questionnaire	Staff Satisfaction questionnaire Youth Satisfaction questionnaire *Adapted from the Youth Satisfaction Survey (YSS)	Program Staff Youth	Case Manager	July 2014 Post data

Outcome Evaluation Framework

EVALUATION QUESTIONS (What do we want to know about this program?)	**LINK TO OUTCOMES IN LOGIC MODEL** (What outcome from the logic model does the evaluation question relate to? e.g. increased self-esteem)	**INDICATOR(S)** (What is one possible measurable approximation of the outcome?) e.g., Increased score on the Rosenberg Self-Esteem Scale	**DATA COLLECTION METHOD(S)** (What data collection method will be used to measure the indicator? e.g. survey, focus group, interview, document review, etc.)	**DATA COLLECTION TOOL(S)** (What specific tool will be used? Specify the name and whether it is a standardized tool or internally developed)	**RESPONDENT(S)** (Who will provide the information needed? For example, parent, child, clinician, teacher, program staff, etc.)	**PERSON(S) RESPONSIBLE FOR DATA COLLECTION** (Who is responsible for ensuring the data are collected?)	**TIMING OF DATA COLLECTION** (When will the data be collected?)
Does the global functioning improve for the youth who participate in the mental health program?	↑ global functioning	↑ sleep ↑ eating ↑ physical health ↑ activities of daily living limited criminal involvement	Questionnaire	CANS-SC	Youth	Case Manager	February/July 2014 Pre/post data
Does youth participation in the Community Mental Health Program decrease emotional symptoms?	↓ anxiety symptoms ↓ depression symptoms	↑ ability to regulate emotions	Assessments	CDI 2 MASC 2	Youth	Mental Health Worker	February/July 2014 Pre/post data
Does youth participation in the Community Mental Health Program decrease behavioral symptoms?	↑ attention ↓ hyperactivity ↓ opposition ↑ ability to organize time and possessions ↓ difficulties with conduct	↑ ability to regulate their behavior	Assessment	CONNORS 3	Youth	Mental Health Worker	February/July 2014 Pre/post data

APPENDIX C:
COMMUNITY MENTAL HEALTH PROGRAM REFERRAL FORM

An internally developed document used across the various programs served by the Community Mental Health Program. The Referral Form is designed to capture identifying information and concerns regarding the youth's thoughts, feelings and behaviors.

Download this document at: www.homelesshub.ca/systemresponses

APPENDIX D:
COMMUNITY MENTAL HEALTH PROGRAM TRIAGE FORM

An internally developed document used at the triage interview, typically the first scheduled appointment with a youth. The Triage Form is designed to elaborate on the information collected at referral, prioritize the youth's needs, and specify the type of participation in the program.

Download this document at: www.homelesshub.ca/systemresponses

APPENDIX E:
COMMUNITY MENTAL HEALTH PROGRAM MENTAL HEALTH ASSESSMENT

An internally developed document used during the clinician led assessment period. The Assessment Form is designed to gather diagnostic impressions and begin to determine treatment approaches.

Download this document at: www.homelesshub.ca/systemresponses

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2.8

VIGNETTE:
YOUTH RECONNECT: SYSTEMS PREVENTION IN A CRISIS MODEL

Michael LETHBY & Tyler PETTES

INTRODUCTION: YOUTH HOMELESSNESS IN CANADA

Over the past two decades, homelessness has become a serious concern in many urban centres across Canada. Throughout the 1990s, homelessness became a social crisis resulting from fewer affordable housing initiatives, problematic social assistance programs and shifting employment opportunities (Canadian Institute for Health Information, 2007). It has been estimated that between 186,000 and 220,000 individuals experience homelessness every year in Canada (State of Homelessness, 2013). Moreover, the same report suggests that homelessness costs our economy up to $7 billion every year. These problems are compounded by the fact that there has been a steady reduction in federal funding targeting affordable housing initiatives and other services responding to homeless populations. In particular, funding for affordable housing has dropped from $2.7 billion (2013 dollars) two decades ago to $2.2 billion in 2013 (State of Homelessness, 2014).

More recently, youth homelessness has become a nationwide concern. Segaert (2012) suggests that youth comprise 30% of the homeless population accessing the shelter system. This accounts for approximately 35,000 individuals annually, or up to 6,000 homeless youth on any given night (Segaert, 2012). Unfortunately, these statistics do not describe the entire population of homeless youth because youth often enter homelessness via a different pathway than adults and because homeless youth are using different survival strategies than adults who are living on the street. For example, youths are often less visible due to the transient nature of their homelessness and because they are likely to 'couch surf' with friends or acquaintances rather than access shelters.

Originally, organizations attempted to respond to youth homelessness using the same strategies that were being used to address adult homelessness; however, these initiatives often proved to be ineffective (Gaetz, 2014). Youth are still developing physically, emotionally and psychologically. Many have little to no work experience or have dropped out of educational institutions. In many situations, youth homelessness arises from family conflict that forces them to leave

their homes (Youth Homelessness, 2013). Lastly, there are separate systems in Canada that facilitate youth care in terms of welfare support, legal needs, social and emotional growth, healthcare and education (Kamloops, 2014). It would be difficult to adequately and effectively provide support for youth experiencing homelessness using traditional adult homelessness services. As a result, a reconceptualization of Canada's response to youth homelessness – from a systems or cross-sectoral perspective – is an integral step in preventing and reducing youth homelessness in Canada. However, to date, there has been limited systems integration and coordination between social services, which has allowed youth in some communities to 'fall through the cracks' into homelessness. This case study will describe an innovative program in Niagara, Ontario, that focuses on integrating wraparound services and the education system to prevent youth homelessness.

YOUTH RECONNECT AND SYSTEMS INTEGRATION

Youth Reconnect was launched as a pilot project in 2008 in Niagara, Ontario by the Niagara Resource Service for Youth called the RAFT[1]. The project was developed to address youth homelessness in a rural community. The project systemically brought together numerous stakeholders from across the region. These stakeholders included front line support workers, housing workers, Youth Reconnect workers, teachers, principals, school counsellors and RAFT support personnel.

Until quite recently, homelessness was considered to be an urban issue and the prevention of rural youth homelessness was largely overlooked within the social service sector. Community-led responses – where they existed – were narrowly focused on providing traditional homelessness sector services (e.g. emergency food and shelter), rather than drawing on supports from multiple social systems. Recognizing these limitations, a stakeholder committee in the Niagara region began developing a system-wide response aimed at preventing youth homelessness, rather than the provision of emergency service for youth experiencing absolute homelessness. The stakeholder committee recognized that it would be most effective if a preventative response was integrated within existing systems that engage youth *before* they became homeless (e.g. education, healthcare, social services). Considering youth cannot become crown wards after they have turned 16, we had to consider alternative strategies that did not involve the province's child protection services or Children's Aid Societies (CAS). Our anecdotal evidence also suggested youth were hesitant to become involved with CAS due to the negative stigma associated with the services. As a result, Youth Reconnect partnered with several schools and school boards in Niagara to address youth homelessness.

The choice to partner with the school boards was supported by research conducted at the RAFT, which noted that the average age of youth homelessness in the region was 15–16 based on the clientele that the organization was serving. Empirical data collected by the RAFT concluded that the vast majority of youth accessing the shelter system were attending high school immediately prior to their homelessness. In many cases youth stop going to school in order access emergency

1. Niagara Resource Service for Youth is the incorporated name of the organization popularly known as the RAFT. This change occurred when teen participants chose to rechristen the organization in 1994. At that time the youths decided Resource Association For Teens (RAFT) represented them better and the name has been in general use since then.

shelters in other cities. An internal review conducted at the RAFT prior to the development of the Youth Reconnect program suggested that 51% of youth accessing the shelter in St. Catharines had to leave the region where they were originally from, which likely resulted in a disrupted school year, or were unable to attend classes and had to drop out of high school.

To ensure that precarious housing does not lead to social exclusion and educational disengagement, the Stakeholder Planning Committee developed the Youth Reconnect Initiative. Youth Reconnect is a community-based prevention program that reconnects high-risk youth to their home communities. Referrals come from high schools, community partners, social service agencies and police services. The top three crises identifiers school officials referred to in order to identify at-risk youth were changes in 1) school attendance, 2) behaviour, and/or 3) grades (Geelong, 2014). Program participants are adolescents, between the ages of 16–19. Participants are precariously housed and in imminent danger of becoming homeless. The initiative helps clients access resources and increase their self-sufficiency by assisting them to maintain school attendance, secure housing and develop a social safety net in their home community.

Once a youth has connected with Youth Reconnect, a Youth Reconnect worker becomes their primary wraparound[2] worker and helps to connect them with various services. Wraparound supports ensure youth are able to maintain housing, stay in school and stay in their home region where they may have friends and family. Youth Reconnect provides advocacy, life skills training, one-on-one mentoring, emergency hostel access, family reunification and community integration supports. Provided in partnership with other social service agencies and schools, this initiative focuses on helping clients to live independently and reduce high-risk behaviours while maintaining school attendance.

SCOPE AND FOCUS OF CHAPTER

This chapter draws on administrative data collected by the RAFT from March 2013 – April 2014. Individuals are eligible to receive services through RAFT between 16–19 years of age. In order to track the efficacy of the program, participants are administered a questionnaire at intake and then at the three month, nine month and one year marks (see Appendix). A final questionnaire is administered when the youth is discharged into stable housing in the community. The questionnaire is used to gather a range of information, including demographic data, housing status, income and access to education.

In this chapter, we explore descriptive statistics summarizing the reasons for homelessness from 239 youth who had accessed the Youth Reconnect Program. A cost-savings analysis was also performed to determine the economic impact of housing youth and retaining youth in educational institutions over the past six years. All statistical analyses were analyzed in 2014 and performed using the Statistical Analysis System (SAS) software version 9.3 (SAS Institute Inc., Cary, NC). In what follows, we summarize our key findings using the RAFT's administrative data.

2. Wraparound services provide comprehensive supports to help address a client's underlying causes of homelessness. These supports may include psychiatric care, medical support, housing, employment, life skills training and/or counseling services (Alberta Human Services, 2012).

KEY FINDINGS

Securing Housing for Youth

Youth who were accessing the Youth Reconnect program cited many reasons for becoming homeless however the majority (67%) had experienced some form of parental tension which may have included parental conflict, being kicked out and/or being pregnant. Of the remaining homeless youth, 11% experienced a change in their housing conditions (relationship breakdown or needing new housing because of issues with landlords or payment issues), six percent had been living in unsafe living conditions (not a safe home, alcohol/drug abuse by the parent or youth or experiencing physical, emotional or sexual abuse), six percent had been diagnosed with mental health disorders, and a small proportion (two percent) had been discharged from social services such as incarceration facilities or foster care.

The Youth Reconnect program focuses on securing housing for youth or maintaining housing in the same region where youth had originally accessed services. This strategy allows youth to stay in contact with their pre-existing social support networks and remain in a setting where they are comfortable. This also lessens the burden on social services because youth are more likely to also receive support from family, friends and peers rather than relying solely on institutional resources. Overall, of the youth accessing the Youth Reconnect program, 86% were able to secure accommodations in the same region where they had originally accessed services and 88% had found stabilized housing or had prevented housing breakdown with their family.

Access to Education

Given that the majority of youth where attending high school immediately prior to their first homeless episode, school officials (e.g. teachers, principals, school nurses, etc.) are often aware of a youth's precarious housing. These officials can provide an early referral to prevention services. Forty percent of youth were referred to the Youth Reconnect program by a school official.

Access to education is a basic human right but also an important developmental resource for youth. Unfortunately, youth who drop out are three times more likely to come from low-income families; further, dropping out has been linked with two times greater unemployment and lower salaries (Pathways to Education, 2012). Moreover, 63–90% of homeless youth have reportedly not graduated from secondary school in Canada despite being the appropriate age to have earned their diploma (State of Homelessness, 2014). In response to these stark statistics, the Youth Reconnect program has ensured 70% of youth were attending an educational institution at the time of discharge.

Economic Benefits

According to Shapcott (2007), it costs approximately $1,932 to house a homeless individual in a shelter bed over the course of one month. All the youth who access the Youth Reconnect program were at risk of accessing an emergency shelter in the near future. Thus, based on the fact that the program secured housing for 361/463 clients, savings of $697,452 were accrued by various government departments over the life of the project.

The annual cost of dropping out of high school is approximately $19,104 every year (Havinsky, 2008). The Youth Reconnect program assisted at least 247 youth to return to an educational setting, which equated to a savings of $4,718,688 over the entirety of the program.

DISCUSSION: MAKING THE SWITCH FROM PRIMARILY EMERGENCY TO PREVENTION FOCUS

In the Niagara region of Ontario, a number of citizens became concerned by the increasing number of youth who were sleeping rough on our streets. This growing awareness of a youth homelessness crisis in the region led to the creation of the RAFT, which offered drop-in programs and ultimately a hostel. Providing a hostel service was a natural progression in service delivery, as it reflected concurrent response methods being used to manage adult homeless populations and was the best strategy to secure the limited funding available at that time. Starting in 2002, the RAFT began offering four emergency hostel beds and by 2007 had expanded to offer 24 emergency hostel beds. By 2008, the RAFT took its first major steps towards a prevention-focused response, with the creation of Youth Reconnect.

This experience isn't exceptional, but few youth homeless agencies have made the transition from managing crises to preventing youth homelessness. A few factors critical to advancing the adoption of a prevention mandate include:

- Shifting expertise from a reactionary response to a preventative one;
- Ending reliance on models to support adults experiencing homelessness;
- Developing compelling evidence for prevention; and
- Repurposing infrastructure to support prevention.

To some degree working in homeless services will require some form of a reactive response. When a homeless youth shows up on your doorstep, questions of prevention are nonsensical. Emergency responses are well developed and can be quite effective during emergencies. The fact that so much has been invested in these emergency systems, however, creates a barrier to preventative thinking. Intellectual space needs to be created in order to allow for true reflection. This is not an easy proposition in the middle of continual crisis. Effort will be required to investigate and develop local expertise in prevention.

Youth homeless crisis thinking has also emulated current emergency adult homelessness strategies. This creates the awkward adoption of core assumptions about adult homelessness., notably that homelessness is urban, male, exacerbated by mental health and/or addiction issues and due to poverty. These core assumptions when applied to the youth population are nearly if not all completely misaligned. Youth homelessness is as likely to begin in rural/suburban areas as urban, genders are equally represented, mental health/addictions issues often involve their parent(s) and all socio-economic backgrounds are represented. Developing a youth-specific understanding of homelessness is an important opportunity for the introduction and implementation of preventative services. Youth resilience and comparably shorter street exposure make prevention programs realistic alternatives with greater opportunities for success.

Difficulty developing compelling evidence for prevention is largely due to a lack of research regarding youth homelessness in general. The majority of available research focuses on the adult homeless population and crisis intervention due to the lack of a locus for homelessness prevention for adults. This situation is beginning to change where older models and best practices are being challenged; however, the

understanding and models have yet to reach a critical mass, which will eventually lead to prevention being the generally accepted model of service delivery. Collecting and documenting data by youth servicing agencies is critical to the development of research focused on understanding youth homelessness. Understanding the divergence points between youth homelessness and adult homelessness will allow for better prevention responses and potentially reduce the number of homeless youth.

Finally, even assuming that prevention does become generally accepted as a service delivery model, the current infrastructure is crisis focused. Further, it is poorly placed to address youth homelessness given its largely urban location. Unless there is a shift to provide substantially more funding, any large-scale shifts with the current funding support would jeopardize the entire youth homeless system and would likely be insufficient to bridge the gap between transitioning a crisis-focus system to a prevention-focused response. Developing a prevention response will require strategic planning and collaboration within the youth sector. Importantly, communicating this strategic shift with partners and funders will aid in the transition as prevention work begins to lower the total number of individuals accessing emergency services. Schools and school boards will play a key role in aiding this transition because they are connected with the majority of youth who may experience housing crisis and the physical schools are present in the majority of communities both urban and rural.

The opportunity for youth servicing agencies is present. Youth serving agencies are maturing and realize that a youth-specific service is fundamental to their work. The success of programs like Youth Reconnect show that investments in strategic planning and change management will be critical to making this transition as smooth as possible as will a willingness to engage with new partners across sectors. This willingness to integrate will require cooperating with existing systems, like education, and repurposing them to address the needs of youth experiencing homelessness.

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3.0

Inter-sectoral Collaborations

Inter-sectoral Collaborations

3.1

PREVENTING YOUTH HOMELESSNESS: THE NEED FOR A COORDINATED CROSS-SECTORAL APPROACH

Naomi NICHOLS

Youth homelessness is the manifestation of multiple and inter-related personal and structural phenomena that combine in unique ways to shape young people's lives. It is beyond the scope of the homelessness sector alone to resolve such a multi-faceted problem. A comprehensive and sustainable response will require expertise and interventions from across a number of sectors, recognizing that what happens in one organizational setting will influence and be influenced by things occurring elsewhere. The current response to youth homelessness in many Ontario cities remains challenged by insufficient inter-sectoral coordination.

One barrier to coordination is a lack of shared inter-professional knowledge—that is a fulsome understanding of the work organization of the various sectors that need to be working cohesively together. I use the term "work organization" to refer to the distinctive institutional processes, policies, knowledge and cultures in a particular organizational context. The implementation of an effective cross-sectoral response requires that people who work in the homelessness sector understand how things work, so to speak, in the various other sectors where young people experiencing homelessness are active as learners, service users, in-patients, citizens, defendants and so on. I have written this chapter so that people who work in the youth homelessness sector can improve their understanding of the organizational contexts shaping how things work in the other sectors where homeless and precariously housed youth may be active as service users. I also want to highlight key organizational disjunctures that arise between sectors and influence the degree to which the homelessness sector alone can resolve the problem of youth homelessness.

The chapter offers an ethnographic account of three key inter-sectoral relations impacting experiences of homelessness and/or housing stability among youth in Ontario, Canada. Rather than focusing on the delivery of services in the youth homelessness sector, I reveal how things work in other sectors that influence interactions between service providers and youth in the homelessness sector. By granting visibility to the inter-organizational contexts that influence the development and well-being of homeless and precariously housed youth, service providers and organizational leaders can focus on coordinating their efforts productively across the various organizational settings where youth are active.

THE LITERATURE

An experience of homelessness can operate like feedback loop, exacerbating the inter-related individual, social and structural factors that underpin homelessness or housing instability in the first place (Kilmer, Cook, Crusto, Strater, & Haber, 2012). As such, Kilmer et al. (2012), suggest that a highly contextualized bio-ecological model might be most appropriate for understanding and intervening in the lives of children and youth experiencing homelessness. Effective interventions with precariously housed or homeless children, youth and families must attend to people's evolving social development, cultural and linguistic competencies, as well as the structural determinants of homelessness (e.g. poverty, insufficient mechanisms for rapid re-housing, and generally inadequate safe and affordable housing stocks).

While there is considerable diversity among the needs and experiences of youth (16–24 years of age) who are homelessness, there are also some shared characteristics linked to this phase of social and emotional development. For example, many youth experiencing homelessness have had or will go on to have relationships with other youth institutions, such as child protection, children and youth mental health and/or youth justice (Dworsky & Courtney, 2009; Gaetz & O'Grady, 2002; Gaetz, 2002; Gaetz, O'Grady & Buccieri, 2009; Karabanow, 2004; Lemon Osterling & Hines, 2006; Lindsey & Ahmed 1999; Nichols, 2008; 2013; 2014; Mallon, 1998; Serge, Eberle, Goldberg, Sullivan, & Dudding, 2002; Mendes & Moslehuddin, 2006; Public Health Agency of Canada, 2006; Raising the Roof, 2008).

Research identifies a connection between childhood experiences of abuse and/or neglect (leading to involvement with child protective services) and delinquent behaviour (leading to involvement in the youth justice system) as well as increased incidence of mental health and substance use disorders and struggles with work and education (Wiig, Widom & Tuell, 2003). Experiences of trauma shape human development and are linked with substance abuse (Suarez, Belcher, Briggs, & Titus, 2012). Trauma and traumatic stress also interfere with learning and development and are linked to a range of mental health disorders, including depression and anxiety as well as conduct and oppositional defiance disorders (Ford, 2002; 2003) and increased use of mental health services and involvement with the justice and child welfare systems. Further, conduct and oppositional defiance disorders also make full participation in school and the labour market difficult.

Clearly, when it comes to youth well-being a coordinated, cross-sectoral response is required to bring key institutions together. In general, this type of response would provide opportunities for inter-professional learning and training, the establishment of shared goals/target outcomes across institutions, the development and implementation of a comprehensive and coordinated policy framework and coordinated processes for sharing information and engaging in monitoring and measurement. Where institutional responses to youth homelessness and its root causes are not effectively coordinated, the interventions we put into place to help youth may actually contribute to further harm.

While there is considerable diversity among the needs and experiences of youth (16–24 years of age) who are homelessness, there are also some shared characteristics linked to this phase of social and emotional development.

THE RESEARCH

My research in the area of systems coordination for youth began in 2007 when I collaborated with a youth shelter in a small Ontario city on a project about human service delivery for street-involved youth (Nichols, 2008; 2009; 2014a; 2014b; 2016 forthcoming). During this project, people talked a lot to me about young people who "fall through the cracks." I could see that the phenomena that researchers describe as systems failures were very similar to what youth and adult practitioners describe as "cracks," and that both terms ended up glossing over what was actually happening when young people fail to get what they need and want from their participation in institutional settings. From this early observation, I set out to discover how young people and adult practitioners' work is coordinated across institutional sites such that young people experience this thing we have come to call a "systems failure." This research marked the beginning of a multi-year, multi-sector investigation of the inter-organizational and cross-sectoral disjunctures or gaps that influence young people's interactions and experiences with organizations like schools, child welfare associations, youth justice facilities and so on.

This research marked the beginning of a multi-year, multi-sector investigation of the inter-organizational and cross-sectoral disjunctures or gaps that influence young people's interactions and experiences with organizations like schools, child welfare associations, youth justice facilities and so on.

This chapter draws on findings from three studies in different cities across Ontario: Peterborough, a small city in Eastern Ontario (about 85,000), Hamilton, a mid-size city in Southwestern Ontario (around 500,000) and the Greater Toronto Area (GTA), an amalgamated urban centre made up of a number of cities in Central Ontario (2.8 million people). The studies represent distinctive and overlapping periods of data collection. The first project occurred in Peterborough over a year and a half between 2007 and 2008. The second project began in the GTA in 2013 and is ongoing. The third project occurred in Hamilton over a period of six months in 2014. Data collection for all three projects involved participant observation, in-depth qualitative interviews and focus group conversations with youth and human service providers and extensive textual and policy analysis.

In the first project, data was generated through traditional ethnographic fieldwork methods, including 27 formal interviews with young people and 14 interviews with service providers, including shelter workers, educators, youth workers, mental health professionals, police officers and child protection workers. The research also included a focus group discussion with six young people involved with Child Welfare services as Crown wards. Throughout my year and a half in the field, I engaged in extensive participant observation at a youth shelter and in the other institutional settings where youth were active (e.g. welfare offices, the courts, an alternative school and sexual health clinic) and conducted informal conversations with youth and service providers that I later recorded in field notes. I also analyzed the workplace texts, policies and legislation that connect people's work across institutional settings.

The second project also uses traditional ethnographic fieldwork techniques but takes a team-based and participatory approach. For the last two years, I have led a team of researchers (including youth) in an ongoing (2013–2018) investigation of community safety from the standpoint of youth who have been institutionally categorized as "at risk." The research seeks to identify the inter-institutional relations that contribute to processes of exclusion (including interrelated processes of racialization and criminalization). The research is grounded in young people's stories of their experiences in schools, in social housing environments, in youth custody and/or detention centres, in social service agencies and on the streets. To date, we have engaged in outreach, participant observation (and the production of field notes) and policy analysis. We have also conducted interviews with 60 youth, as well as four focus group discussions and 14 individual interviews with organizational leaders and service providers, including educators, police officers, youth advocates, youth workers and correctional staff. In total, we have spoken with 48 professionals who work with youth.

The third project is somewhat smaller in scale than the first two. Following a number of site visits, meeting observations and casual conversations with people who develop, manage, provide or access a continuum of services for street-involved youth, I conducted three in-depth semi-structured interviews and seven semi-structured focus group discussions with youth, service providers, organizational leaders and community planners. The focus group sizes ranged from four to 15 participants per group. This particular study site was chosen because the municipality has endeavored to create and implement a continuum of services for street-involved youth. Given my desire to generate findings that can inform a more coordinated approach to the delivery of services for homeless and otherwise vulnerable youth, I sought to document and understand the organizational change process employed by this city to improve the coordination and delivery of services for street-involved youth.

FINDINGS

The impetus for writing this chapter comes from the results of the research I conducted in Hamilton, Ontario. By all accounts, the grassroots service collaborative I studied in Hamilton has improved the breadth and depth of its services for street-involved youth. Based on the data collected for this project, I observed, heard from participants and reviewed administrative data and reports that suggest the collaborative has:

- Identified and filled service delivery gaps to ensure 24/7 basic needs coverage (e.g. community meal programs);
- Coordinated fund-seeking endeavours;
- Improved inter-organizational communication and joint-working;
- Developed an array of housing options for youth;
- Implemented mobile mental health services and improved frontline capacity to identify and respond effectively to mental health needs;
- Created a number of shared housing support positions;
- Improved in-house addictions and mental health supports; and
- Engaged in ongoing research and data collection.

Despite all this, they have not seen a dramatic reduction in the number of young people who are homeless or street-involved in their city. In fact, the numbers of homeless youth in their city have slowly risen.

While this trend might reflect differences in how the point in time counts of homeless persons were conducted, participants in this study observed that the number of homeless and street-involved youth in their community is influenced by an ongoing trickle of youth entering the street-youth serving continuum of services from elsewhere. Given my ongoing research on the governance and policy relations influencing

young people's access to and experiences in publically funded youth-serving institutions, I wrote this chapter to shed some light on the persistent cross-sectoral gaps that undermine local efforts to coordinate services within the youth homelessness sector, alone. I want show why service-delivery coordination, alone, will not solve youth homelessness.

The three big systemic feeders influencing the numbers of street-involved youth in Ontario are the youth (and adult) justice system, the child welfare system and inpatient mental health services. Youth homelessness is not caused by service delivery failures in these sectors; rather my research suggests organizational disjunctures or gaps occurring between sectors contribute to young people's exclusion and ongoing marginality, including but not limited to experiences of homelessness and housing insecurity. A central gap is the lack of suitable housing options for youth with complex needs.

In 2008, I interviewed a woman named Karma—an educational assistant at an alternative school for homeless and precariously housed youth in Peterborough. In our interview, she paints a damning picture of her community's response to hard to house and at-risk youth. She observes how youth cycle through and then age out of a system that is unable to address their needs:

> ***Karma:*** *There's no one to follow it up with—to sit down and talk to about it. And we know that the shelter workers don't have time to do this. It's not part of their jobs. So there's no one to say, "I think we need to sit down and review the case to see how it's going." Once they are out of your hands, it's like, "I wonder what happened to them." I guess you could find out if you wanted to, but who actually follows it up? And who says, "Ok, it's not working. What can I do to make it work?" Instead, it's "ok, we've done everything [we can]," so whatever.*
>
> ***Naomi:*** *Pass it on to the next guy.*
>
> ***Karma:*** *Or we'll let them back in the door again so it's like, let's grind out the same program we did before… It's like they keep going through the system, going through the system and it's the same people they see and the same strategies and it's not working… And the kid gets so institutionalized that it's almost like, "This is all I know. So I'm just going for this ride and now I know what's going to happen. I'm going to go here and now I'm going to go there." And it's like "ok, let's do it…" They just get stuck in a current—wherever people tell them to go and then, they're 18 and they're told that they better make their own decisions. And it's like well, "I've never had to before… Now what do I do?" Well now we have a problem. Now we graduate from the probation system to the parole system.*

Karma made these observations in 2008—almost seven years ago. But much of what she says still rings true. Some youth continue to cycle into and out of the homelessness, youth justice, mental health and child protection systems until they age into adult services.

During my research in Hamilton in 2014, homelessness sector service providers observed that they have difficulty accommodating the needs of some youth in their programs—particularly youth who have been diagnosed with Fetal Alcohol Spectrum Disorder (FASD) and/or young people (between 18–24 years) involved in adult correctional services that discharge into the emergency shelter system for youth. At a Housing First planning meeting I attended in Peterborough last year, service providers wondered aloud about how they would find and maintain housing for youth who are known to start fires. Without comprehensive and integrated supports (including, but not limited to housing) for youth with complex needs, the end of the road—as Karma alludes in this passage—is the justice system.

YOUTH JUSTICE

My current program of research in the GTA demonstrates how interactions with the justice system are connected to experiences of homelessness and/or housing insecurity—prior to and post-detention or incarceration. A lack of culturally appropriate and coordinated diversion and re-entry supports for youth and their families mean that conflicts at home lead to justice-involved youth being kicked out of family and institutional housing. At this point, street-involvement and shelter use influences a young person's ongoing interactions with the police in his or her neighbourhood, increasing the likelihood that he or she will incur a number of justice offenses (e.g. breaches of one's probation order) and decreasing the degree to which one is able to effectively re-integrate back into the community after incarceration.

In reality youth report that rehabilitative programs in justice facilities have long waitlists, are frequently cancelled or are boring and irrelevant to their lives (ON Youth Advocate Report, 2013).

For youth in custody, planning for community re-integration is meant to start when a youth is sentenced, placed in custody and is assigned a youth correctional officer (Youth Criminal Justice Act, S.C. 2002, c. 1; S. 38(1); 90(1)). The re-integration process ends in community, where ideally the youth is assigned a probation officer and seamlessly transitions into community programming including housing. In reality youth report that rehabilitative programs in justice facilities have long waitlists, are frequently cancelled or are boring and irrelevant to their lives (ON Youth Advocate Report, 2013).

When youth transition out of custody, youth workers and advocates discover that waitlists and narrow eligibility requirements (e.g. educational minimums for participation in job-readiness programs) make it difficult to engage youth in suitable programming in community environments. Some youth are unable to return home and, as such, simultaneously find themselves navigating the province's social assistance and shelter systems—as well as any number of community sector organizations—as part of their re-entry process.

In 2007, I met a young woman named Jordan who was living in a homeless shelter for youth on a permanent basis, having been placed there by child protection services. When Jordan was last released from criminal custody, her mother refused to let her return home. This is a common scenario impacting the re-entry experiences of justice-involved youth across Canada. In other cases families decline to post bail for youth awaiting trial. As such, there are more youth in Canada detained on remand than incarcerated. According to Statistics Canada, in 2011 and 2012, 81% of custody admissions for youth were to pre-trial detention. This trend is shaped as much by a lack of suitable pre-trial detention housing options and conflict resolution and respite supports for families as it is by the backlog in the court system. The lack of suitable pre-trial housing options for youth and/or family mediation supports to enable families to effectively post bail for their children is another inter-sectoral gap, where the youth homelessness sector should position itself as an ally to the justice system. In particular, communities might want to consider the merits of family and community reconnect programs (e.g. Eva's Family Reconnect program in Toronto or RAFT's Youth Reconnect Program in the Niagara Region), designed to provide young people and caring adults with the support they need to have young people remain in their home and/or community of origin. Otherwise, young people are likely to transition out of the justice system and into a homeless shelter or the streets.

Darren, a GTA youth advocate I interviewed in 2014, explains how he gets "calls from everywhere" for him to help youth navigate a highly fragmented system of supports during re-entry:

I get a call from the courts, from the Crown attorney, from the prohibition officer and sometimes from, believe it or not, police officers who've seen my card. And community leaders, community social workers, school social workers, principals, vice principals, teachers, etc. —I get calls from all of these places and they say, "We have a youth who we think might benefit from your mentorship, doing what you do. Right now the youth is in incarceration and needs you to come out." Or, "right now we're trying to have a bail for a youth. He has nowhere to go, so we think you might be able to help him navigate the shelter system because he can't go home.

Ideally, the re-integration process would be coordinated, targeted and planned. Unfortunately, it is just as likely that a youth will go to court one day and simply not return to custody or detention (field note, ON Youth Justice Facility, school staff). As such the re-integration process ends up occurring with no planning or coordination.

Darren's description of his work suggests an ad-hoc system where the degree to which a young person experiences a sustained transition from custody may depend on whether or not the youth is able to connect to someone like him. But even if youth do connect with an advocate like Darren, his response to housing issues is to place someone in an emergency shelter. Even in the large urban centre where this research takes place, emergency shelters are likely to be located outside of the young person's neighbourhood (i.e. rival gang territory). More problematically, there are no supportive or youth-friendly housing spaces operated by the youth homelessness sector in the neighbourhood where my research on community safety occurs. For youth involved in gang activity and street life, the prospect of entering a homeless shelter in another neighbourhood represents considerable risk. As such, they are much more likely to crash with friends, sleep in a "trap" (or drug) house or stairwell, and return to hustling on the streets to make a bit of money.

A clear understanding of how the community re-entry process is meant to work (and how it actually occurs) is key to the creation of a coordinated response to youth homelessness. Inter-professional learning and planning between youth housing support workers, corrections officers, advocates, youth workers, and probation officers will ensure young people receive appropriate housing supports during re-entry. People who work in the youth justice system have a vested interest in seeing youth effectively re-integrate into the community—this is a key focus of Canada's *Youth Criminal Justice Act*—but it is not something that our youth justice institutions can do on their own. The youth homelessness sector should position itself as a key player in the re-entry process if it wants to support a coordinated effort to effectively transition young people out of custody and into suitable housing in the community. In a large metropolitan area like the GTA, the youth homelessness sector should work with all levels of government to ensure that there is a range of culturally and developmentally appropriate housing options in neighbourhoods where significant numbers of youth are transitioning out of custody or detention.

Child Welfare Services

Another other key inter-sectoral disjuncture influencing a young person's experience of homelessness and housing insecurity is the use of emergency shelter services by child welfare institutions where a young person under the care of the state is deemed to be "hard to house," or where temporary emergency shelter is required after a housing breakdown. When I was conducting research on service provision for homeless youth in Peterborough, for instance, it was common practice for child protection workers to place young people in care at the youth shelter. While I knew that child protection-involved youth touched the shelter system in other Canadian cities, I wondered whether the prevalence of this response was idiosyncratic to a small city with fewer housing options for youth in care. Last year, when I was studying the grass-roots systems-response to youth homelessness in Hamilton, a distinctively more urban city with a much larger population, I observed similar practices employed by child protective services there. Despite efforts to build collaborative relations between the youth homelessness and child welfare sectors, child protection workers continued to use the large youth shelter in the city as a housing placement.

The impacts of this practice are significant for youth. Earlier in this chapter I introduced you to a young woman named Jordan. She was 15 years old when she was released from criminal custody. As such, the child protection system was legally obliged to become her temporary guardian. A temporary care agreement was established with Jordan and her mother, and Jordan was placed at a youth homelessness shelter. No other housing arrangements for Jordan were pursued by her child welfare worker while Jordan was in provincial care.

The temporary care agreement ended when Jordan turned 16. A short-term care agreement with child protection services cannot be established (for the first time) past a young person's 16th birthday and cannot last beyond a young person's 18th birthday. They also require consent. The only way for Jordan to remain involved with child protection services beyond the terms of the agreement was if her case was brought before the courts in order to establish a protection order. Once a young person turns 16, there are no legal grounds to establish one of these protection orders. Even in situations where a protection order has been established prior to the youth's 16th birthday, once a youth is 16 years of age, a status review can be conducted and the wardship order terminated by the courts if the youth is "refusing to co-operate with the Society" (C04.05.12 – Preparation for Independent Living of a Crown Ward, 2006, p. 5).

While under the care of child welfare, Jordan refused to attend school and failed to show up for her social work, medical, psychological and legal appointments, attend probation meetings or appear at her court dates. Jordan's refusal to co-operate with the Society, made her an unlikely candidate for a status review prior to the expiry of her temporary care agreement after her 16th birthday. When the agreement expired, she established eligibility for welfare and applied to have them cover the costs of her bed and lodging at the youth shelter. She effectively moved from one floor of the shelter designated for kids in care to the general residents' floor. Shortly thereafter she was discharged to the streets for failing to abide by the rules.

Jordan's story helps us see how the use of emergency shelters as a housing placement by child protection contributes to a young person's street involvement. Capping the length of these placements so that they really do represent an emergency (that is, temporary) response is a first step to preventing the flow of youth from child protection into homelessness. A more sustainable solution is the development of a continuum of youth-appropriate housing options for youth involved with the child protection system. In Hamilton, for instance, the youth homelessness sector has created a number of housing options (with varying degrees of support) to address this void, but the demand for housing for adolescent "youth in care" continues to exceed the city's resources and youth continue to be placed in the emergency shelter by child protection services.

Mental Health

The final cross-sectoral gap I want to focus on in this chapter is the one that arises between the mental health and homelessness sectors. The Mental Health Commission of Canada estimates that between 25% and 50% of people who are homeless in Canada are living with a mental health disorder (mentalhealthcommission.ca/English/system/files/private/document/MHCC_Annual_Report2011-2012_ENG.pdf retrieved June 9, 2015). While the Mental Health Commission advocates and implements a Housing First approach to recovery, many hospital inpatient psychiatric wards across Ontario continue to discharge people into unsuitable and unstable housing environments like homeless shelters.

In a focus group discussion I conducted with the mobile mental health team associated with Hamilton's continuum of services for street-involved youth, a mental health clinician named Esme noted:

> *Youth are inpatient for a week to three weeks and there is absolutely no conversation to facilitate a discharge to [the youth shelter]. In my opinion—and I think this is a shared opinion—when a young person or young adult is discharged to the shelter, you're discharging that kid to the streets, right? And that happens a lot. And then we get to know these kids because they arrive with a sack—I think about that metaphor with a stick and the bag—literally with a sack, and there was just nothing to precede their arrival. And they're incredibly sick—forget about that—they're incredibly without help. So that instability only aggravates all of their compounding difficulties. What we know particularly is mental health and that transience, that instability, that "what next?" that hyper-vigilant life very much disrupts their perpetual complex needs (Esme, focus group discussion, 2014).*

In order to staunch the flow of youth from psychiatric care into the city's large emergency shelter for young people, sometimes Esme and her colleague Lynn request that the hospitals discharge young people to a crisis unit, rather than simply discharging a youth straight out of in-patient services into the shelter system. Ideally, this interim arrangement can provide an opportunity for housing support workers to quickly mobilize a more suitable housing plan for the youth. At the very least, it allows for a gentler transition from the hospital to the social complexities and hyper-vigilance that Esme notes are characteristic of shelter living. Lynn explains:

> *So what we have done for the last few years is we have requested that the hospitals discharge to B--- Centre and then to the shelter, because that—for anybody who has been in hospital—going home is a huge transition. The reality is you're not coming home coming here. You're coming to a shelter. Whereas [with the crisis unit], you know, there's that little step-down, and we work very hard for that to happen during those transitions. Now, I realize other communities likely don't have a B---- Centre, but there needs to be some plan for the transition from hospital to shelter for kids with significant mental health problems, otherwise they're going to be back in hospital very quickly. And I think our back and forth from hospital, I think we can safely say we now have evidence to show that the back and forth tends to occur when it's a poor discharge. When there's a good discharge and we're all working together, the young person tends to settle, either into the shelter, or back to B---- House, and back to W--- Transitional Housing. (Lynn, focus group discussion, 2014).*

The mobile mental health team has actively sought to learn how things work in the mental health sector, adapting the hospital's clinical tools and models to fit with a mobile approach. For example, they elected to use common intake tools to facilitate clear communication across sectors. With these systems in place, the team has endeavoured to build capacity among frontline staff in street-youth-serving agencies so that they can now effectively identify and respond to symptoms associated with common mental health disorders, thus avoiding unnecessary discharges from street-youth-serving organizations into the hospital.

The mobile mental health team has actively sought to learn how things work in the mental health sector, adapting the hospital's clinical tools and models to fit with a mobile approach.

Hospital staff, on the other hand, still fail to grasp (in Lynn's words) the "capacity, skills and knowledge" of the street-involved youth-serving sector. As such, hospital staff continue to approve transitions from the inpatient psychiatric ward directly to the shelter, even though Esme and Lynn advise that this is effectively discharging a young person onto the streets and that there is insufficient consulting psychiatry capacity in the community to ensure that such a transition is safe. In Hamilton, the mobile mental health team has deliberately sought to align their work with the way things operate in the mainstream mental health system. In this case, opportunities are needed for the two sectors to engage in inter-professional learning, such that mental health professionals at the hospital grasp the "capacity, skills and knowledge" of the street-involved youth serving-sector, as well as the organizational contexts shaping how work is done here.

DISCUSSION

Cross-sectoral thinking, learning, planning and working are essential to the development of a preventative solutions-oriented approach to youth homelessness. While it is essential to improve service-delivery coordination *within* the homeless-serving sector, a failure to identify and collaboratively repair inter-sectoral cracks means that this important work will not have the desired effect on the numbers of youth experiencing homelessness.

An active and coordinated prevention- and intervention-oriented approach is needed to effectively ensure all youth in Ontario have access to safe and appropriate housing. A systems-level reform agenda begins by shifting professional culture and practice such that collaboration and joint-working are valued and supported. Inter-professional collaboration begins with opportunities to compare differences and similarities in practice, policy, terminology and mandate across the various sectors where youth are active. Later, opportunities for inter-professional learning and training will support the identification of shared language and mutually desirable goals.

Once shared language, goals and targets have been established across institutions/sectors, an integrated policy and accountability framework is necessary to support the implementation of this shared agenda. Of course, for individual organizations to work collectively on a shared agenda, approaches to monitoring and reporting administrative data will need to shift. Protectionist approaches to the production and sharing of administrative data should be eschewed in favour of an approach to monitoring and reporting that reflects an integrated service delivery model—that is, where service impacts are measured across (rather than within) the individual service delivery contexts where youth are active. Shared budget-lines, staffing positions and/or multi-sectoral funding opportunities are also important facilitators of collaboration. Homeless youth-serving organizations should consider taking the lead in developing collaborative funding proposals that seek to address the interrelated determinants and symptoms of homelessness.

There is also a role for research to play in supporting inter-professional learning and collaboration. Two theoretical orientations stand out as particularly useful in this regard: complex adaptive systems theories and developmental systems or ecological approaches to youth well-being. Human development is the result of complex interactions between our biological, emotional, social and physical worlds (Lerner, 2005). A systems response to youth homelessness requires that we understand how an intervention in one sector influences and is influenced by interventions taking place elsewhere and that we recognize how the experiences of individual youth are shaped by their relations with family, their communities, and various inter-related social-structural phenomena (e.g., housing, health, education, nutrition, poverty, stress).

CONCLUSION

Throughout this chapter, I have highlighted specific inter-sectoral relations that influence the likelihood that a young person will experience homelessness. I've also sought to identify key roles that the youth homelessness sector could play in improving coordination between sectors and/or positioning their organizations as having the capacity to fill the gaps that my research identifies. I think these are important first steps; however, if Ontario really wants to implement a youth homelessness *prevention* strategy, then perhaps we need to shift the discourse—or reframe the problem.

Youth homelessness remains an issue in Ontario because there is a lack of developmentally and culturally appropriate housing options for young people who must, for many different reasons, live outside the direct care and support of their families—particularly those young people who get described institutionally as "at risk" or "hard to serve/house." Every child and youth in Ontario deserves a stable, developmentally and culturally appropriate, emotionally and physically safe home. No strategic effort to ensure that Ontario's youth are well can be successful when this fundamental right is not being met. Clearly, this is not the homeless-serving sector's problem. It is a provincial and federal issue requiring strategic planning and coordination at all levels of government and between government and the non-profit and charitable sectors. Even so, the homelessness sector—perhaps better positioned as the "youth social housing sector"—has a role to play. It is here, where many of Ontario's hardest to serve youth will end up when the other systems fail to meet their needs.

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I am an engaged scholar who studies institutional and policy relations that contribute to processes of social exclusion and marginalization. I am committed to making sure my research contributes to socially just change processes.

Inter-sectoral Collaborations

3.2

A 10-YEAR CASE STUDY EXAMINING SUCCESSFUL APPROACHES AND CHALLENGES ADDRESSING THE DETERMINANTS OF HOMELESSNESS: THE EXPERIENCES OF ONE CANADIAN CITY

Kathy KOVACS BURNS & Gary GORDON

INTRODUCTION

People living in poverty and/or those who are homeless face many more challenges and obstacles than the average person. This includes their increased vulnerability for poor health, multiple social problems, diminished quality of life, higher morbidity and premature mortality (Guirguis-Young, McNeil & Hwang, 2014; Mills, C., Zavaleta, D. & Samuel, K., 2014; Phipps, 2003). They also face social exclusion and isolation (Mills et al., 2014), inequality, discrimination and stereotyping by landlords, health and support providers and the general public in their communities (Khandor, E., Mason, K., Chambers, C., Rossiter, K., Cowan, L. & Hwang, S. W., 2011). Their experiences walking into public facilities, accessing traditional health and social services, renting and being considered for employment are often negative. In many instances there are discrepancies between what people who are homeless need or want, what service providers can offer and what the provincial or local governments can afford or support as best practices (Shinn, 2007). In this chapter, we refer to these conditions as the 'determinants of homelessness' – a term that is deliberately similar to the term, 'determinants of health.' The term invokes the multiple and interlocking social and structural factors that impact the capacity and resilience of individuals or families living in poverty and/or homelessness/housing insecurity. There is a direct relationship between the determinants of homelessness and the determinants of health. Both include income status, housing, personal and environmental factors. Both impact on health and well-being of individuals and families. Exploring how best to manage or balance the determinants of health and homelessness is an essential part of preventing or ending homelessness.

By investigating the experiences of individuals and families experiencing homelessness, the complexity of homelessness, the challenges living with it or addressing it and the lack of public policies to support a systems approach to successfully resolve it are revealed (Hulchanski, D. J., Campsie, P., Chau, S., Hwang, S. W. & Paradis, E., 2009). Although different Canadian cities had their own community plans with various housing and support programs (e.g. emergency shelters as well as supportive, transitional, social and affordable

1. Homeless was defined as living on the street, living in unsuitable accommodation such as an abandoned home/car/shed, living in emergency shelter or couch-surfing.

housing), to address the various challenges and needs of people who were at risk of becoming homeless and those who were currently homeless, the Housing First strategy was the first opportunity to pilot the systems approach across multiple cities in Canada with federal, provincial and municipal supports for the goal to end homelessness in 10 years.

Considering the various housing and support programs implemented over the past decade, including the Housing First strategy, we pose some questions worthy of a retrospective investigation within one Canadian city: What have we learned over the past decade about the determinants of homelessness and related experiences of those delivering and receiving the various programs and strategies to manage the determinants and, in turn, manage or prevent homelessness? What has been the impact or outcomes of various programs and strategies implemented over this past decade, including Housing First, on managing or reducing homelessness and, specifically, on the experiences of people at risk of becoming homeless or who were homeless (micro level), service providers and the broader community (meso level) and government decision makers (macro level)? What further adaptations or changes were or are needed for a strategy like Housing First to be more effective at addressing micro, meso and macro system challenges and staying on course to end and prevent homelessness in 10 years?

These questions are the focus of this chapter. The authors apply a system-wide analytical lens (i.e. examining responses at the micro, meso and macro levels), seeking the experiential knowledge of people who were homeless, service providers and decision makers. We situate our research in a case study of one city, highlighting its experience and outcomes with managing homelessness as various programs and strategies, including Housing First, were implemented over a 10-year time frame between 2005 and 2015. We draw on data from three separate projects as part of the case study. We also explore the successes, challenges and barriers related to managing or ending homelessness. Recommendations are discussed in the context of what we have learned from the three projects in this case study which provide data over the 10 years from 2005 to 2015 regarding specific and system-wide decisions and changes in practices aimed at preventing and ending homelessness.

The Significance of Homelessness for Individuals, Communities and Governments

Homelessness is a community affair, involving individuals, families and community service providers.

Homelessness is a community affair, involving individuals, families and community service providers. Each of these groups come into the relationship dealing with many unknowns but sharing a goal to address the determinants of homelessness (Guirguis-Younger, M., McNeil, R. & Hwang, S.W., 2014; Hwang, 2009; Mills et al., 2014; Oudshoorn, A., Ward-Griffin, C., Poland, B. et al., 2013). The first challenge in addressing the determinants of homelessness is to identify individuals or families as being homeless and in need of housing and other services. However, homeless counts are point-in-time estimates, which often underestimate those who are precariously housed. Further, the affordable housing supply may be limited when demand is high. Community capacity in terms of human and other resources providing health and social supports and services in safe and appropriate spaces are also limited (Oudshoorn et al, 2013). The biggest challenges are associated with policy and funding. Without a national agreement to support an affordable housing

policy, there is always the chance that the federal government can abdicate its housing responsibilities to the provinces and municipalities (Zon, N., Molson, M. & Oschinski, M., 2014). In summary, responses to homelessness at the micro, meso and macro levels have not been proactively planned with consideration for the determinants of homelessness, including adequate affordable housing stock, appropriate health care and support service access and sufficient human and financial resources to sustain all that is needed to end and prevent homelessness. More often than not, the micro and meso levels are dependent on macro level conditions, with governments having the final say on what, when and if homelessness or housing strategies will be funded. We see this approach to solving homelessness as fragmented, inefficient and ineffective.

Alberta, Canada has not historically been proactive at addressing poverty. About 300,000–400,000 people lived in poverty over the past five years, costing between $7.1–9.5 billion (Vibrant Communities Calgary, 2012). Up until 2015 when Alberta introduced *A Blueprint for Reducing Poverty in Alberta*, it was one of three provinces without a poverty strategy.

Of the 6,663 individuals experiencing homelessness in Alberta in 2014, about 35% were located in Edmonton. Over the past decade, Edmonton experienced an increase in the number of individuals and families who were identified as homeless. In 1999, 1,125 homeless were counted, which more than doubled in 2006 (2,618) (Homeward Trust, 2014). With the introduction of Housing First in 2008, homeless counts and related costs began to decrease. By 2014, 2,307 were identified and costs decreased from around $100,000 to $35,000 per person per year (Homeward Trust Edmonton, 2014).

Over the past decade, Edmonton experienced an increase in the number of individuals and families who were identified as homeless.

In Search of the 'Grail' to Prevent and End Homelessness – The Edmonton Context

This section provides background information for our study of the implementation of Housing First in Edmonton, Alberta over the past 10 years. Addressing homelessness and its associated costs requires aggressive and proactive approaches (Burt, M., Hedderson, J., Zweig, J., Ortiz, M. J., Aron-Turnham, L. & Johnson, S. M., 2004). Municipalities must shift from the 'staircase' approach in which individuals are shuffled through shelters, transitional and social housing and have to prove readiness for independent housing, to a systems approach focusing on collaboration, coordination and integration of housing-led or Housing First approaches along with various supports (De Vet, R., van Luijelaar, M. J. A., Brilleslijper-Kater, S. N. et al., 2013; Neale, K., Buultjens, J. & Evans T., 2012; Stergiopoulos, V., Rouleau, K., & Yoder, S., 2007). However, money must be invested up front to build the necessary infrastructure for affordable housing as well as health and support services and income security (Gaetz, S., Scott, F. & Gulliver, T., 2013; Shinn, 2007).

Housing First as a systems approach had the underlying principle of: "if people are housed, they are more likely to move forward in their lives" (Gaetz et al., 2013) and was viewed as relevant for not only managing and ending homelessness but also preventing it (Burt, 2007; Stroh & McGah, 2014). However, effective prevention initiatives have proven to be challenging to implement. First, because determining if someone is vulnerable to becoming homeless is difficult to do and, second, because in order to effectively prevent homelessness in cases like this the community needs to have a rapid rehousing system in place (Culhane, D., Metraux, S. & Byrne, T., 2011).

In addition, prevention approaches are associated with high uncertainty, in part because they require a framework that examines efficiencies and effectiveness from the outset (Burt et al., 2005). Barriers to homelessness prevention also need to be explored. Research suggests

the following potential barriers: funding and planning with community-based services trying to ensure availability of services for different populations (i.e. youth, women, families, seniors, etc.); housing benefit restrictions, particularly with the supply of affordable safe housing; restrictions in the use of private sector housing; community capacity to monitor impact and outcomes; and challenges associated with culture change (Pawson, H., Davidson, E. & Netto, G., 2007).

To address these challenges, the Alberta Government implemented its *Plan for Alberta: Ending Homelessness in 10 Years* (The Alberta Secretariat for Action on Homelessness, 2008). The plan is based on Housing First principles and philosophy. Similar approaches were used with the youth plan (Government of Alberta, 2014), which engaged youth and parents, communities and government in the planning.

Four years after the plan to end homelessness was initiated, the Alberta Government (2012) conducted conversations with communities to determine what worked well with the initiation of Housing First and what else needed to happen to ensure the province achieved its goal of ending homelessness by 2019. Participants in these government consultations indicated that improved cooperation, collaboration and communication among service providers worked well during the implementation of Housing First across the province. Ten recommendations for changes to reach the goal of ending homelessness were also identified, including restructuring, streamlining and improving access to programs; providing a range of housing and support service options; changing the funding formula; building the capacity of community-based agencies; focusing more on prevention and long-term planning; and initiating public awareness and education.

Methodology

A single case study design (Yin, 1994) was used to focus on one Canadian city (Edmonton, Alberta, Canada). Specifically, we were interested in understanding the community's approach (whether traditional or systemic) and capacity (i.e. resources, knowledge/experience, policies, other supports) to address or manage the housing, health and support services needs of people who were vulnerable to becoming homeless or who were homeless (i.e. determinants of homelessness). The case study explores the community response to managing homelessness in three different projects conducted in 2005, 2009 and 2009–2015. Our analysis focused on the outcomes for the community.

Researchers, community service providers, decision makers, private or corporate sectors and those individuals living in poverty or who were identified as either homeless or at risk assisted with various aspects of the study from the design to the reporting of findings.

Community-based participatory research methods (Bennett & Rogers, 2004) were used to design and explore this case for the projects in 2005 and 2009. Researchers, community service providers, decision makers, private or corporate sectors and those individuals living in poverty or who were identified as either homeless or at risk assisted with various aspects of the study from the design to the reporting of findings. This approach gave those with the expertise or experience more control over the research questions and process, and more influence over how findings were used and by whom (Bennett & Roberts, 2004; O'Toole, T. P., Aaron, K. F., Chin, M. H., Horowitz, C. & Tyson, F., 2003). In contrast to the two projects conducted with community participants (i.e. people who were homeless, service providers and decision makers in government) in 2005 and 2009, the third project spanning 2009 to 2015 was a document content analysis of community homelessness reports and plans. The document study from 2009 to 2015 not only provided a contrast as a method, with examination of different homelessness reports and plans, but also an analysis of homelessness housing and support practices over the six years.

Participant and Document Access

Participants for the 2005 and 2009 projects were purposive samples of people living in poverty and vulnerable to becoming homeless, those who were homeless, various community health and support service providers, housing developers and landlords, and decision makers in federal, provincial and municipal governments. They were accessed through community contacts and snowball sampling methodologies. For the 2005 project, 12 dialogue or focus groups were set up, each focused on experiences of targeted populations – seniors, youth and a separate group of students, families, singles, Aboriginal people, immigrants, people who are deinstitutionalized (from prison/correctional facilities or mental health institutions), persons with disabilities, persons with mental health issues, persons with addictions and victims of family violence. Each of these groups except the students were mixed or diverse groups consisting of 15 to 20 people of which two to five were individuals/families who were vulnerable or homeless. Other participants in these focus groups included housing providers, community health and support service providers as well as professionals, government decision makers and landlords or guardians. These larger than usual non-homogeneous focus groups were intentionally structured to provide the necessary diversity of stakeholder experiences and perceptions regarding the varied issues and recommendations for targeted populations. Everyone in each group was given an opportunity to provide input on each question. Questions were the same for each focus group to ensure comparability of responses across the 12 groups. Specifically for students, a town hall session was initially held at a post-secondary institution (with over 100 students in attendance). These students were asked to self-identify if they were interested in taking part in a focus group to discuss identified issues, needs and recommendations in more detail. Eleven self-identified students consented to take part in a focus group.

"If people are housed, they are more likely to move forward in their lives."
-Gaetz et al.

For the 2009 project, participants were purposely selected for interviews and focus groups pursuing the same focus and questions as pursued in the 2005 study. A total of 16 service providers, three decision makers and 10 homeless individuals (representing seniors, youth, single males and females, Aboriginal people, immigrants, women who experienced violence and those with mental health and addictions issues), and three individuals living in poverty (of which one had disabilities and two were families) were interviewed. Three focus groups were set up with some of the same people and others to validate the interview findings – one focus group of 15 service providers and two groups of 10 diverse individuals and families with low income and who were homeless.

To track the system response in Edmonton to the initiation of the provincial strategy to end homelessness in 10 years (2008), a different approach to a third project was conducted to align with findings from the 2005 and 2009 studies. For the 2009 to 2015 study, because the community was reluctant to have further interviews and focus groups with people experiencing homelessness, service providers and decision makers following similar community planning dialogue, a comprehensive document search was conducted. The search was for relevant homelessness annual reports, community plans and other documents describing programs/services, housing and topics related to targeted groups (i.e. seniors, youth including students, families, single women and men, Aboriginal people, immigrants, institutionalized individuals from corrections or other facilities, victims of family violence and persons with mental health issues, disabilities or addictions).

Data Collection and Analysis

Questions focused on the determinants of homelessness and specifically participants' perceptions/ understandings of the experience of living with low income and/or in homelessness...

The 2005 and 2009 projects received ethics approval (University of Alberta Health Research Ethics Board). The dialogues/focus group discussions held in the 2005 study and the semi-structured interviews and focus groups of the 2009 study were conducted with people who were at risk of becoming homeless or who were homeless, service providers and decision makers. Questions focused on the determinants of homelessness and specifically participants' perceptions/ understandings of the experience of living with low income and/or in homelessness as well as the experiences of people providing or accessing health and support services in Edmonton (i.e. what community services were available and working well and where improvements were needed) and what recommendations participants had for changes to services/programs and policies to better accommodate individuals or families who were at risk of becoming homeless or who were homeless. All sessions were audiotaped and transcribed. Qualitative thematic content analysis with flexible open coding (Asbjoern Neergaard et al., 2009) was applied to all transcripts based on the focus of the questions and particularly the determinants of homelessness. Each transcript was coded by two raters, ensuring inter-rater reliability for coding. Codes were clustered into themes as shown in Tables 1 (2005 study), 2 and 3 (2009 study).

TABLE 1 *Themes and Sub-themes Identified by 12 Focus Groups/Dialogues Consisting of People Who are Homeless, Community Service Providers and Decision Makers (Gordon & Kovacs Burns, 2005). Groups Include Seniors, Youth and Students, Women, Singles, Families, Aboriginal People, Immigrants, People Who were Deinstitutionalized, People with Mental Illness and/ or Addictions, People with Disabilities and Victims of Family Violence.*

Themes	Sub-themes
HOUSING	Emergency housing – need for: • More shelter spaces for single women, intoxicated people, couples and people with disabilities/special needs. • Housing (from emergency to long-term) for youth ≤18 years of age. • Emergency shelter for families in crisis. • Long-term strategy to address the shortage of winter emergency shelter spaces. • Culturally sensitive policies and staffing at emergency shelters. • More emergency housing for older men and women who have been abused. • Emergency housing for men (some with children) suffering from domestic violence. Transitional housing – need for: • Transitional housing for families in crisis, refugees with special needs, youth ≤18, immigrant families and singles. • More affordable aftercare (sober) housing with support. • Transitional tolerant housing with support but no treatment (harm reduction). • More affordable, supportive housing for mental illness/dual diagnosis. • Transitional housing for older men and women who are being abused. • Short-term housing for people waiting for addictions treatment. • Respite care for mental health clients and care-providing families. • More second-stage housing for victims of family violence.

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HOUSING	**Long-term supportive housing – need for:** • More supportive (transitional) housing for people leaving institutions. • Long-term supportive housing for seniors with special needs (hard to house). • Long-term tolerant housing with support but no treatment (harm reduction). • More affordable aftercare (sober) housing with support. • More affordable, supportive housing for seniors, immigrant/refugee families, people with disabilities and people with mental illness and dual diagnosis. • More long-term supportive housing for youth 18 years of age and older. • Long-term supportive housing for families in crisis. **Affordable housing – need for:** • More affordable aftercare (sober) housing with support. • More permanent housing for low-income families and singles. • More housing for large Aboriginal and immigrant families. • More affordable and subsidized housing for people with disabilities and mental health issues. • Assistance to help families become homeowners.
PREVENTION	**Need for:** • Support programs for families to help them retain and live in healthy homes. • Communities to stop creating ghettoes/gentrifying older neighborhoods. • Private sector to improve practices and understanding.
COMMUNICATION AND AWARENESS	**Need for:** • Strong advocacy and awareness on all housing-, homelessness- and poverty-related issues. • Improved government coordination/collaboration with private/ nonprofit sectors. • Increased awareness of services and supports. • Aboriginal communication strategy.
REGULATION AND POLICY	**Need for:** • Sufficient income and benefits from government support programs. • Adequate standards for housing and support (staff qualifications, procedures, etc.). • Governments to be more flexible in performance expectations. • More accessible and adapted housing (need to define 'accessible' and 'adapted'). • The establishment of a provincial Disabilities Ministry. • Access to surplus government assets (land and housing). • Implementation of the recommendations from the Mayor's Task Force on Affordable Housing.
CAPACITY BUILDING/ COORDINATION/ PARTNERSHIPS	**Need for:** • Sustainable operational funding for support agencies • Increased funding for 'capacity building' for organizations to develop housing. • Ensured continuing funding for the administration of plans. • The enhancement of Aboriginal community cohesiveness and involvement. • A dedicated fund for Aboriginal enhancement and capacity building.

RESEARCH AND ADVOCACY	Need for: • Sufficient income and benefits from government support programs. • Strong advocacy and awareness on all housing-, homelessness-, and poverty-related issues. • Accurate statistical data on the needs of Aboriginal peoples. • A national social housing strategy/program.
SUPPORT SERVICES	Need for: • A central point of entry/exit for subsidized housing and related support services. • Adoption of a case management/coordination of housing and support services. • Reliable, affordable and accessible transportation. • More affordable childcare and after-school care. • Funding for home care services. • More funding for life skills, anger management and other programs. • Funding to reintegrate people back into community. • More funding for training and education. • Identification of sustainable funding for onsite staff requirements. • Joint work between homelessness committees, the City, Capital Health and the Alberta government.

TABLE 2 *Summarized Results of Transcribed Interviews of Individuals Living in Poverty or Who Were Homeless, Community Service Providers and Government Decision Makers in Edmonton, 2008–2009*

THEMES	DESCRIPTORS
The issue – living in poverty	"Being poor is a full-time job" (quote from person living in poverty) requiring support from different sources.
Identifying with the process and outcomes, not the label of 'case management'	• Supported referrals and adequate sources of appropriate services in the community • Guidance and assistance to access and use services • Case management used by social workers and nurses • Sensitivity with being identified as a 'case' • Case management – too formal as a term and process • Preferences for navigation, problem solving, holistic care, mutual support, community strategies or for those in crises or crises intervention or crises-oriented care; outcome assessment; and harm reduction
Service providers coordinate efforts – 'unspoken agreements'	• Service providers coordinate with other agencies without formal agreements – unspoken coordination • Issues exist with sharing client information

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Services more often respond to client-driven or team-driven needs, not client consent	• Agencies, teams and client need to be plugged into existing community services closest to where client resides or frequents • Needs of clients are not like a cookie cutter; many clients have specific service needs • No one agency or service provider can provide for all needs – collaboration needed amongst service providers
Gaps in the system	• For users and service providers • Sense of community and 100% buy in • Evaluation of services effectiveness in meeting outcomes of clients • If services cannot do effective integration, the whole community is challenged • No formal partner agreements between or amongst • Leadership to set the stage for events • Resources to train staff • Bridging services from micro to macro levels for support • FOIPP issues and sharing of client needs and information • Discharge planning processes
Common and specific goals for service providers, clients and community	• Social inclusion • People receive care and support in their own community or neighborhoods • Individuals take initiative to connect with other community services and resources • Advocacy through coordinated case management, supported referral or other • Transitional care • Community capacity building; community mobilization • Micro to macro level coordination and support • System makes referrals to community services • Prevention of homelessness • Supports in housing complexes • Availability of professional care to clients on 24/7 basis • Native counseling and services available in community • Immigrants, refugees and others needing language or cultural considerations
Specifically for people with low income or those who have experienced homelessness, there are daily challenges for survival	• Basic needs must be met daily • Places to stay in winter – biggest challenge • If people are sick or have a tooth ache, urgent care needed • Do not trust many people in their immediate community • Constant fear of losing personal possessions

TABLE 3 *Summarized Results from the Dialogue Sessions with Individuals Living in Poverty or Who are Homeless in Edmonton, 2008–2009*

- Ill individuals or families with children went to nearest emergency department as last resort.
- Daily challenges and issues to survive; focus on one day at a time acquiring the basic survival needs.
- Some individuals need their friends – many look out for each other.
- Some preferred to be left alone.
- Some enemies were within their own group – did not trust each other.
- Their own worst enemy with alcohol and drug abuse and other physical problems.
- Those on the streets for years know how to get by.
- Get help when they get really cold, hungry, desperate or sick – go Boyle McCauley Health Centre or Northeast Community Health Centre.
- Shelters are good places for many – know the people and the place well.
- For assistance or services, they go to the same place – they feel comfortable there.
- Do not like going to the hospital – not treated well in most hospitals.
- Some individuals kicked out of too many places for being difficult.
- No follow up with most of them – they choose not to be followed.
- Some hope they can get off the street, find a place to live and work; others would probably die on the streets.
- Few people focused on family and kids; most individuals had not seen their families for a long while.
- Some avoided their families – had been abused by them; reason for why they are on the street and homeless.

Of 27 documents identified as being relevant between 2009 and early 2015, 16 were screened using the identified criteria (authenticity, credibility, representative and relevant) (Mogalakwe, 2006) and selected for their specific focus on the determinants of homelessness, including housing and support practices, their alignment with the two previous studies and their public release between 2009 and 2015. The documents included community plans, annual and other reports on homelessness programs and strategies. The remaining 11 documents were excluded as they were homeless counts, bulletins, newsletters or specific organization promotion materials. A priori (with predetermined themes) document content analysis, both quantitative and qualitative (Bowen, 2009), was conducted on the 16 selected documents. Analysis focused on content related to the targeted populations previously mentioned and on specific programs and strategies to manage homelessness such as Housing First or related initiatives. Documents were specifically explored for details regarding identified practices, services or programs for people who are homeless or at risk of becoming homeless, housing, support services, outcomes or results related to programs or strategies, experiences of persons who were homeless, service providers and decision makers, and related aspects. A document data collection and analysis table (Table 4) was used to track the following data: title of report, date, authors/organizations, target or type of population/s in report or involved in study, determinants of homelessness identified (i.e. housing and non-housing as in health, support services, income/funding, identified issues/needs, other), approaches or programs applied to address needs and gaps, and outcomes as well as key recommendations. In addition, the document content analysis included searching for challenges, successes, changes in practice, evaluation of effectiveness of programs and strategies, and related findings that would suggest that either progress had been made in managing homelessness, or additional challenges/barriers were identified which needed to be addressed if ending homelessness and preventing it could possibly happen by 2019.

TABLE 4 *Summarized Relevant Housing/Housing First and Services Documents from 2009 to 2015, Edmonton, Alberta, Canada*

TABLE 4.1
A PLACE TO CALL HOME: EDMONTON'S 10-YEAR PLAN TO END HOMELESSNESS, *EDMONTON COMMITTEE TO END HOMELESSNESS, 2009*

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
All people who homeless but chronically homeless for Housing First	Permanent housing options; adequate supply of permanent, affordable housing; emergency accommodation; rapid transitioning	Appropriate supports that are accessible; support with housing to transition people into permanent housing; prevention of homelessness	Housing First; prevention; governance structure; implementation process; develops community capacity; promotes collaboration, innovation & cost-effectiveness; measures progress; Streets to Homes program
OUTCOMES OR RECOMMENDATIONS	Homeless Commission will produce an annual progress report – five goals identified in plan		

TABLE 4.2
THE WAY WE LIVE — EDMONTON'S PEOPLE PLAN — THE QUALITY OF LIFE NEEDS & PRIORITIES OF EDMONTONIANS FACING SOCIAL & ECONOMIC BARRIERS, *EDMONTON SOCIAL PLANNING COUNCIL FOR THE CITY OF EDMONTON, 2009*

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
Disadvantaged Edmontonians – those facing social, economic cultural barriers to a good quality of life	Housing – dominant issue in this book with primary concerns focused on physical condition and quality of housing, availability and affordability of housing and issues regarding emergency housing; affordable units in new housing developments	Transportation, services and roads; efficiency of transit service; affordability of public transit; DATS service and its affordability Affordable educational opportunities, child care and after-school care could be improved. Safety of neighborhoods	Seven focused discussion groups in partnership with community agencies that serve disadvantaged Edmontonians, including seniors, youths, mental health clients, immigrants and homeless or low-income Edmontonians. The ESPC also conducted a quality of life survey, which asked people to rate the importance of, and their satisfaction with, a variety of components of quality of life
OUTCOMES OR RECOMMENDATIONS	Key solutions identified for housing, transportation, affordability and safety		

TABLE 4.3
STRATEGIC PLAN FOR SERVICES TO EDMONTON'S SENIORS: TOWARDS 2015
EDMONTON SENIORS COORDINATING COUNCIL, 2009

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
Seniors in Edmonton	Housing – recommendations to address issues: affordable housing options are available for older people; essential services (electricity, gas and water) are available to seniors; homes are designed with older persons in mind; home modification options are available; maintenance services are affordable and workers are qualified to do the maintenance; home services are accessible and affordable; community and family connections are made (older persons can stay in their familiar neighborhood); the living environment has sufficient space and privacy	Community health & support services issues and recommendations: a system for screening service providers; providing more funding for services; co-locating social and health services in communities & providing more funding for services; shelter and protection for homeless and destitute older adults and seniors who have been abused; meal services and programs, discounts on utilities for people with low incomes, registers of older people living alone, assistance in obtaining pensions and spiritual support; availability of residential facilities for people unable to live at home; sufficient volunteers to assist seniors with support services, such as driving, shopping, home care, yard help, pet walking, etc.; consideration of older persons in planning for emergencies; health services and transportation need to be more senior focused.	Stakeholder consultation is conducted with the intent to develop discussion paper and strategic plan towards 2015
OUTCOMES OR RECOMMENDATIONS	Recommendations are stated as goals suggested to issues identified for both housing and services for health, support and transportation		

TABLE 4.4
EDMONTON'S HOUSING FIRST PLAN,
HOMEWARD TRUST EDMONTON, 2009/2010

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
All people who are homeless	Housing options; clients housed in existing market housing; rental assistance; landlord relations management; housing for those with special needs – Pathways Edmonton for those with mental health issues; safe communities pilot – helps people live safely and successfully in community; Supports for Aboriginal Community to access permanent homes; capital projects	Agency advisory committee; mainstream service access; support services for one year or on-going dependent on needs or circumstances; outreach support, landlord relations, centralized administration; training & technical assistance; intensive case management; furniture bank	Housing First Model and principles; "ending homelessness one person at a time"; aligned with A Plan for Alberta – Ending Homelessness in 10 Years; client-centred/client focused; community consultation & engagement
OUTCOMES OR RECOMMENDATIONS	Data collection & analysis; research and evaluation; 2009/10 Housing First program to house and support 500 homeless individuals – budget for administration, furniture bank and outreach/ support team		

TABLE 4.5
HOUSING FIRST — ANNUAL SERVICE PLAN,
HOMEWARD TRUST EDMONTON, 2010/2011

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
All individuals/families who are homeless in Edmonton and meet the criteria of Housing First	Since start of Housing First in Edmonton in 2009, almost 900 people were housed in safe, permanent and affordable housing. Housing assistance – landlords and property managers in agreement with Housing First; rental A assistance program successfully launched; furniture bank effectively met needs of clients Youth Housing First team – interim housing for youth and young men in high risk activities was funded but project did not proceed in 2009/10	First year was a learning experience – change management and learning Housing First priorities; flexibility of support workers to respond quickly to situations was critical; critical intervention outreach teams; Housing First workers need the tools and orientation to the program – ongoing training and technical support will be provided to the Housing First teams to enable effective case management; interaction and collaboration amongst the team leads is critical; access at intake stage was a bottleneck as demand is greater than supply of services. Homeward Trust will initiate a coordinated intake process to address potential clients	Housing First model
OUTCOMES OR RECOMMENDATIONS	Model has proven to be effective and efficient. Commitment to meet targets and outcomes: 1. Improved intake processes for outreach and program access 2. Focus on sub-populations with unique service needs 3. Continued improvement in service delivery and evaluating client progress 4. Services to support transition to greater independence 5. Implementation of strategies in support of provincial and municipal 10-year plans		

TABLE 4.6
PERSPECTIVES ON THE HOUSING FIRST PROGRAM WITH INDIGENOUS PARTICIPANTS,
BODOR, CHEWKA, SMITH-WINDSOR, CONLEY & PEREIRA,
BLUE QUILLS FIRST NATIONS COLLEGE, 2011

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
Aboriginal homeless people	Indigenous Housing First program and program staff learnings	Relational and therapeutic supports; trauma resources; indigenous staffing issues; staff training	Housing First program model and principles; circle process; storytelling
OUTCOMES OR RECOMMENDATIONS	Indigenous Housing First program learnings: formalizing structures, staffing and processes to assist participants, including staff and clients, with Indigenous identify development; Homeward Trust organizational learnings; broader policy and research		

TABLE 4.7

BOYLE MCCAULEY HEALTH CENTRE —PATHWAYS TO HOUSING EDMONTON,
ANNUAL PROGRAM REPORT, 2011-2012

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
People who have severe mental illness and who are both chronically and currently homeless	Market housing rental rates are increasing which places a pressure on new admissions and lease renewals – this is a larger community issue	Assertive Community Treatment (ACT) team delivers recovery services; ACT teams are multidisciplinary, available 24/7 and provide outreach to clients in the community	Housing First model – Pathways to Housing is committed to harm reduction, client-centered care, housing as a basic human right and a recovery orientation; ACT is most effective and cost-effective treatment approach for persons with severe mental illnesses
OUTCOMES OR RECOMMENDATIONS	Model highly effective at improving outcomes for clients and decreasing the use of local institutions such as hospitals and jails. Pathways to Housing program has served 70 clients, 87% of its 80 client capacity. It has been recognized that some individuals do not have the cognitive capacity to live independently. In partnership with Homeward Trust Edmonton, the Homeless Commission, The City of Edmonton and Alberta Health Services will be used in developing a systemic plan.		

TABLE 4.8

PATHWAYS TO HOUSING – EDMONTON: A HOMELESSNESS HOUSING INITIATIVE, PHASE II – FINAL REPORT,
SUROOD, MCNEIL, CRISTALL, GODBOUT AT ALBERTA HEALTH SERVICES, 2012

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
Individuals with very serious, severe, persistent and multiple problems in their health and living situations; individuals with physical and mental illnesses, ongoing comorbid health conditions, psychosocial problems, drug and alcohol problems, have been hospitalized or incarcerated within the last year, have experienced chronic and absolute homelessness for an average of six years, have lower levels of education, are unemployed, and on income assistance	Continuum of housing is discussed but with the emphasis on getting people to prepare for moving into permanent affordable housing wherever possible	Treatment for mental and physical health problems and/or addiction issues; provide comprehensive services through Boyle McCauley Health Centre in Edmonton	Based on Housing First Model
OUTCOMES OR RECOMMENDATIONS	At 12 months, provision of a home provided improvement in living conditions, work and leisure activities and overall total health outcomes		

TABLE 4.9

UNDERSTANDING TENANCY FAILURES AND SUCCESSES,
EDMONTON SOCIAL PLANNING COUNCIL AND EDMONTON COALITION ON HOUSING AND HOMELESSNESS, 2012

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
All people who are homeless	Examining reasons for tenancy failures, including inability to afford rent or accommodation; housing requires references which may be a challenge for some with a criminal history; housing is unsafe or unfit to live in; losing housing due to health conditions or conflicts with landlords/tenants or inability to manage finances or other aspects of daily living	Recognition that some tenants will need various supports on an indefinite basis	Housing First approach; working with landlords who wish to support their tenants; involved in study: eight focus groups of 105 homeless, formerly homeless and vulnerably housed persons; 87 online survey responses from providers, policy makers and landlords
OUTCOMES OR RECOMMENDATIONS	Person with high life challenges as addictions or mental illness are more likely to experience tenancy failure; 95% tenancy success rate with non-Housing First but an 80% tenancy success rate for Housing First clients		

TABLE 4.10

EDMONTON, ALBERTA: NIKIHK HOUSING FIRST/HOMEWARD TRUST
FIONA SCOTT, HOMELESS HUB, 2013

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
Focuses on Aboriginal people in Edmonton	Housing is one part of program; housing availability; cost of repairing units; rent supplements	Access to support location; coordinated access and intake; sssessment and acuity matching; address complexity of client needs; addressing other housing-related needs – furniture; all agencies integrate culture into Housing First program; create an inclusive governance structure to address needs of sub-populations; collaboration, partnerships	Housing First in Canada model; ongoing review and evaluation; sustainability; education and training on Aboriginal issues
OUTCOMES OR RECOMMENDATIONS	Aboriginal team is one part of solution to end Aboriginal homelessness; context matters in governance; transformative role of education and teachings; targets set to assess reduction of a sub-population's homelessness		

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TABLE 4.11
2013 ANNUAL REPORT
HOMEWARD TRUST EDMONTON, 2013

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
All people who are homeless; focus on Aboriginal people	>2800 people in safe shelter; opening of Hope Mission's Green Manor (52 new housing units); NOVA provides transitional housing for 19 at-risk youth (through John Howard Society); Homeward Trust created 24/7 permanent supportive housing referral review placement committee to route most vulnerable and those with many barriers; funded 18 new permanent supportive housing units; interim housing; Boyle Street Community Services Winter Warming Bus; renovations to E4C WEAC, Hope Mission Place & Salvation Army Cornerstone	Foyer program implemented for at-risk youth – access to resources for employment, education & life skills; MAP 24/7 Project – expand coordinated access; increased spectrum of services, as training, employment and education for youth; rental assistance and graduate rental assistance initiative; NOVA targets landlord relations, persons with developmental disabilities and property management	Systems planning; "everyone deserves a home" – Homeward Trust's Housing First philosophy; project review committee – provides advice on funding; Aboriginal Advisory Committee; community plan committee with >20 stakeholder groups – recommending and monitoring community plan on housing & supports
OUTCOMES OR RECOMMENDATIONS	Funds raised for Raising the Roof – 1,268 toques sold - $16,350 raised; First Annual Homeward Walk Run; research on the intergenerational impact of colonialism and Aboriginal Homelessness in Edmonton; homeless management information system		

TABLE 4.12
INTENSIVE CASE MANAGEMENT CONSIDERATIONS TO IMPROVE HOUSING STABILITY AMONGST WOMEN INVOLVED IN HIGH RISK AND/OR EXPLOITIVE SITUATIONS,
ORG CODE CONSULTING, INC. & E4C. EDMONTON, 2013

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
Women who are homeless and involved with sex work, substance use and trauma; chronically homeless women with multiple barriers, including mental illness, trauma, high-risk behaviors	E4C housing program supporting women experiencing chronic homelessness and sexual exploitation	Supports targeted to this population of women; intensive case management approach	Housing First approach
OUTCOMES OR RECOMMENDATIONS	Significant findings: study participants have high needs and experienced chronic homelessness; substance use identified as trigger for homelessness; intensive case management service delivery approach is effective; harm reduction philosophy helps women remain housed; being housed had positive impacts on women's quality of life and well-being and on service utilization; women desire to offer and/or receive support with other women with similar experiences; women need subsidy for rent; E4C clients continue to face discrimination from service providers		

TABLE 4.13
WINTER EMERGENCY RESPONSE,
HOMEWARD TRUST, 2013-2014

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
All people who are homeless; service providers for referrals	This is an inventory of all locations in Edmonton prepared to provide emergency shelter during extreme winter conditions		Shelter response program for city

TABLE 4.14

A PLACE TO CALL HOME – EDMONTON'S 10 YEAR PLAN TO END HOMELESSNESS: UPDATE YEAR 5
HOMELESS COMMISSION, 2014

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
All people who are homeless; chronically homeless in Edmonton	Permanent homes; scattered housing approach in neighborhoods outside of inner city; permanent supportive housing; rapid re-housing	Intensive case management; assertive community treatment; specialized referral outreach services – 24/7 outreach services; Government of Alberta funding for support services	Housing First; Housing First teams
OUTCOMES OR RECOMMENDATIONS	***Challenges:*** capacity to accommodate in-migration; permanent supportive housing to accommodate those who will never live independently; graduating Housing First reasonable for some but not all – some qualify for the Graduation Rental Assistance Initiative Program; shortage of affordable housing and high rents; lack of prevention; NIMBYs. ***Successes:*** Housing First teams do intensive case management; other supports and outreach; develop Aboriginal capacity; create a housing link to connect people to crises housing 24/7; rental supplement program is being enhanced; provincial income supports; progress continually measured		

TABLE 4.15

EDMONTON AREA COMMUNITY PLAN ON HOUSING AND SUPPORTS:
EDMONTON COMMUNITY PLAN COMMITTEE; 2011–2015

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
All people living in homelessness or who are vulnerable; broad community consultation and involvement in plan development	Housing supply; short-term and permanent supportive housing; home-ownership and equity building; supply of market and non-market rental units; existing stock of housing; future developments; interim and permanent supportive housing; address access issues	Support services – information, resources and access points; coordinated approach; access to treatment, continuing care and managed transition from institutional care; culturally appropriate support services for Aboriginal population; prevention and early intervention – coordinate outreach services, remove barriers, promote knowledge sharing	Plan supports and complements many of the regional, provincial and federal plans (i.e. linkages between community plan and 10-year plans to end homelessness, Alberta's Addiction, and Mental Health Strategy and Homelessness Partnering Strategy Edmonton Priorities); move from continuum to framework

TABLE 4.16

WELCOME HOME PROGRAM, CATHOLIC SOCIAL SERVICES (2015),
*LOCATED ON HOMELESS COMMISSION WEBSITE**

POPULATIONS IDENTIFIED/ TARGETED	ISSUES OR IDENTIFIED RESULTS FOR DETERMINANTS OF HOMELESSNESS		APPROACHES DESCRIBED TO ADDRESS NEEDS & GAPS
	HOUSING	NON-HOUSING	
All people who are homeless	This program matches community volunteers with newly housed Edmontonians with the intent of welcoming them into their new communities, showing them around and ensuring that they have the companionship they need to feel at home; some clients require re-housing; rental assistance was not available; rental market was getting difficult with no flexibility	Volunteers are matched to newly housed Edmontonians to provide companionship and assistance, as per case management. It must be anticipated that some clients need support services longer than anticipated and some do not graduate from support services	Various programs are mentioned.
OUTCOMES OR RECOMMENDATIONS	Program has matched 33 newly housed individuals with community volunteers; barriers identified – keeping up with demand, sustainability of Housing First graduates, tightening of the rental market, providing permanent supportive housing and prevention		

→

* http://homelesscommission.org/index.php/newsevents/9-updates/89-welcome-home-program-sees-results

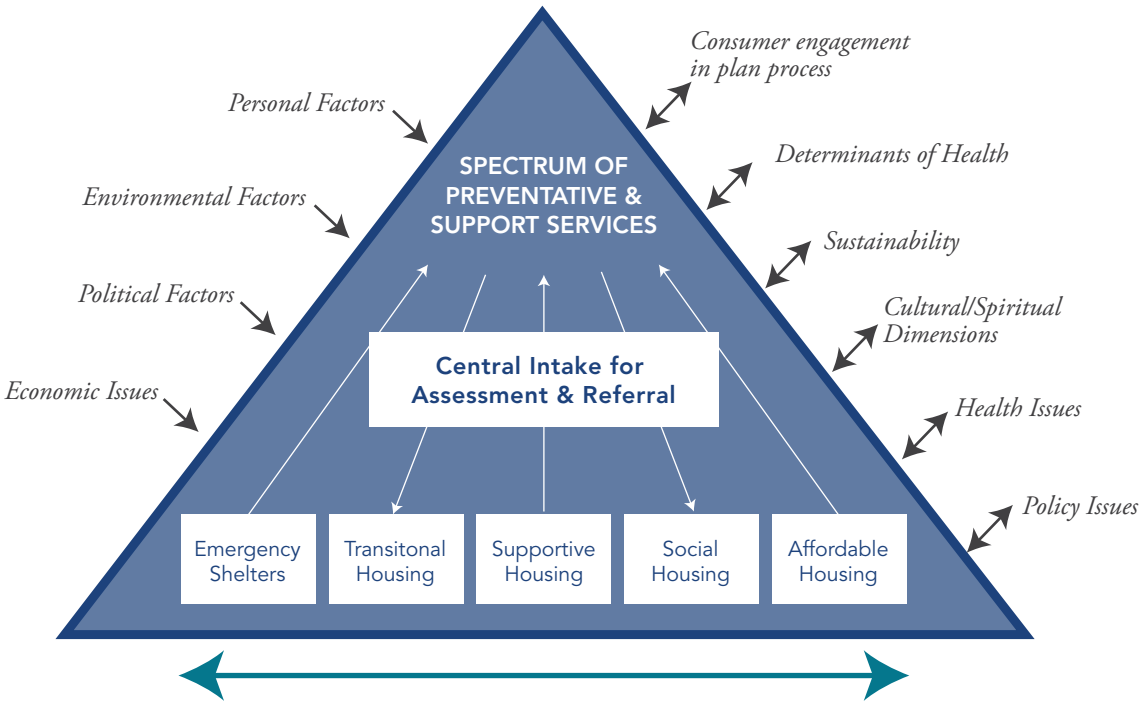
RESULTS

2005 Study Results

The 12 diverse focus groups identified a number of common issues or concerns, challenges, gaps and needs related to services

The 12 diverse focus groups identified a number of common issues or concerns, challenges, gaps and needs related to services, including housing and improvements needed in housing and support services. Across the 12 focus groups, thematic analysis revealed seven themes: housing (emergency, transitional, long-term supportive, social, affordable), prevention, communication and awareness, regulation and policy, capacity building/coordination/partnerships, support services and research and advocacy. Details of subthemes, specifically the needs identified by the groups for each theme, are provided in Table 1. A total of 70 recommendations were also identified – 10 general ones, 21 housing related and the remainder for non-housing considerations, including five recommendations for capacity building/coordination/partnerships and six for support services (Gordon & Kovacs Burns, 2005).

FIGURE 1 *Continuum of Housing and Spectrum of Preventative and Support Services with Central Intake and Consideration of One- and Two-way Influencing Factors*



Housing Themes

Based on the dialogue with all groups, there was general agreement regarding a number of identified issues related to the needs of targeted populations and recommendations. One general agreement was that "there can never be one package of housing and support services that will meet the needs of all low-income or homeless people" (Community Service Provider). Although there were common housing and supports identified as being needed for all targeted populations, each diverse focus group also identified some specific or unique needs for targeted populations that had to be considered. For example, seniors with complex health needs and some experiencing abuse as well as with fixed or very low income, would have different housing, support and health needs compared with youth or Aboriginal people or immigrant families. Specific discussion of focus groups regarding different needs for different populations centered on the need for a "continuum of housing and support services," (focus group Participants) such as depicted in Figure 1, so individuals and families who were vulnerable to becoming homeless or those who were homeless would have their specific needs identified and management would be tailored to address their needs. This included the perspectives of the majority of homeless people participating in the focus groups who had a goal to get out of homelessness and become independent.

Participants, whether those who were homeless or service providers, described their experiences with one or all of the housing types in Edmonton – emergency shelters, transitional, supportive, social and affordable housing. There was agreement amongst the 12 focus group participants that services need to be appropriate to the needs of individuals and sensitive to their language and cultural backgrounds. Generally, participants from the 12 groups also agreed that this included the need for sustainable funding for housing and community health and support services, and that service providers should be appropriately trained around homelessness and its determinants as well as be aware of what community services for both managing homelessness and preventing it existed other than their own programs. Services within the community were viewed by all participants as being fragmented and difficult to navigate. Participants preferred to have a coordinated centralized system of housing and support services access and follow up. They wanted case management to help each individual or family to access appropriate services more easily, to transition as appropriate and to be assisted as needed towards gaining independence. Safe and non-threatening supports, transportation, respite services, health and home care services were identified as desirable by all groups in order to enable easier follow up and transitioning for anyone experiencing homelessness for any length of time. Visually, these needs and coordination are depicted in Figure 1.

There was general agreement among the 12 focus groups that governments needed to be more coordinated with community planning, particularly if these plans were linked to funding. More specifically, they supported a national housing program or strategy, including sustainable funding. Speaking out in the various focus groups were service providers who agreed with a new model approach to managing individuals/families in need, case by case, but felt that they had neither the capacity nor funding to support this transformation. As well, decision makers said that they wanted more evidence about service utilization rates across housing and support services and cost effectiveness measures through which to assess whether an integrated service model would be more cost effective and sustainable to fund. Service providers and decision makers recommended more focused research or evaluation of housing programs and services and their effectiveness in meeting the needs of specific population groups. In addition they also suggested more policy research to determine outcomes value related to costs and cost-effectiveness of programs in existence.

Looking specifically at housing issues or needs or recommendations related to the targeted populations, additional experiences and perspectives of the 12

focus groups were captured. In the youth focus group, participants between the ages of 16 to 25 who were at risk or homeless identified issues they faced. They spoke of the many youth who came to Alberta for work who were high school dropouts, some with addiction issues, all of which complicated their situation for finding work, accommodation and obtaining other living essentials. Once on the street, these youth did not know where to go or who to trust for help or support. Rules, regulations and expectations became barriers for youth to access shelters or housing and support services, but support services and counselling were required in order for them to qualify for social assistance. The solution identified by youth participants in the focus group was the implementation of a continuum of housing and various support services, including case management and a semi-independent living program to assist youth in finishing school or finding work. In the families focus group, homeless participants who were either from small Aboriginal or large extended immigrant families identified complex issues, starting with being put up in hotels rather than appropriate family-oriented accommodations by provincial and municipal social assistance and family support systems. No shelter facility existed for families in need. Cultural and language sensitivity were two major issues identified by one family participant in the focus group discussions. "Families with different issues and needs will require different types of housing and supports for varying lengths of time" (Family Group Participant). For example, accessing food banks was seen as a necessity when most of a family's income would have to be used to pay for housing.

People with addictions also identified their issues being homeless or at risk of homelessness. Some were waiting for treatment and others wanted housing but not the treatment. Many shelters in the community did not accept individuals who were drinking or using drugs at the time of entry. This inflexible structure was viewed as prohibitive for some people to access shelters, treatment programs or other supports. Harm reduction programs were available but having safe flexible shelters or housing to assist people with addictions to stay sober were also needed. As well, people experiencing mental illness or a dual diagnosis of mental illness and addictions identified additional discrimination issues with regard to getting employment or renting. If they had rental accommodation, they ran the risk of losing their place if they were institutionalized (e.g. in hospitals or prisons). People with disabilities and seniors revealed some similar issues with regard to having low income and trying to find affordable housing. People with disabilities, living on minimum income or social supports felt they were always at risk of becoming homeless. The programs that provided their disability funding did not allow individuals to share accommodation, which added to the frustration for these individuals. Seniors with fixed or no income said that the costs associated with private supportive living facilities in communities were prohibitive for them. Subsidized facilities had long waiting lists. If seniors had behavioral problems or had been abused by family, they experienced more difficulty finding shelters or accommodation with the support services they needed. Victims of family violence, particularly women with or without children, were another group experiencing challenges to get into safe shelters which were always overbooked. Many needed subsidized housing when they were ready to leave shelters or transitional housing. Aboriginal people, singles and families identified many issues, including insufficient income support, lack of subsidized housing and discrimination related to employment, renting and accessing services they needed. Cultural sensitivity, as in service providers and programs/services incorporating the Aboriginal culture and respect for Aboriginal traditions and language, was noted as being absent in most services except those provided by Aboriginal organizations such as Native Friendship Centres. The group also felt that the Aboriginal people and organizations needed to work together better in supporting their own people. It would also help if more service providers had Aboriginal staff.

Non-housing Themes

A number of key priority non-housing or support issues and gaps were identified during the 12 focus groups and contributed to some key recommendations. Regarding preventive initiatives, participants suggested that changes were needed in housing and support programs and strategies to prevent people from either being at risk of homelessness or assist people to exit and stay out of homelessness. Changes identified included in-house and community support services and improved practices within communities (i.e. preventing ghettoization and gentrification) and within the private sector (i.e. improved understanding and decreased discrimination). However, the challenge they identified was that governments needed to be convinced that preventive measures would result in reduced expenses.

Participants also indicated a need for more communication and awareness about homelessness and its costs to individuals and society. The whole community needed to be part of the solution to end homelessness by addressing issues pertaining to ghettoization, gentrification, Not-in-my-back-yard attitude (NIMBYism) and poor collaboration among private or nonprofit sectors and the levels of government. In addition, focus group participants felt that all levels of government needed to focus more on relevant policies or strategies to support initiatives to prevent and end homelessness. A national housing policy was viewed as critical to resolving homelessness. More relevant research and advocacy would provide the evidence to support or inform such policies and push governments to make changes in existing policies regarding housing and support strategies. The different participants in focus groups (people who were homeless, service providers and decision makers) recommended capacity building initiatives (ensuring sustained funding for housing and supports, having trained community staff in services/programs and specific resources for Aboriginal programs), the development of a practical housing and support continuum such as illustrated in Figure 1, and an effort to coordinate various stakeholders and partnerships for funding.

2009 Project Results

This follow-up project reflected on the themes and findings of the 2005 study report. From the analysis of the 29 diverse interviews with people who were homeless, service providers and decision makers and the three focus groups which validated the interview findings, seven themes were identified:

- Primary issue: living in poverty;
- Client service process and outcomes: case management;
- Unspoken agreements:
- Client-driven services and team-driven needs;
- System gaps and impacts;
- Common goals and
- Daily challenges for survival.

These themes are described in more detail in Table 2.

These themes and differences of opinion were validated in the focus group/dialogue sessions which revealed challenges people faced accessing various services, including health care facilities (other than the inner city health care centre) and social services. The summarized highlights of the focus group/dialogue sessions are provided in Table 3.

In answer to the question of what low income and homeless people wanted from the services they accessed, the majority of participants indicated that they wanted a place to go where they were not judged or insulted and where they could get what they needed to survive. Some looked for friendship as well. They liked going to the same places where there were people they could trust. The sense of community was important.

People we interviewed acknowledged that the process of locating and accessing services was complex. In addition, some service providers were not willing to help low income or homeless individuals beyond their own service mandates. Participants connected this limited scope of service provision to community service providers having issues with integrated services. Many service providers interpreted integration as the merging of services and agencies to provide broader more encompassing services and included possible elimination of one or more community service agencies from receiving government funding (Kovacs Burns, 2007). Participants discussed the term 'case management' and preferred 'navigation through the system.' Service providers provided people with directions to all types of services but most interviewed participants explained that they just wanted somewhere safe to go for food or shelter, or talking with friends or people they trusted. Often people would get their advice from other low income or homeless people who had gone through similar experiences.

For case management to be effective as a delivery model, participants generally felt that care and services need to be integrated, providing and coordinating care and support across a service continuum, such as illustrated in Figure 1. Sustainable funding is needed for this, separate from agency-specific funding.

2009 to 2015 Document Study

Sixteen documents were screened for their focus on housing and support practices as follow-up from the 2009 study and in alignment with findings from both the 2005 and 2009 studies. Table 4 captures the key points from the document content analysis focusing on the population proposed to benefit from the programs, the issues and results for housing and non-housing determinants of homelessness, approaches or strategies implemented to address issues and needs, and outcomes (including benefits, successes and challenges) as well as recommendations.

All 16 reports identified and numbered chronologically in Table 4 included housing and non-housing determinants of homelessness issues, approaches and outcomes. Following the initiation of *Edmonton's 10-year Plan to End Homelessness* (Edmonton Committee to End Homelessness, 2009), which is Document 1 in Table 4, followed by the development and implementation of *Edmonton's Housing First Plan, 2009/10* (Document 3 in Table 4), it is not surprising that the majority of documents (11 of 16) made specific mention to the Housing First approach, model, plan and principles. Of these 11, six focused on all people who were homeless and specifically chronically homeless (Documents 1, 4, 5, 9, 11 and 14). The other five focused on specific groups – Aboriginal people, people who had severe mental illness and/or other multiple health or drug and alcohol addiction issues, incarcerated individuals, and women involved with sex work, substance use, trauma and other high-risk behaviors. Of the five documents that did not mention Housing First, three described specific plans or approaches for addressing or managing homelessness – a community plan (Ddocument 15 – 2011–2015) , a 'people plan' (Document 2 – 2009) and a systems plan (Document 11 – 2013) . All three provided a broad look at community agencies serving disadvantaged Edmontonians regardless of age, health or other status. Stakeholder consultations were conducted and described as part of their planning approaches, providing perspectives of various individuals/families who were homeless as well as service providers within the community. Of the other documents, one (Document 3 – 2009) described a strategic service plan for seniors, including stakeholder responses to access, issues, challenges/barriers and needs, as well as suggestions. Unlike other documents, Document 16 described a very specific approach to matching community volunteers with newly housed Edmontonians with the intent of providing companionship and case management related to issues or needs (Welcome Home Program). This program report contained stories from individuals and families with positive outcomes resulting from the housing and supports they received. Challenges were also identified.

Each of the 16 documents described housing-related issues for the time frame in which the document was written, or housing and support approaches provided to either general homeless or specific targeted populations. For example, for the 11 reports discussing or referencing Housing First, the housing component was developed around permanent affordable housing. Some alluded to having a choice of housing, as not all individuals selected for a Housing First opportunity were able to sustain their independence and needed more assistance. In addition to the availability of affordable housing stock, there was mention of rental assistance programs (Document 5 – 2010/2011) or the need for them as well as home and maintenance services.

Regarding non-housing services and supports, reports on Housing First approaches included services and supports as part of the program or model. Keywords like integration, collaboration and cooperation were used in their descriptions of successful housing and support interventions for people who were homeless (Document 5). Some reports mentioned case management, including intensive case management. Staff and outreach teams were identified as having

deficiencies in understanding Housing First or applying its practices and principles, particularly with Aboriginal people (Document 6 – 2011). Ongoing training and technical support was seen as critical for outreach teams and frontline service providers.

As the Housing First strategy focused on chronically homeless individuals and families, most reports were about managing homelessness through housing and supports. Prevention was not mentioned after it was introduced in the 2009 *A Place to Call Home: Edmonton's 10-year Plan to End Homelessness* (Document 1). Nothing more about prevention appeared in reports until the 2011 – 2015 community plan on housing and supports (Document 15), and specifically with the provision of preventative and early interventions through coordinated outreach services, removal of barriers and promotion of knowledge sharing. More focus on prevention to complement ending homelessness was found in the 2014 documents.

Within the first two years (between 2009 and 2011) of the implementation of the Housing First strategy as part of the 10-year plan to end homelessness, early successes were mentioned such as those individuals who were successful transitioning from being homeless to being housed and were ready for their independent-living journey. Other documents from 2009 to 2012 reflected on the implementation of Housing First or related programs and the identification of gaps or needs regarding housing, different types of support, health services, transportation and income to help sustain the independence of those who transitioned into housing during these early years of Housing First. Documents in 2011 indicated commitment to meet targets and outcomes based on some successes with improved intake processes for outreach and program access as well as with follow-through regarding service delivery and supports for those in transition. Also at this time, Aboriginal Housing First programs were proposed with the changes in approach needed, including the 'circle process' and storytelling as part of cultural consideration, as well as more formalized structured support to assist individuals and families in their transition into permanent affordable housing. Further evaluation of Aboriginal Housing First was documented in 2013 (Document 10) – this report discussed the value of Aboriginal teams but emphasized the need to focus on the complexity of Aboriginal individuals and families and the need to integrate traditional Aboriginal culture into all Housing First programs.

By 2013, documents clearly identified the challenges experienced with the rapid implementation of Housing First (Document 14), including sustaining tenancy within the program. The 80% tenancy failure rate was acknowledged and explained (e.g. inability to afford rent, health conditions and conflicts between tenant and landlord), as the plan was to use these findings to guide changes in the program and improve tenancy experiences and rates. In the *2013 Annual Report* (Document 11), mention was made of changes needed and made, including targeted assistance with 24/7 permanent supportive housing, a spectrum of other support services and levels of case management to meet various needs, including for youth, people with disabilities, women involved in sex work, people experiencing violence and/or Aboriginal people. By 2014, which was year five of the 10-year plan to end homelessness, permanent housing was scattered in neighborhoods outside of the inner city, and some were set up to be permanent supportive housing. Supports were offered 24/7 and rental supplement programs were being enhanced to address some tenancy failures. Even still, challenges were identified in terms of housing shortages, high rents, NIMBYism and lack of prevention. Successful outcomes cited by the report include building Aboriginal community capacity and providing income supports.

Discussion and Conclusion

In this case study of one Canadian city, Edmonton, Alberta, a systems lens was applied in the description and analysis of three projects spanning 10 years from 2005 to 2015 and focusing on the determinants of homelessness and the outcomes (i.e. successes, benefits, challenges and barriers, as well as failures) related to various programs and strategies implemented to manage and/or prevent homelessness. The three projects in this case study provide the experiences of individuals and families who were at risk of becoming homeless or were homeless (micro level), community housing and service providers (macro level) and government decision makers (macro level) over the 10-year span. The case study, based on the findings of the three projects, provides answers to our study questions.

The three projects in this case study provide the experiences of individuals and families who were at risk of becoming homeless or were homeless

A chronological description of the micro, meso and macro system experiences acquired in projects conducted in 2005, 2009 and from 2009 to 2015 confirmed that gaps identified in 2005 and 2009, as in understanding the determinants of homelessness, in integrating and coordinating a continuum of housing and support services as a community or city response and in implementing case management and navigation approaches (Figure 1), went unheeded until a plan to end homelessness in 10 years was implemented in 2009. Through this plan, the documented changes from 2009 to 2015 involving programs, services and strategies such as Housing First illustrate the favourable outcomes for people who were chronically homeless and the advantages of a structured systems approach to managing homelessness. Limitations and challenges at micro, meso and macro levels concerning Housing First and related strategies are acknowledged for the system to address. There has been a change in attitude and practices concerning the intent to end and prevent homelessness over the past decade.

Based on the rising homeless counts and associated direct and indirect costs of poverty and homelessness identified in Edmonton before 2009 (Homeward Trust, 2014), community service providers and decision makers could see that the approaches they had implemented and funded up to that point in time had not worked to address the determinants of homelessness and move people out of homelessness. Prevention did not exist. The community and decision makers recognized that they had to become more proactive in their approaches and more aggressive in implementing structured or coordinated housing and supports (Burt et al., 2004), including case management and making it easier for people experiencing homelessness to access needed services, as illustrated in Figure 1.

Housing First as a strategy was viewed as this structured systems approach to manage the determinants of homelessness and end homelessness. The first two studies explored in this chapter (conducted in 2005 and 2009) also indicated the need for something very similar to the Housing First approach but focused generally on all individuals and families in need as opposed to only those who were chronically homeless. The community participants identified the key components of solving some of the homelessness issues and addressing the determinants of homelessness and needs of homeless people in Edmonton, as seen in the summary of themes in Tables 1, 2 and 3. These summaries reflected the majority of the Housing First principles and philosophies. Participants in the 12 diverse dialogue/focus groups in the 2005 project had the broad-based experience to be able to describe what the community needed in the way of a structured systems approach to housing and support services access (deVet et al., 2013; Neale et al., 2012; Stergiopoulos et al, 2007), delivery/implementation and follow-up. Among the many things they identified in Table 1, Housing First was favoured but they also suggested some choice in a continuum of housing and support services to better meet the needs of the diverse homeless population. Visually, this continuum, as confirmed by participating stakeholders, was depicted as shown in Figure 1. They suggested having a central intake to coordinate the access and pathway of care and support for individuals and families, and case management appropriate for the needs of families and individuals who were seniors, youth and students, singles, Aboriginal people, immigrants, people who were deinstitutionalized, persons with disabilities, persons with mental health issues and/or addictions and victims of family violence (Lloyd & Wait, 2005).

With the Government of Alberta's introduction of its 10-year plan to end homelessness, there needed to be a rapid shift in thinking and planning around the Housing First principles which fit with what was needed, particularly for those who were chronically homeless (The Alberta Secretariat for Action on Homelessness, 2008). It was a systems approach aimed at coordinating and integrating services in the community and connecting the micro (individuals/families who were chronically homeless), meso (service providers) and macro (decision makers) levels to be part of the process and outcomes.

To deliver this kind of program, the community service providers identified the need for a total systems change with processes (Burt & Spellman, 20007), including stable funding and decision makers needing to develop appropriate housing programs or policies, perhaps a national housing strategy and preventive components. They also wanted to see prevention approaches (Burt et al., 2005; Culhane et al., 2011). But none of these suggestions were implemented in Edmonton prior to 2009 by any of the decision makers, although the ongoing community recommendations were focused on these changes.

The 2009 project clearly still showed the lack of uptake of Housing First approaches as community service providers and decision makers were still at odds about integrated collaborative services, central intake or case management (Kovacs Burns, 2007). The community was not prepared for a systems approach such as Housing First. Services were still operating with fragmented approaches as their funding by decision makers was based on annual funding proposals with stipulations for each service provider. Integrated service delivery was not funded. People who were homeless were still frustrated with finding and accessing the services they needed. A systems approach was not recognized although governments had plans. There were many challenges and barriers to overcome (Pawson et al., 2007).

Documents between 2009 and 2015 confirmed many of the experiences and perceptions gathered in the 2005 and 2009 studies. There were clear issues and challenges in managing the determinants of homelessness for chronically homeless people, particularly if they also were from targeted populations facing other priorities and challenges – e.g. Aboriginal people, seniors, youth, immigrants and women. The document content analysis provided an overview of further progress

made with Housing First implementation. Housing First took a few years to become established and results also took a while to indicate if the process was effective and efficient. Although it was shown to be an effective and efficient model for some individuals and families, it was also found to not be a solution for everyone as tenancy failure was identified (Edmonton Social Planning Council, 2012; Homeless Commission, 2014). By 2014, those delivering Housing First learned from the early challenges identified and were able to make changes. Eventual successes included enhanced housing and support initiatives with rental supplements, income supports, intensive case management teams and Aboriginal capacity development. Other challenges emerged that needed to be addressed, including the shortage of affordable housing, ongoing discrimination and NIMBYism, higher migration numbers and high rents.

Since the completion of the document content analysis, Homeward Trust Edmonton released its 2014 annual report entitled *Moving*. It is not included in the document content analysis but mentioned here specifically because it highlights some key changes in the management of homelessness. Highlights of this report include a 27% reduction in Edmonton's homeless numbers; an increase in specialized staff on the Housing First team to focus on the complex needs of homeless families; the opening of a permanent supportive housing program for First Nations; increased capacity for high-risk youth; re-opening of a facility to accommodate immigrant women and children escaping domestic violence and human trafficking; expansion of rapid rehousing and intensive case management teams; and opening of permanent supportive housing units for individuals with severe or persistent mental illness who are at risk of homelessness.

In conclusion, the case study illustrates the challenges Edmonton's community members experienced in managing homelessness and its adaptation to managing homelessness with the onset of the Housing First strategy. Prior to and at the start of Housing First, there was far more uncertainty about managing the homelessness situation in the community as counts continued to rise and ad hoc approaches delivering fragmented care and services were proving ineffective. The community identified the need for system-wide changes to address the determinants of homelessness and health. This included what they described as a continuum of housing and supports with centralized follow-up as in navigation assistance or case management. Figure 1 depicts the authors' interpretation of the community members' feedback. Housing First is a good fit with Figure 1 as it has provided the much needed structure and follow-through for individuals/families who were chronically homeless and for whom the determinants of homelessness signaled the need for the type of intervention provided by Housing First. The question remains as to what housing and supports will need to be sustained as part of the ongoing continuum to manage the determinants of homelessness of those who are not chronically homeless and to thus completely manage and/or prevent homelessness. To achieve the goal to end homelessness by 2019, the ongoing evaluation and learnings from Housing First initiatives (Homeward Trust Edmonton, 2015) will enable a better understanding of the determinants of homelessness and better management options for individuals and families who are homeless and more preventive interventions for those at risk.

Recommendations

Housing First as implemented in Edmonton starting in 2009 demonstrates a systems response, with both successes and challenges. It unfortunately took a decade for one city to make changes similar to Housing First that the community identified as needed in 2005. As hindsight would suggest, following a 'people first' or 'community first' approach and listening to the people affected by homelessness in the community as they identified their needs and gaps, might have resulted in earlier system-wide implementation of Housing First and immense cost savings.

Not only is a housing and homelessness evaluation strategy necessary, but so is a research strategy (Felix-Mah et al., 2014)

One key challenge remains for the system approach to be more comprehensive in ending homelessness, and that is to expand the strategy for all people who are homeless or at risk, which includes incorporating or integrating the prevention component into Housing First. As long as the door into homelessness is not blocked and people are not prevented from becoming homeless, ending homelessness will not become a reality.

Although progress has been shown in building Aboriginal capacity regarding Housing First, this systems model needs to be reflective of a dual-systems approach with consideration of not only the City of Edmonton but also Indigenous people (Bodor et al., 2011). Special adaptations in programs and services to include more coordinated assessments and a continuum of supportive and mainstream housing also needs to be extended to other vulnerable populations (youth ages 13 to 24, women and families, persons with disabilities and immigrants, refugees and migrants) (CSH, 2015).

Further monitoring and evaluation of all aspects of Housing First in Edmonton is needed to measure the successes and challenges of Housing First and the 10-year plan to end homelessness, at least for those who have been chronically homeless. Indicators have been identified (Pauly et al., 2012) which could be piloted in evaluation strategies with Homeless First initiatives. These could serve as benchmark indicators and provide a baseline of data from which to establish grounds for support or change.

Not only is a housing and homelessness evaluation strategy necessary, but so is a research strategy (Felix-Mah et al., 2014), both to inform housing policies and poverty strategies in Alberta. This case study presents several other lessons for research with urban and rural communities. For example, the community-based participatory research approach is preferred and includes the direct involvement of key stakeholders in the design, development and implementation of the research study within the community – by the community, for the community (Bennett & Roberts, 2004). The participation of low income and homeless individuals and families is inclusionary and has resulted in findings confirmed by Housing First principles. The dialogue sessions stimulated discussion about the real world challenges faced by people who are homeless and service providers, and about why communities need to be engaged in system-wide decisions. Further studies are needed to explore changes in community experiences with Housing First and for those not eligible for this initiative.

Just as the Canadian Housing First Toolkit (Polvere et al., 2014) will be useful for communities to develop their systems approach for their community, a mapping of the city's progress over 10 or 20 years can provide evidence of what has or has not worked, of challenges and success benchmarks, all of which could be used to inform what policies or strategies as well as what funding should be considered when aiming for community transformation. This mapping would also be useful for presenting the value of a systems approach with a continuum of housing and supports as well as case management for not only addressing homelessness but also other social, health and education issues which are the determinants of homelessness and health.

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Inter-sectoral Collaborations

3.3

HOMELESS IN, HOMELESS OUT AND HOMELESS ZERO USING SYSTEM DYNAMICS TO HELP END HOMELESSNESS

Robbie BRYDON

If you understand the dynamics of stocks and flows – their behavior over time – you understand a good deal about the behavior of complex systems.
– Donella Meadows (2009: 19)

How many people do you have to house to end homelessness? To answer that question, we have to answer three related questions: How many people are presently homeless? At what rate are people becoming homeless? And, importantly, how long will it take?

This paper develops a method for analyzing flows into and out of homelessness that will allow users to see where investments need to be targeted and what level of resource is required to end homelessness within their community over a given time frame. Edmonton will be used as a case study to build a model for analysis. As one of the 7 Cities in Alberta, it was a leader in instituting a Housing First approach and has seen parallel reductions in homelessness. Edmonton is a pertinent example because a few – but not all – of the elements of the required data for this model sit under one organization. By looking at which components of the data are held by which actors, we can get a sense of who needs to be at the table and willing to share their knowledge in order to develop a robust strategy within a municipality.

Edmonton launched a 10 Year Plan to End Homelessness in April 2009 and designated Homeward Trust Edmonton as the organization responsible for coordinating the plan. Between then and October 2014, when the most recent Homeless Count occurred, Homeward Trust and the agencies it supports housed 3,300 people. Yet the number of people experiencing homelessness only declined from 3,079 to 2,118 between the 2008 and 2014 counts (Homeward Trust Edmonton, 2015). What factors caused this difference and what can we learn from them?

STOCKS AND FLOWS

The number of people counted as homeless in Edmonton is a 'stock'; the two observation points presented here are October 2008 and October 2014. The number of people housed through the Housing First program in the period between then is a 'flow' out from the homeless population.

A stock is a quantity at a point in time. A flow is the movement of things into or out of a stock. The classic case is a bathtub: if I have a half-full tub, that is a stock of water. If I turn on the tap, I create an inflow, which will change the stock as time goes by. If I open the drain at the same time, I create an outflow. Five minutes later, if I observe the tub again, I will know whether the rate of inflow or outflow is greater by whether the tub has gained water or lost it.[1] I will not, however, know what the rate of inflow and outflow are (and I will also have wasted several litres of perfectly good water).

The problem with stocks and flows is that humans are notoriously bad at understanding how they operate and what their effects will be; as a neophyte in systems dynamics, I am no exception. I have to stare long and hard at the parameters of a simple system to work out its effects and I quickly turn to electronic assistance if the flows change over time. Thankfully, I am in good company – even the brightest minds tend to struggle with these concepts. In one MIT graduate class, only 36% of students – most with math, engineering, science or economics backgrounds – correctly identified the behaviour of a system with only one stock, one outflow that did not change at all and one inflow that changed in a linear manner (Sterman, 2002). When we start to add in feedback loops, where initial actions or processes end up affecting themselves over time, outcomes become very hard to predict without the support of computer simulations. However, this understanding is vital since ending homelessness requires, by definition, that outflows from homelessness exceed inflows for a period long enough that the stock is reduced to zero – and that outflows are maintained at the same level as inflows thereafter.

A SIMPLE MODEL OF HOMELESSNESS

So how many people do you need to house to end homelessness? In order to answer this question, we need to build a model of the elements involved. Most of the time, those of us working in the homeless-serving sector only report the number of people housed through our programming and, at best, the number of people experiencing homelessness during a point-in-time count. If we only use that information, our model would look something like the image in Figure 1a: There was a fixed stock of homeless Edmontonians – 3,079 according to the 2008 count – and we simply had to house them all (in these diagrams, a box represents a stock and an arrow with a valve represents a flow). Clearly that is not correct, as we found housing for 3,300 people between 2009 and 2014.

1. It is important to note that this is only the case if the tap and drain were opened at the same time and the rate of flow is constant throughout. Imagine I turn on the tap first, wait a minute, then pull the plug and wait four more minutes. If I end up with more water than I originally started with, there is not sufficient information to conclude whether inflow or outflow is greater. I would have had to measure the tub again at the time when I unplugged the drain to make that conclusion.

While keeping the model very simple, we can make it complete[2] by adding in a few additional flows and one more stock, as in Figure 1b. Now we can see that while some people are finding housing, others are losing theirs. People are also moving into and out of the community, some of whom do not have housing. Two-way flows can either be shown as two separate arrows, as in the top half of the diagram about new housing or loss of housing, or as a single net flow, as in the bottom half about migration.

FIGURE 1 A *An Incomplete Model of Homelessness*

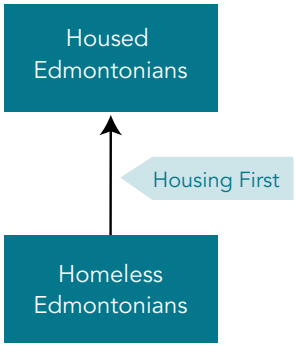
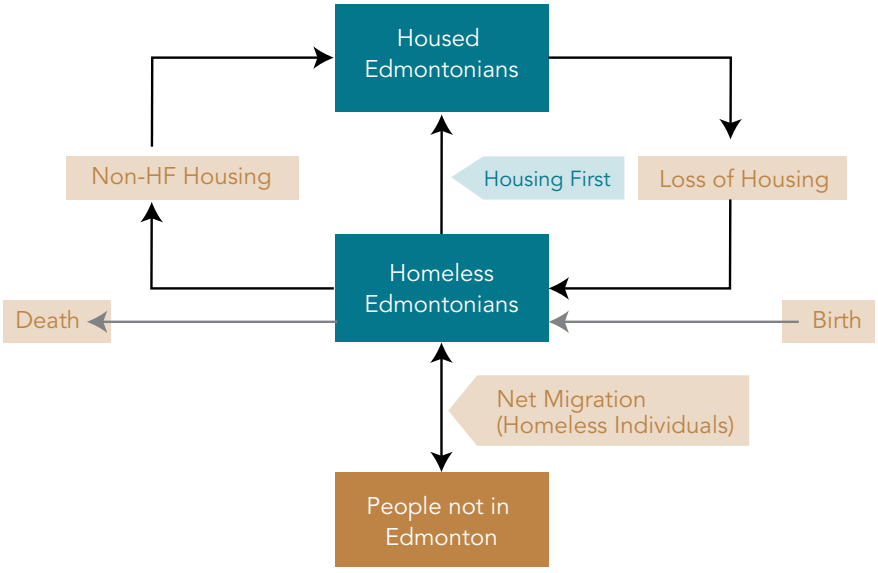


FIGURE 1 B *A Simple, Complete Model of Homelessness*



2. This representation assumes that all people can be classified as housed or homeless, which requires assigning those Provisionally Accommodated to one group or the other (e.g., those currently incarcerated, in hospital, staying in a motel or 'couch surfing' with no permanent address). A more detailed model can examine this explicitly, if it is important to the dynamics of homelessness, as it usually is.

REFINING THE MODEL

This representation is useful to us in its ability to tell us about the system: what we know, what we do not know and the most promising places to target investments to reduce homelessness overall. To do this, we will need a bit more detail in our model. The data from periodic homeless counts helps to estimate the population at a point in time (stock) and to estimate the aggregate of all flows between measures, much as checking the level of the bathtub told us whether we had more or less water overall, but not much about the flows. Since there were only two flows in that example, knowing their levels was not all that important. When we begin to apply numbers to our model, we may need to divide some of these flows to examine key areas of interest (e.g., how many people are being released from correction services into homelessness?) or to align with the way we capture data, where we know something about part but not all of a flow (e.g., we already separated out people housed through Housing First programs because we have the data to measure that flow).

We also need to incorporate things we already know about the system from prior research. Kuhn and Culhane (1998) identified three types of shelter users: transitionally homeless, who have relatively short and less frequent stays; episodically homeless, who have relatively short but more frequent stays; and chronically homeless, who have relatively few stays but for very long periods (sometimes the entire length of the study). Based on their work, several studies of shelters in Canadian and American cities – most recently in Calgary – have shown that this pattern holds across a variety of locations and with both singles and families (Aubry, Farrell, Hwang & Calhoun, 2013; Culhane, Metraux, Park, Schretzman & Valente, 2007; Kneebone, Bell, Jackson & Jadidzadeh, 2015).

One of the primary challenges of system dynamics analysis is selecting a scope that captures all of what is important to the outcome of interest, but does not get lost down the rabbit hole offered up by tangentially related variables.

Homeward Trust's focus is on helping to permanently house chronically and episodically homeless individuals.[3] Our model should reflect this focus. In Alberta, the term 'chronically homeless' includes the episodically homeless; more precisely, it includes anyone who has been homeless for at least a year continuously or has had four episodes of homelessness in the past three years. For simplicity, this definition will be used throughout the rest of the paper.

It is worth noting that those staying in shelters do not represent the entire homeless population: there are some notable differences among people who are sheltered, people sleeping rough and those who are provisionally accommodated (Homeward Trust Edmonton, 2015). As such, it is possible that the typology established by Kuhn and Culhane would not hold for unsheltered or provisionally accommodated populations. The best available indication in Edmonton comes from the Homeless Connect event,[4] where sheltered and unsheltered populations have relatively similar shares of chronically homeless individuals, with the unsheltered having a slightly higher figure (74% versus

3. A few other priority groups are also included, notably families with children, women fleeing domestic violence and youth. These groups could be jointly modeled, but this paper will focus primarily on chronically homeless people.

4. More details on this data source are provided below.

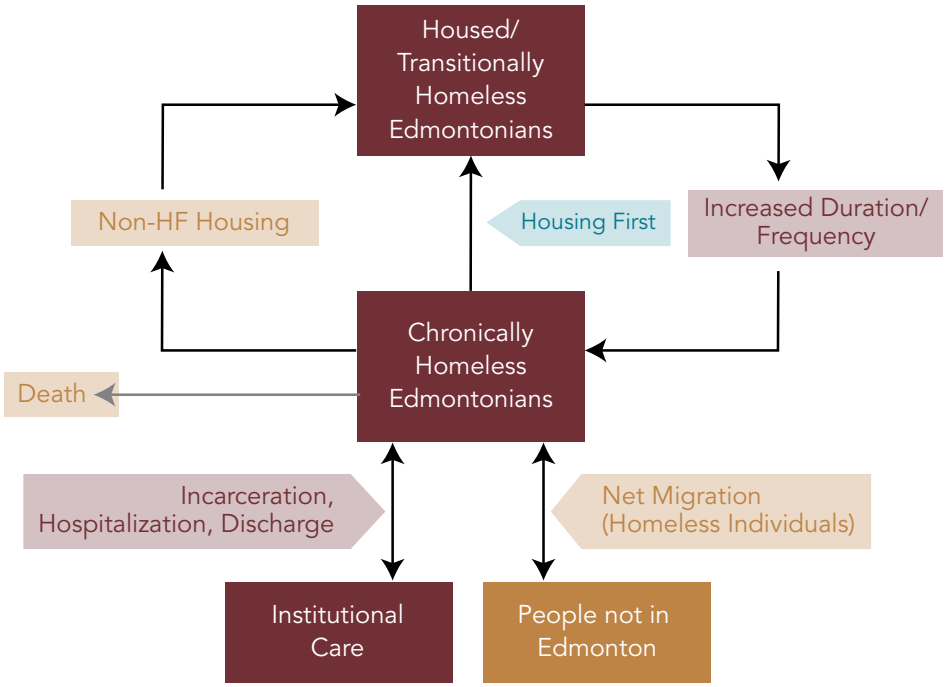
67%, p<0.1). While this is fairly weak evidence in support of the typology, we will continue to use it to guide this paper given its replicability across locations and the way it underlies many Housing First approaches.

One of the primary challenges of system dynamics analysis is selecting a scope that captures all of what is important to the outcome of interest, but does not get lost down the rabbit hole offered up by tangentially related variables. One rule of thumb in causal loop diagrams is to ignore variables where a doubling or halving would not significantly affect the outcome of interest (Kim, 1992). Because the transitionally homeless move into and out of homelessness relatively rapidly, they make up the majority of the the inflows and outflows, but since this group is not the core of our focus, it does not affect our key outcome of interest. Since this group is not the core of our focus, spending time trying to track down this information is not very productive.

Instead, we will focus on those who are chronically homeless.[5] We will now bring in a revised model that represents this population, Figure 2, to use as our basis of analysis.

Along with the focus on the chronically homeless, three additional changes have been made. We have added a dimension that captures chronically homeless individuals moving into or out of institutional care, as anecdotal evidence suggests that this is a significant flow and there are data sources that may be able to capture most or all of it. Secondly, instead of loss of housing beginning an instance of homelessness, we are now focused on people who are initially transitionally homeless increasing their duration or frequency of homelessness and becoming chronically homeless. Finally, we have removed births from the diagram, as it takes time to become chronically homeless, as spelled out in this definition, so one is not born chronically homeless.

FIGURE 2 *A Model of Chronic Homelessness*



5. A model looking at all people experiencing homelessness, instead of just the chronically homeless, would likely have to limit itself to those who interact with the homeless-serving system in some way (e.g. staying at a shelter), since no data would be available on some of the hidden homeless (such as couch surfers).

HOW MUCH OF THIS PROCESS DO WE UNDERSTAND?

We will now examine each of the components of this model to see what we do and do not understand, where additional data is available and what we can conclude about flows into and out of chronic homelessness.

Chronically Homeless Edmontonians

The first place to start is with the stock of chronically homeless individuals: Most communities in Canada have more information about the stock of homeless people than flows into and out of homelessness and Edmonton is no exception.[6] In Edmonton, homeless counts have been conducted every two years since 2002.[7] The 2014 Homeless Count found 2,307 Edmontonians who were homeless. While this includes all of the shelter beds in the city, we know this is an undercount of the unsheltered and provisionally accommodated: we do not find absolutely everyone who is experiencing homelessness and some of those we do approach decline to participate. However, we can estimate the undercount by responses to a large survey conducted three days later.

Most communities in Canada have more information about the stock of homeless people than flows into and out of homelessness.

Since 2008, Homeward Trust has also been conducting a biannual service event called Homeless Connect. With more than 2,000 participants in October 2014 – 85% of whom completed an extensive survey – this gives us some additional insight into the characteristics and size of the homeless population, as participants were asked if they had been approached during the count three days earlier. Approximately half of those who participated and completed surveys (804) were presently homeless and answered a subset of questions about their experience with homelessness, including duration and frequency.

At Homeless Connect, 39% of people who were sleeping rough reported having participated in the count, as did 27% of those provisionally accommodated and 53% of those staying at shelters.[8] Since administrative data was used for the shelter count, we do not need to modify that figure, but if we assume that we only spoke to 39% and 27% of the other groups, that would give us a stock of about 4,200 people experiencing homelessness. These figures are not completely reliable for three reasons: the participants at this event are not perfectly representative of the homeless

6. London, England has developed a simple system based on staff observation to estimate flows of rough sleepers (CHAIN, 2014) and several American cities have estimated inflows through the Zero: 2016 campaign.

7. Four prior counts were conducted in 1999 and 2000, but they were somewhat smaller in scope and were not conducted in October, so are excluded for comparison purposes.

population, there may have been some changes in homeless status or migration in the intervening days and some participants may just forget that they were asked a few questions earlier in the week. However, we know what our survey response rate was for the shelter count and we can compare it to the share of individuals at Connect who said they were staying in shelters and had participated in the count to get an idea of the measure's reliability. The number of people who responded to the survey portion of the Homeless Count and said they were staying at a shelter (and so should have indicated such if they were at Connect) was 67% of the total staying at shelters on the night of the Homeless Count. This is a variance of 26% (or 14 percentage points) from the actual response rate at Connect. If the same level of under-reporting exists in the other two categories, this would suggest that we actually covered 49% of rough sleepers and 34% of the provisionally accommodated in the count, which gives a population of about 3,700. While only an estimate, this gives us a range of values – 3,700 to 4,200 – that is likely close to the actual stock of people experiencing homelessness in Edmonton in October 2014. This range exceeds the point estimate that one study generated by applying the plant-capture ratio in Toronto to Edmonton's data, but falls well within their 95% confidence interval (McCandless, Patterson, Currie, Moniruzzaman & Somers, 2012).

To arrive at the stock of chronically homeless individuals, we will also need to calculate the share of people experiencing homelessness who are chronically homeless. Unfortunately, the 2014 count in Edmonton did not include a question about duration of homelessness, so we cannot calculate the share of chronically homeless individuals directly. However, a certain amount can be inferred from other data sources. Alberta's 7 Cities all conducted Homeless Counts within a week of each other, most on the same night, and five of them asked about chronically homeless status. The range of results was bounded by Medicine Hat with only 35% of homeless respondents being chronically homeless and Calgary with 55%. At the Homeless Connect event in Edmonton, 67% reported being chronically homeless, though this event may be more likely to reach chronically homeless individuals and therefore overstate the results. Given Edmonton's greater similarity to Calgary than the five smaller cities and the results of the Connect event, a betting researcher would be tempted to wager on the upper end of the range, but a firm conclusion will not be available until a question on chronic homelessness is included in the next count. Nonetheless, as a best estimate, applying a factor of 50–55% to the estimated homeless population gives a range of 1,800 to 2,300 chronically homeless individuals in Edmonton.

One other large source of data on the stock of chronically homeless people exists, but has not yet been utilized. Several shelters in the city keep track of clients over time. As with the aforementioned studies in cities across the continent, it would be possible to estimate the number of chronically homeless people staying at shelters over a period of time. Such a study could have additional benefits, as highlighted below in the section on Increased Frequency/Duration of Homelessness.

8. The results are virtually identical when we limit to just those who were chronically homeless, as the share of chronically and transitionally homeless individuals who participated in the count was not significantly different.

Housing First

We also know a lot about the flow of chronically homeless people through the Housing First program. Since 2009, Homeward Trust has helped to house more than 1,690 chronically homeless adults, including 415 in the last fiscal year (April 2014 – March 2015).[9] Since dependents are not interviewed, we do not observe directly whether they are chronically homeless, so we assume they have the same status as their caregivers: this gives us an estimate of about 170 dependents in chronically homeless families. As such, we will approximate the number of chronically homeless clients and dependents housed last year at 570.

To develop a net outflow from chronic homelessness, we also need to know how many people returned to homelessness from the Housing First program. During the same year, about 295 formerly chronically homeless clients and dependents left the program: 150 were in stable housing when they left, 130 were not and 15 passed away while housed.[10] Subtracting these 13 from those housed during the year produces a net outflow of 450.

Some of the clients who exited the program successfully will since have returned to homelessness and some of those who exited unsuccessfully will have achieved housing or never have lost it (a client who refuses further service without completing the program is considered an unsuccessful exit, even if they are still housed). Unfortunately, relatively little information is available on rates of housing retention after the program, as it is often difficult to contact former clients for follow-up interviews, especially those who left the program unsuccessfully. If privacy legislation allows, generally the best supplementary source of data is from provincial income support and disability programs, as most clients are on income assistance. Australia has one of the better systems for tracking this data across government and non-profit delivery systems (Pinkney & Ewing, 2006).

Migration

those who had arrived in the city within the last year – and especially within the last six months – were almost three times more likely to be experiencing homelessness than other Edmontonians (Homeward Trust Edmonton, 2015)

From the count and Connect, we actually have a reasonable picture of the flow of migrants into chronic homelessness. The Homeless Count report showed that those who had arrived in the city within the last year – and especially within the last six months – were almost three times more likely to be experiencing homelessness than other Edmontonians (Homeward Trust Edmonton, 2015); however, this trend disappears as soon as the one-year mark is eclipsed. Homeless Connect participants displayed identical trends and, further, these two groups reported having participated in the count at the same rate, suggesting that the population at Connect is a fair representation of new arrivals.

Connect participants were also asked about their duration of homelessness. Participants who had been in the city for less than a year were much less likely to report being chronically homeless than those who had been here more than a year (53% versus 72%, $p<0.01$). Applying this ratio to the results of the count suggests

9. This only includes Homeward Trust-funded Intensive Case Management, Rapid Re-Housing, Assertive Community Treatment and Permanent Supportive Housing programs. All figures are provisional, pending end of fiscal year data verification.

10. The Assertive Community Treatment programs are not included in this portion of the analysis.

that in-migration annually accounts for about 12% of the chronically homeless population. This is still double the share of the overall Edmonton population normally comprised by recent arrivals and suggests a potential target population for intervention. However, it also tells us that recent arrivals experiencing homelessness are more likely to be able to resolve their own issues, as fewer are chronically homeless presently and the people who have been here more than a year are not overly represented among the homeless.[11]

It also tells us that recent arrivals experiencing homelessness are more likely to be able to resolve their own issues, as fewer are chronically homeless presently and the people who have been here more than a year are not overly represented among the homeless.

We have no direct measure of chronically homeless people migrating out of Edmonton. National population estimates show that in 2012/2013 the Edmonton Census Metropolitan Area gained 64,300 people from migration and lost 32,900, putting outflow at about three percent of population or 50% of inflow (Statistics Canada, 2015a; Statistics Canada, 2015b) As we have seen, though, characteristics of the general population do not always accurately reflect those of the chronically homeless. Our next best possibility would be to look at the rate of people in the Housing First program who are moving out of the city. We expect this to be biased downward because these people have achieved independent housing and have more to leave. For clients who were active on January 1, 2014, this figure was three percent over the course of 2014, the same as the rate in the general population. Our best guess for out-migration would then have to be three percent, but it could easily be as high as six percent if out-migration among the chronically homeless is higher than among the general population, as it is with in-migration. This gives us a net migration rate of six to nine percent, or 110–220 people annually when applied to the estimate for the stock of chronically homeless Edmontonians. Increased precision, or even solid confirmation of this range, will remain very difficult to achieve for the foreseeable future.

Deaths

Every year, the Edmonton Coalition on Housing and Homelessness conducts a memorial for homeless people who have died, with a list compiled by service agencies. In 2015, they reported just under 50 deaths during the previous year, a number similar to the average over the last 10 years (Ostad, 2015). While it is possible that not all of these people are chronically homeless, it is also likely that a few people are missed. Given that this is one of the smaller flows, that bit of variability will not be very important to the overall stock of homeless people.

11. It is possible that the pool of people experiencing homelessness at one- to three-years in the community is not larger because some chronically homeless migrants come and go from the city, appearing to have just arrived whenever they are interviewed. Because this is a cross-section and not longitudinal data, it is impossible to know the extent of this phenomenon.

WHERE IS COLLABORATION NEEDED?

We now have a reasonable picture of one stock, every two years, two outflows and one inflow. This is the extent of data that is available in-house to Homeward Trust; while research collaboration on the previous items in this section could add significant precision to measurements, collaboration on the following items is necessary to have any picture of these flows at all.

Entry Into and Discharge From Institutional Care

This is an area where excellent data exist, but we do not have access to that data. In previous Homeless Counts, Homeward Trust has received aggregate numbers of people discharged to No Fixed Address on the day of the count (inflow), whereas the Calgary Homeless Foundation has sought to find out everyone who was in a corrections, health or rehabilitation facility and had No Fixed Address at intake (stock).

The net flow into institutions is likely slightly positive, as it is typical for most facilities to be roughly constant in size (i.e., inflow equals outflow) and a few people will pass away while in care (i.e., not be discharged into homelessness). However, some previously homeless people may be supported to find housing and some transitionally homeless may cross over the one year mark without a home and thus become chronically homeless while institutionalized.

Strategy number nine in the provincial plan to end homelessness is to "Develop approaches to prevent provincial systems from discharging clients into homelessness" (The Alberta Secratariat for Action on Homelessness, 2008). Different ministries in the Government of Alberta have undertaken several pilot projects to this end, but there are still great strides to make. A partnership between Homeward Trust and Alberta Health Services or the Ministry of Justice and Solicitor General could shed light on inflows and outflows, provide a mechanism for tracking outcomes and set the stage for a concerted effort to move discharges to homelessness toward zero in the city.

Increased Duration/Frequency of Homelessness

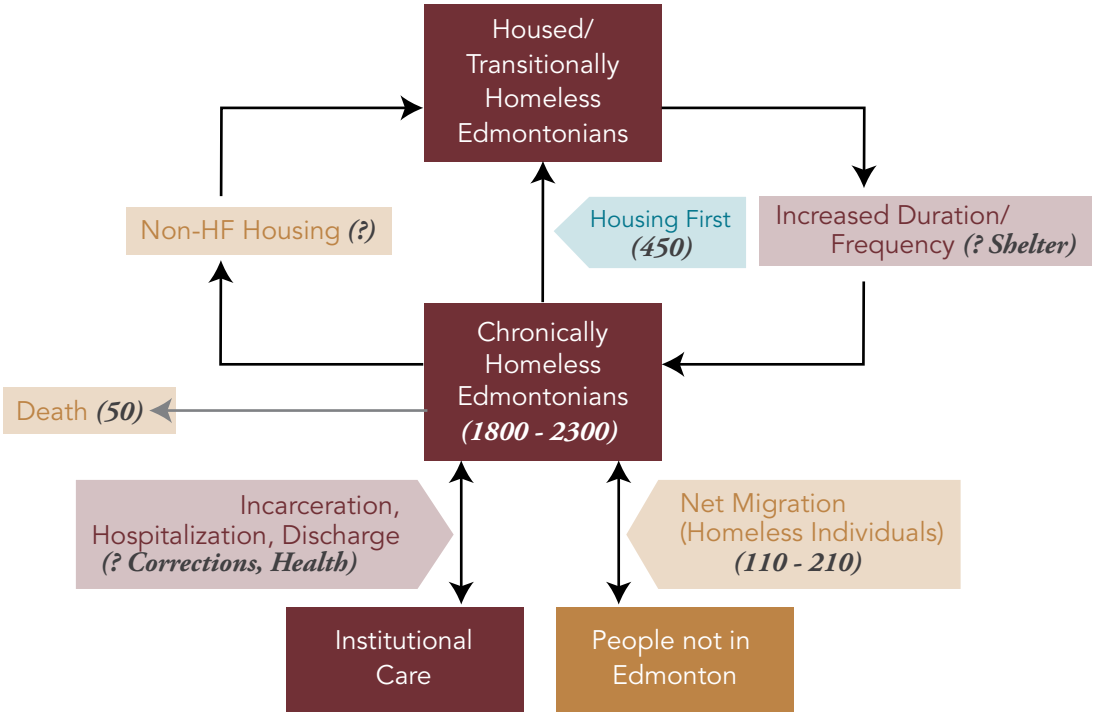
Another area where reasonable data exists but is not available to Homeward Trust concerns the transition from transitionally homeless to chronically homeless. Over the last six years, the share of homeless people staying in shelters or short-term supportive housing has increased significantly as the number of rough sleepers has fallen (Homeward Trust Edmonton, 2015). An extension of the previously proposed study replicating Kuhn and Culhane could include an additional year of data to examine how many users initially classified as transitionally homeless move into the chronically homeless category over the course of that year.

There are also programmatic advantages to this exchange of data. All of the major shelter providers are also Housing First agencies and so are natural intervention points for housing chronically homeless individuals in shelters. However, as not all clients will connect with programs in shelter, a connection to Homeward Trust, which serves as a coordinator among Housing First providers, would allow increased targeting of that population for permanent housing.

Non-HF Housings

Finally, we will never know the extent of housing outside of the Housing First program: many of these interactions occur entirely privately, through family reunification or individual initiative with the support of family and friends. If the rest of the model is well estimated, it would be possible to approximate the combined flow of people into housing and out of the community, our two major unknowns, based on changes in the stock between Homeless Counts.

FIGURE 3 *A Partially Calibrated Model*



ALL MODELS ARE WRONG, SOME ARE USEFUL

Having looked at each of our stocks and flows, we can now get an overall picture of the system of chronic homelessness in the city, shown above in Figure 3. This model is not a precise depiction of the exact stocks and flows of chronically homeless Edmontonians – no model is. However, it does highlight areas for cooperation with other agencies and ministries.

As mentioned earlier, ending homelessness requires, by definition, that outflows from homelessness exceed inflows for a period long enough that the stock is reduced to zero – and thereafter outflows are maintained at the same level as inflows. The introduction of Edmonton's Housing First program in 2009 added a significant outflow that – concurrent with the financial crisis – initially created a large reduction in the homeless population. That population has since stabilized, which means that other net flows into homelessness have increased recently. One explanation posited for this was an increase in pressure on the housing market (Homeward Trust Edmonton, 2015). Our diagram shows that this is a possibility, but so is an increased flow of net migrants. Additional data from shelters could help to determine which cause is stronger and help us to target resources effectively.

So how many people does Edmonton need to house each year to end homelessness by 2019, the end of its 10-year mandate? If we have shelter data, we can make a reasonable estimate. With that information, we could estimate the rate at which people become chronically homeless. This figure – along with all of our other flows and changes in the stock over the past six years – then allows us to estimate how many people achieved housing outside of Housing First.

So how many people does Edmonton need to house each year to end homelessness by 2019, the end of its 10-year mandate?

If we have shelter data, we can make a reasonable estimate.

We can set up a linear equation from this model, where X is the number housed through Housing First per year, Y is the number housed outside of Housing First and Z is the number becoming chronically homeless. For simplicity in this model, we use rounded numbers near the midpoints of the estimated range of people who are presently chronically homeless and net migration into chronic homelessness.[12]

In this example, if 100 people became chronically homeless every year and 50 chronically homeless people become housed, Homeward Trust would have to house about 650 chronically homeless people per year to eliminate chronic homeless within four years – or affect one or more of the other flows into and out of chronic homelessness. If we expect that these rates will change over time (and given the recent change in Alberta's economy, they probably will) we can model more complex systems of equations that account for these changes in a program like Vensim.[13] Since our model also includes some imprecise estimates, we can repeat the exercise using the limits instead of the midpoints to determine the bounds of the range for our target variable.

An extension of our model would allow us to look at major external factors that influence each of these flows, such as economic growth. Figure 4 shows an example of what this could contain, but the development of that sort of model is beyond the

$$\textit{Years} = \frac{\textit{Present number of chronically homeless}}{\frac{\textit{HF}}{\textit{yr}} + \frac{\textit{Non HF}}{\textit{yr}} + \frac{\textit{Deaths}}{\textit{yr}} - \frac{\textit{Net migration}}{\textit{yr}} - \frac{\textit{Becoming homeless}}{\textit{yr}}}$$

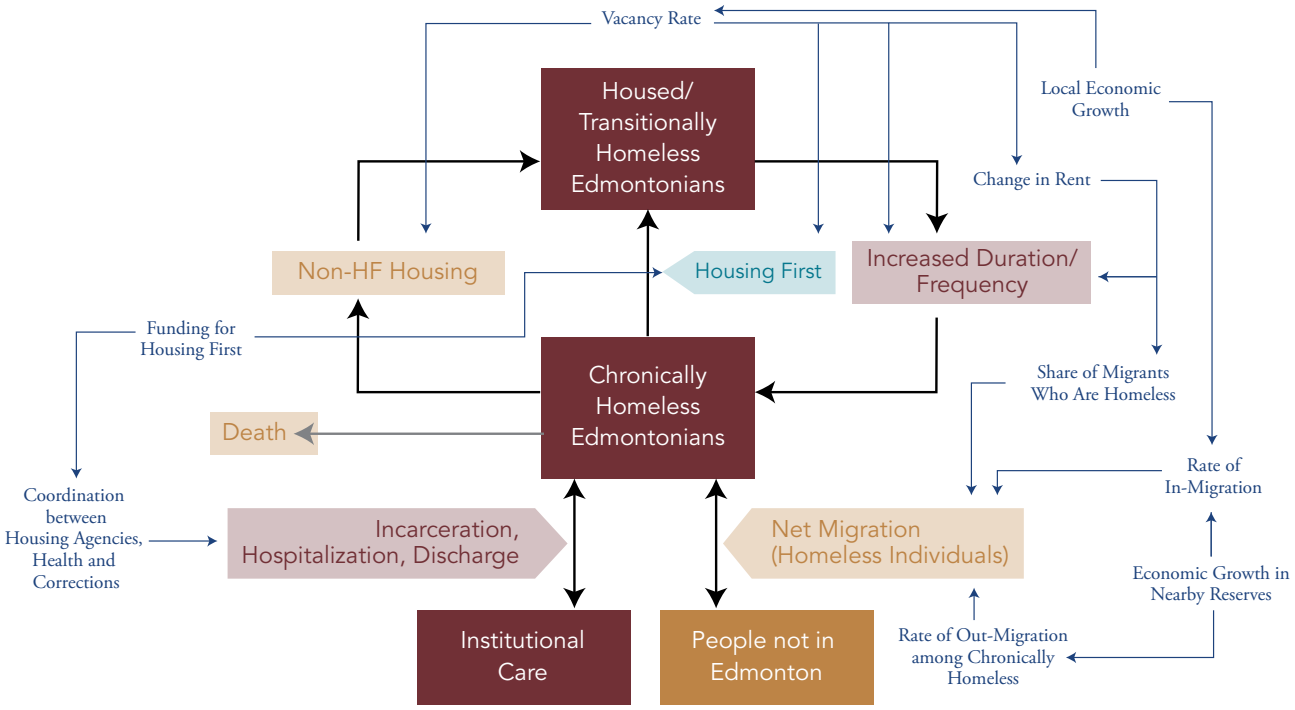
$$4 = \frac{2000}{X + Y + 50 - 150 - Z}$$

$$X = 600 - Y + Z$$

12. The number of people moving into and out of institutional care do not affect the total, since they are considered homeless in either case.

13. Deaths would also be better represented as a percentage of the chronically homeless population. As this population falls, there should be fewer people dying on the streets.

FIGURE 4 *Example of Factors Influencing Rates*



scope of this paper. This level of model, however, would enable a level of predictive power that could forecast how large the flow of people through a Housing First channel would need to be to maintain or reduce chronic homelessness and could help to determine the required resources to achieve that goal.

With the existing model, we can see that additional information on flows into chronic homelessness from hospitals, corrections facilities and shelters could nearly complete our understanding of the movement into and out of chronic homelessness. Each of these areas is a potential leverage point for increasing the flow out of – or reducing the flow into – chronic homelessness. Coordinating organizations like Homeward Trust need to determine where the largest flows are and what their ability to intervene is in order to tip the overall system flow from zero to negative or to accelerate the rate of decline in the homeless population.

Coordinating organizations like Homeward Trust need to determine where the largest flows are and what their ability to intervene is in order to tip the overall system flow from zero to negative or to accelerate the rate of decline in the homeless population.

Any community with this data can create realistic targets for outflows (housings), reductions in inflows (e.g. migrants arriving without homes) and a time frame for eliminating homelessness. Such analysis could prove useful in many other communities, especially those deciding where to allocate resources.

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Inter-sectoral Collaborations

3.4

BUILDING RESEARCH CAPACITY TO IMPROVE SERVICES FOR THE HOMELESS AN INTEGRATED COMMUNITY-ADACEMIC PARTNERSHIP MODEL[1]

Annie DUCHESNE, David W. ROTHWELL,
Georges OHANA & Amanda GRENIER

INTRODUCTION

Community organizations that address homelessness operate and design their interventions in a local context, taking into account factors that vary by region such as job availability, climate, social services offered, social housing availability and social assistance payments (Gaetz et al, 2013). Therefore it is important to generate place-based knowledge incorporating expertise from key stakeholders including practitioners and service users. An integrated community-academic partnership is one vehicle to increase local knowledge and better design community interventions. In this chapter, we present an example of one such partnership intended to better understand the needs of homeless people and increase the effectiveness of community-based responses in Montreal. We begin with a short history of community-academic partnerships including their challenges and new opportunities. Next we describe the OBM-McGill partnership in detail including priority development, the respective roles and responsibilities of community and university partners and some notable research outcomes. We then outline a few successes and setbacks of the example project and the importance of organizational support for both partners. We conclude with lessons learned and focus on the critical importance of digital information management systems in facilitating partnerships.

COMMUNITY-ACADEMIC PARTNERSHIPS

Arguably, the social service environment has become increasingly conducive to the development of community-academic partnerships in Canada. More funders are recognizing the importance of such arrangements and have set up grants specifically to foster these relationships (Hall et al, 2009; Jackson, 2014). There is also a good deal of potential in new digital homeless management systems that help to bridge distances between institutions and generate better research. These systems give researchers access to information with minimal disturbance to everyday community activities. They offer a consistent way of collecting information to compare groups and assess need, and can be the basis for multiple projects over time.

1. We'd like to acknowledge the previous personnel who have made substantial contributions to the project over the years. These include Matthew Pearce, Lise Marion, Sebastian Mott, Marie-Pierre Hamelin, Malorie Moore, Stephanie Taillon and Jessica Spagnolo.

However, mutually beneficial research requires more than reliable data. Research and community organizations work in different contexts, and have different objectives, scopes and parameters. These distinctive approaches can present challenges to partnerships. A clear understanding of the differences between these two sectors is necessary for a fruitful partnership.

Universities have traditionally been positioned as knowledge generators and gatekeepers working independently from their communities (Soska & Johnson Butterfield, 2004); however, this role is shifting. However, recently universities have started to actively engage with local governments, not-for-profit organizations and local service providers to contribute to regional development (Hall & Tremblay, 2012). This shift has been useful to community organizations as they very rarely have the expertise or resources to evaluate need and test interventions. This is an especially important gap because of funders' growing interest in investing in evidence-based practices (Hall et al., 2009). In the homeless sector, short-term academic-community partnerships are common, though these often focus on specific issues within homelessness including physical health, substance use and mental health. Such projects tend to be initiated by academic researchers who approach community organizations to collect data on a specific issue for a defined period of time. This too often results in short-term one-way relationships that do not lead to sustainable change in the partnering organization. Local groups sometimes cite negative experiences with 'ivory tower institutions' that have come into the community to conduct studies, but have not adequately consulted community groups to inform their research or made extensive enough efforts to share their findings in an accessible way (Soska & Johnson Butterfield, 2004). As a result, community organizations have difficulty turning these findings into practical plans. One solution is to bring both sectors together in a long-term integrated fashion (Hall & Tremblay, 2012). Integration can facilitate research that has direct relevance to programs and policy, which should be the aim of all projects, and enables community organizations to assess trends in the population and help plan for the future. This type of partnership also allows researchers to engage in more meaningful participatory research with stakeholders,resulting in more clear interpretations of findings. (AUCC, 2008).

A clear understanding of the differences between these two sectors and how to manage these different cultures is necessary for a fruitful partnership.

PARTNERSHIP DESCRIPTION

Montreal's Old Brewery Mission (OBM) shelter made the decision in recent years to shift to a more evidence-based model that aims to promote self-sufficiency. This shift was driven by a change in organizational leadership that pushed for evidence to help improve services. Research and knowledge development was seen as a critical ingredient in this shift; however, the organization did not have the internal capacity to engage in the long-term in-depth research required. The OBM had engaged in short-term partnerships with local universities in the past. Based on this experience, the organization decided to approach former partners to see if they were interested in more long-term work. In 2011 the OBM teamed up with the Social Development Research Group located at the McGill University Centre for Research on Children and Families (CRCF) to build research capacity and engage in new research on homelessness that would ultimately provide better services to homeless clients using evidence-informed practices. The project merged the analytical expertise from a third-party academic institution with the homelessness expertise of a service-driven not-for-profit organization to better understand the homeless population in the area and improve on service models. The approach taken in the OBM-McGill partnership is similar to partnerships found in the U.S. including the California-based Community Technology Alliance (CTA), which uses big data to address issues related to poverty and homelessness ("Community Technology Alliance," n.d.). In addition to understanding trends and adjusting services, the partnership also strives to go beyond organizational walls by presenting findings to the public in the hopes that others can benefit. The project has involved numerous personnel over the years that have contributed greatly. Currently a full-time research coordinator, a director of research at the OBM and a professor at McGill support the partnership.

In addition to understanding trends and adjusting services, the partnership also strives to go beyond organizational walls by presenting findings to the public in the hopes that others can benefit.

The OBM-McGill research project has grown organically since 2011 to become a fully integrated, mutually beneficial long-term partnership. Since inception, the partnership has launched an in-depth exploration of homelessness in Montreal that aims to learn more about the the factors that contribute to chronic and episodic homelessness. Initial consultations with academics and social work experts led to the identification of five research priorities, including the need to:

1. Build research capacity at the shelter;
2. Identify key research topics;
3. Conduct new research;
4. Engage in knowledge translation and dissemination; and
5. Apply findings to improve policies and programs.

Through the project, the partnership hoped to be able to identify factors associated with long-term homelessness; pinpoint groups that 'fall between the cracks' of service delivery; shift the service-delivery model from downstream crisis management to upstream solutions; and prioritize resource allocation to help the greatest number of people.

HOMELESSNESS MANAGEMENT INFORMATION SYSTEMS

In 2001, the OBM adopted the free-to-use Homeless Individuals and Families Information System (HIFIS), developed by the Federal Government of Canada (PYE, n.d.). The digital client-management system was used day-to-day by counseling staff across the organization to reduce paperwork, see years of client data at a glance, present notes in a legible way, flag potential issues, etc. Administrative staff used the HIFIS system's capacity to produce basic population-level descriptive statistics for annual reports. The organization recognized the databases' potential for research purposes many years later.

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At the time when the partnership started, HIFIS was primarily used as an administrative tool to keep track of individual client needs. However, the HIFIS system has he potential to be used for more than just administrative monitoring. It allows researchers to systematically collect information on the population being served, collect in-depth data in a cost-effective way and retrospectively follow individuals anonymously throughout their shelter trajectory using unique, randomly assigned client numbers. This is particularly advantageous because longitudinal studies about homelessness have in the past been either unfeasible or extremely difficult to conduct (Levinson, 2004: 228; North et al, 2012; Sosin et al, 1990)& Pollio, 2012; Sosin, Piliavin, & Westerfelt, 1990. The database can also be used to take into account the complex community-level interactions between individual psychosocial factors, institutional rules and regulations and social context (i.e. laws, rent affordability, minimum wage, job market, social safety net services, etc.).

The introduction of computerized information systems brings unique opportunities and challenges for research and community-based practice. Digital homelessness management information systems enable community institutions to enter data on service users, thereby building a rich database containing demographic background, client need and patterns of service use. Such systems have the potential to provide organizations with detailed information on the needs of the particular homeless population that they serve.

In the case of homelessness, research conducted with these systems has the potential to provide organizations with the necessary evidence to:

1. Plan ahead by reading trends in the population that may lead to changes in service requirements;
2. Make the most out of a resource-limited environment by identifying top priorities for intervention and evaluating the efficacy of services;
3. Learn about the population to develop preventive services to end chronic and episodic homelessness; and
4. Justify funding requests using solid numbers specific to the organization. This can increase the likelihood of successfully funded evidence-based projects.

However, very few community organizations have the capacity to use their digital administration systems in this way. Therefore, most organizations are not able to benefit from this information. Although homeless management information systems hold enormous potential as one of the largest generally untapped resources for community-level research, making use of the data can be challenging. Community organizations may struggle with the demands of data entry and with the know-how of processing and making use of the data. Amidst competing time demands, for example, workers responsible for data entry may miss key areas. Missing client data interferes with the ability of researchers to conduct analysis and to ensure that the group of people being analyzed is representative of the population as a whole. Making use of the data management systems is a complicated process that requires expertise as well as defined goals and priorities.

An integrated partnership between the frontline community organization and an academic institution is thus a possible solution to the problem of accessing and making use of the data collected in these complex information systems. Data management systems would seem to create the opportunity for collaboration between research and community practice. This is especially the case where the complexity of the factors that contribute to homelessness at large demand a more long-term and integrated approach. In this sense, a university-community partnership can build research capacity and provide a consistent feedback loop to improve service provision.

REALIZING THE PARTNERSHIP PRIORITIES

Identifying research partnership priorities can help shape long-term projects and ensure that partners are on the same page. This section reviews and outlines the five partnership priorities for the OBM-McGill partnership.

Priority One: Building Research Capacity

Early partnership activities involved identifying the strengths and weaknesses of the OBM's data management systems. McGill researchers explored the OBM database, in collaboration with HIFIS administration in Ottawa, to determine which variables were consistently collected and which were not. The findings from this exploration were used to determine the limitations of the administrative database and come up with viable solutions.

One example of information that was unsystematically recorded was mental health. This was problematic because mental illness can significantly affect a person's experience in homelessness and length of homeless episodes. Previous research has found that mental health contributes to longer episodes of homelessness (Forchuck et al, 2008; Robertson MJ & Winkleby MA, 1996). Mental illness has also been found to be associated with other complicating factors in the homeless population including substance use (Fischer & Breakey, 1991; Rush et al, 2008) and physical illness (Viron et al, 2014). Furthermore, due to the stigma of mental illness, it can be difficult to find work (Gamm et al, 2003) and build a supportive social network (England et al, 2011; Hulchanski et al, 2009). Therefore, mental health status is an important consideration in any research examining service delivery for homeless persons and it is imperative that this information is collected consistently and carefully.

The research project began a series of activities to address the gaps in the data. A first step to reduce missing data and measurement bias was to train the OBM staff to collect and enter data in a systematic way. The OBM-McGill research coordinator gave group training workshops and disseminated clear protocols for data collection. Next, regular data check-ins were conducted by the research coordinator to address any outstanding issues with data collection. Finally, the McGill researchers developed methods to efficiently organize the data and convert the database so it could be read by statistical analysis software.

Priority Two: Identifying Key Research Topics

Early on in the partnership, an Executive Research Steering Committee (composed of representatives from McGill and the OBM) identified research topics, taking into account community context, research capacity and budgetary limitations. The purpose of the Steering Committee was to identify gaps in knowledge to inform service delivery. First, an extensive review of the existing programs and practices at the OBM was performed. The research coordinator and a research assistant conducted extensive background research on the theories embedded in the OBM's transitional programs. This internal report informed the discussions of the Research Steering Committee.

Early on in the partnership, an Executive Research Steering Committee (composed of representatives from McGill and the OBM) identified research topics, taking into account community context, research capacity and budgetary limitations.

During the first year of the project the primary interest of the OBM was to conduct an impact evaluation. Yet the amount of time and resources that would have been required to track down an acceptably large group considered to be representative of the population was not feasible. Given the constraints, research projects were designed to be smaller in scale and more manageable. A short list of topics ranging from a demographic description to a long-term program evaluation was proposed and approved by the OBM board of directors. Consultations with homeless shelter clients, stakeholders and the Steering Committee helped to determine priorities and potential challenges.

Priority Three: Conducting New Research

McGill researchers developed the methodology for each research question. This process included the identification and development of valid and reliable measurement instruments. The preference was to identify instruments previously validated in the homeless population. For example, the OBM-McGill partnership was interested in collecting information about a variety of psychosocial factors affecting homelessness including severity of mental health problems and substance use issues, quality of support from family and friends, level of involvement in the community, income and adequacy of available housing. An extensive search resulted in the identification of the Arizona Self-Sufficiency Matrix (ASSM) developed for use in homeless populations and verified in research projects conducted in the U.S. (Abt Associates, 2006). The Family Crisis Oriented Personal Scale (F-COPES) questionnaire was also identified (McCubbin, 1996). This instrument was developed for use in low-income populations to describe an individual's self-reported coping strategies in times of crisis.

The partnership eventually decided on a two-phase research plan. The first two years of the project (Phase One: Years 2011 to 2013), focused on building the social scientific foundation for a more expansive study in the future. Improving the quality of data in the HIFIS administrative database was a priority. Phase One also consisted of a literature review and preliminary analysis of administrative data. In addition, the research coordinator conducted focus groups with clients that described their impressions of shelter programs and identified unmet needs. These in-depth discussions provided considerable information on the operations at the shelter, complimenting and providing context for the information collected by

the administrative database. In an early analysis of the administrative data, the researchers also replicated a classification system based on previous work performed in Canada and the U.S. (Aubry et al, 2012; Kuhn & Culhane, 1998). Further, a demographic exploration was used to identify service gaps and design new programs and policies.

Midway through Phase One, the OBM-McGill Research Steering Committee was approached by external researchers involved in a project on aging and homelessness[2] (see aginghomelessness.com) and a shorter term collaborative partnership was negotiated. Findings from the resulting work showed that older persons in the transitional programs stay longer than younger persons (Rothwell et al, (in press)). Understanding this phenomenon from different methodological perspectives was of great interest to both partners so the collaboration was extended into Phase Two of the OBM-McGill project.

Building on results from Phase One, the second phase of the partnership (Phase2: 2013-2015) consisted of using the new and improved database to attempt to identify the characteristics that can lead to chronic and episodic shelter use. This included an analysis of demographic, psychosocial and structural factors that may contribute to long-term homelessness. The ASSM and F-COPES measurement tools that had been put in place allowed the researchers to explore data beyond descriptive statistics. This phase of the project included a longitudinal study looking at the relationship between transitional program policy and returns to the shelter. A latent profile analysis was also used to identify the psychosocial characteristics, coping mechanisms and health issues associated with age, chronic and episodic homelessness.

Priority Four: Knowledge Translation

Knowledge translation has been a priority area for the OBM-McGill research project. Findings are interpreted in conjunction with frontline and administrative staff at the OBM. An understanding of the priorities of each of the organizations is required to put the results into terms that everyone can understand and benefit from.

To date, the partnership has produced a number of products including an extensive literature review (Mott et al, 2012a), and two focus group studies that clarified the client perceptions of the shelter's transitional programs (Mott et al, 2012b; Mott et al, 2013). The results of the first data analysis (Mott, 2012) using the HIFIS system were presented at the International Homeless Conference in Pennsylvania (Mott & Rothwell, 2013). In addition, several reports analyzed health issues (Duchesne & Rothwell, 2014a) and trends of service use over time (Duchesne & Rothwell, 2014b). A training manual for research was also produced (Duchesne, 2014). All public reports have been posted on the project website: mcgill.ca/socialdevelopment/projects/obm.

Extensive efforts are made to ensure that different audiences can understand the results. Results are presented in many ways including PowerPoint presentations, internal reports, infographics, journal articles and conference presentations.

It is also a high priority to share this information with the community to help change the public's perception of homelessness and to provide the most up-to-date information possible to other community-level organizations. For example, the CEO of the OBM was instrumental in spreading findings on chronic and episodic homelessness through op-eds, radio interviews and conference talks.

2. With Social Sciences and Humanities Research Council (SSHRC) funding the project (Principal Investigator Amanda Grenier) explores homelessness and aging at the levels of social programming and personal experience. Four aspects of the inquiry include: (a) late life challenges, (b) changing relationships to place and space in cities and shelters, (c) implications of impairment with regard to long-term care and (d) the influence of economic resources on late-life trajectories.

Priority Five: Apply Findings to Policy & Programs

An important part of the knowledge translation process is evaluating the extent to which programs and practices can be influenced by research results. The Research Steering Committee along with collaborative efforts from OBM staff across the organization use the research results to identify and address gaps in service to create more a comprehensive continuum of services.

Through word of mouth and distribution of reports, the research conducted as part of the partnership quickly finds its way into programming. For example, the research revealed that many individuals who arrived for the first time at the shelter (the newly homeless) often only used the emergency shelter, which offers few of the necessary supportive services to help individuals get back on their feet. It was suggested that intensive interventions targeted toward the first-time homeless might help them stabilize more quickly. As a result, the OBM developed the *Acceuil* program in order to provide personalized counseling services and more stable living arrangements for first-time homeless individuals. In doing so, the shelter was able to provide access to necessary resources in a lower-stress environment with the aim of reducing longer-term homelessness.

At a higher policy level, findings from the aging homeless component of the partnership were influential in shaping Quebec's new homeless policy. Along policy lines, Quebec is leading the way in recognizing and targeting older people in its strategy.

SUCCESSES AND SETBACKS

Successes

This project has seen several successes, including measurable progress in implementing evidence-informed programming at the shelter. Results have been used to design and justify more diverse transitional programs to help accommodate the specific needs of clients. For example, simple analyses have estimated the proportion of clients with problematic substance use, mental health problems and physical ailments. These straightforward demographic studies aided in the development of certain transitional programs including the aforementioned *Acceuil* program and the *Projet Réaffiliation en itinérance et santé mentale* (PRISM) program. This program, developed and offered in partnership with the Centre Hospitalier de l'Université de Montréal, offers mental health treatment programs in-residence to chronic, service-shy homeless clients with concurrent substance use disorders.

Simple analyses have helped to determine the proportion of clients with problematic substance use, mental health problems and physical ailments. These straightforward demographic studies helped in the development of certain transitional programs...

Furthermore, the organization has a greater research capacity that is sustainable in the long term. This enhanced capacity has created a culture of research within the organization that encourages critical thinking, examines biases and promotes constant improvement.

Perhaps most poignantly, the various descriptive studies and classification analyses have given weight to community knowledge. Several results have confirmed systematically what service-driven agencies have known anecdotally for a long time: that their homeless clients are a heterogeneous group of complex people with a variety of needs and survival strategies.

Challenges

Overall, the partnership has encountered numerous challenges. As with any partnership between sectors, there is a need to manage expectations and adapt to new work processes. Impediments to the OBM-McGill research project were similar to those faced in many other partnerships. Chief among them was a clash of cultures between the academic and the not-for-profit sectors. As a result, the partners often experienced different expectations for timelines and resource allocation. From the standpoint of the academics, fostering an environment of co-ownership was also a challenge. There is often a perception that the university researchers are the experts and they should tell service providers what is best. Despite this tendency the research team has remained committed to engendering a climate where service providers feel ownership and control over the process.

One of the main issues was negotiating the community agency demands in an environment of limited research resources. For example, the OBM initially expected that the research team would be able to follow individuals in the community to determine who was able to leave homelessness and who was not. However, this kind of project was impossible to achieve with a single full-time researcher and it was cost prohibitive to hire more individuals to perform this task. Smaller and more manageable projects had to be proposed.

Another challenge was breaking down the academic research versus practice divide in terms of timelines and turnaround. Academic research takes a significant amount of time and hurdles arise often throughout the process including research assistant turnover, delayed ethics approval and the discovery of missing data. Inflexible deadlines in this context are not reasonable. However, community-level organizations require nimbleness when using research results for funding applications as well as the design of new programs and practices. The OBM-McGill project navigated these differences by negotiating compromises; for example, McGill partners compromised by prioritizing practice-relevant knowledge over other types (e.g. peer-reviewed publications). Instead of preparing each individual analysis for publication in a scientific journal, the research team generated concise reports for internal use. This ensured that the majority of the work produced for the partnership was centred on informing and improving services. In contrast to a peer-reviewed journal article, these reports were produced more quickly and were often easier for the OBM management to interpret. The project maintains a commitment to produce formal academic publications, but this is secondary to knowledge translation. The OBM partner compromised by sacrificing some agility; the organization agreed to adhere to the research plan and data collection instruments for a prescribed period of time for the purposes of producing reliable research – an unfamiliar practice in an organization used to making quick and frequent changes. The OBM also learned to accept that quality results would take longer to produce than originally expected. Regular and timely communication was key. All levels of the OBM management were informed of progress and setbacks through quarterly and annual reports. This type of regular reporting established accountability and managed expectations.

A balance also had to be struck when performing research in the context of a busy service-driven agency. A large dataset containing plenty of information allows researchers to perform advanced statistical techniques. However, the complexity of data measurement tools has to take into account all the other responsibilities of the shelter staff. Data collection cannot impede important daily activities. For the OBM-McGill partnership, this balance was negotiated though regular stakeholder consultations with frontline staff members. Stakeholder sessions provided a system of checks and balances on the ground to ensure that instruments were capturing information accurately without being too burdensome and changes were made when required.

THE IMPORTANCE OF ORGANIZATIONAL SUPPORT

Projects such as the community-research partnership between OBM and McGill rely on a strong level of organizational support. This project has a number of features that help to ensure success. First and foremost is the OBM administration that values and prioritizes research. The organization recently created a position for a director of research. The director of research is positioned to champion research activities within the organization, perform the administrative actions necessary to plan the projects and keep them funded and identify and resolve prioritization issues that arise between the institutions. The director ensures that the projects are running smoothly and the results are disseminated in an accessible way to all parties.

The second element is the dedicated OBM program counselors who perform data collection duties on top of regular counseling services. Many engage in research further by providing their expert opinions for improving measurement tools. For example, in 2014, a small committee of counselors met at regular intervals with the Research Coordinator to improve upon a questionnaire that assessed client psychosocial status. These counselors met as a group to offer their ideas and individually to perform cognitive interviews – a process that took months to complete. As a result clear definitions of terms were developed and the instrument became more relevant to the OBM context.

Projects such as the community-research partnership between OBM and McGill rely on a strong level of organizational support.

The third element is a full-time research coordinator whose sole focus is this project. While this set-up is unconventional in academic-community partnerships, it is also productive. It provides the shelter with a regular stream of new information and allows many questions to be answered in a relatively short period of time. A principal investigator with previous experience collaborating with community groups is also an asset. This position opens up publication and additional partnership opportunities.

The fourth major facilitator is the presence of a customizable digital administrative database that has been in place for several years. While administrative data has some methodological constraints, it is extremely useful in a population that is traditionally difficult to follow. The information should be in a format that is possible to convert to the necessary statistical programs. An automatic system that randomly assigns unique client identifiers also allows near complete anonymity.

Finally, for a project of this nature, partners need to be flexible and open to self-reflection. For example, the OBM has expressed its commitment to research even if the findings are counterintuitive to current practices and require organizational changes that may prove difficult to implement. On the university side, the evaluative types of requests that come from agencies are difficult to integrate into the expectations of 'what counts' as academic research. The researchers must commit to performing research that may not lead to traditional indicators of academic success like publishing findings in high-impact journals or being awarded large grants.

CONCLUSION

The OBM-McGill community-academic partnership project provides real life examples of how an existing data infrastructure can be used to create a regular feedback loop to better understand and respond to the needs of the homeless population at the community level. Not only does it provide evidence that services are meeting the needs of the target population, but it also creates a culture of research that encourages critical thinking, the examination of biases and the desire to constantly improve based on client needs.

Research offers a forum for organizations to examine their service activities and to consistently ask:

- Does this service address an identified and documented need within the population?
- What impact is the service having on the population (positive/neutral/negative)? Based on what criteria? Are these criteria representative of the desired outcomes?
- How can programs and outcomes be improved? Is there a regulation or policy that needs revision?
- Are there service blind spots or 'forgotten' subpopulations that need attention?
- Is there enough capacity to serve everyone? Are too many resources dedicated to a single area that only requires a few?
- Is there enough focus on prevention?

Understanding the needs and service use patterns of the homeless population is a major step toward ending homelessness. The OBM-McGill community-academic partnership model described in this paper was based in a shelter with a range of programs such as supported housing and community outreach. As such, it is applicable to many different contexts from the development of homeless-centric healthcare services to designing and implementing the supportive services that are associated with the Housing First models. We hope this partnership description will be informative to others seeking to assess the various approaches to homelessness across the country.

Understanding the needs and service use patterns of the homeless population is a major step toward ending homelessness.

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Inter-sectoral Collaborations

3.5

COLLABORATIVE APPROACHES TO ADDRESSING HOMELESSNESS IN CANADA: VALUE AND CHALLENGE IN THE COMMUNITY ADVISORY BOARD MODEL

Rebecca SCHIFF & Jeannette WAEGEMAKERS SCHIFF

Over the past decade, Canadian municipalities have experienced the emergence of formalized systems-level collaborative approaches to addressing homelessness and housing issues. The implementation of such approaches has been widespread and, to some extent, standardized based on the design of 'community advisory boards' (CABs) created by the federal government through the Homelessness Partnering Strategy (HPS). These local committees have significantly affected systems-level strategic planning to address homelessness in urban, rural and remote areas across the country. Despite marked impact and some success, these groups also face challenges related to effective collaboration and governance. This chapter explores the history of CABs in Canada. It provides a reflection on the need to conduct process and outcome evaluation of CABs in order to understand the usefulness and challenges associated with this approach to systems-level planning.

Collaborations generally refer to the alliances that are created at a local, state or national level, by two or more groups or organizations for the intended purposes of effecting systems-level change. To that end, they may converge around mutual goals, strategies, activities and often share resources to achieve mutually agreed on objectives (Backer, 2003). Collaborations have generally been viewed as the activities of local organizations that assemble in order to address one of a variety of issues: networking, increasing organizational visibility, leveraging resources to create greater impact and building overall capacity of the organizations to increase services (Backer, 2003). The broader literature on community collaboration recognizes that, although collaborative entities might be successful in many ways, there is a need for ongoing structural and process evaluation in addition to documenting successful outcomes.

This discussion is framed in the context of the distinction between service-level and systems-level coordination. While coordination and collaboration may be part of the same process, conceptually and practically they address different aspects of planning and implementation and thus they have different implications for policy, planning and service delivery. Service-level coordination focuses on cross-sectoral (which can include interprofessional) alliances and agreements with the explicit aim of

coordinating service delivery. In the context of homelessness, service-level coordination includes the implementation of case management services to assure that clients receive comprehensive support services from multiple serve providers, or to the utilization of Assertive Community Treatment (ACT) or Intensive Case Management (ICM) teams in the context of "housing first" approaches (McNaughton et al, 2011). This coordination can also refer to the development of formal agreements between organizations delivering coordinated services to a specific population, such as in-home supports provided by caseworkers from a mental health agency, to those living in scatter-site apartments in arrangement with the housing agency that supplies the living units. By contrast, systems-level collaboration focuses on policy development and planning, establishing priorities and creating the conditions for service-level coordination to occur. It normally involves the agreement at senior management levels of organizations to adhere to a set of practice principles upon which the service coordination can be scaffolded. Systems-level collaboration occurs, for example, through homelessness coalitions and committees focusing on community-wide analysis to establish priorities and planning. In this discussion we focus on collaborations for systems-level activities.

We begin with an exploration of the multiple and diverse aspects of systems-level homelessness collaboration in Canada. First we trace the history of formalized, local systems-level collaboration to address homelessness in Canada. This is followed by a brief examination of international literature on evaluating collaboratives to provide some direction for future growth and preliminary reflections on the benefit of evaluation to optimize collaborative efforts.

CABS: COLLABORATIVE APPROACHES TO ADDRESSING HOMELESSNESS IN CANADA

The National Homelessness Initiative

Much of the formalized context of local-level collaboration to address homelessness in Canada can be traced back to the creation in 1999 by the federal government of the National Homelessness Initiative (NHI), situated in the department of Human Resources Development Canada (HRDC)[1]. The design of the NHI was partly based on an interest in creating partnerships between government and community organizations to identify and deliver 'local-level solutions.'[2] Delivery of the NHI involved establishment and facilitation of collaborative community-planning processes. A main initial aim of these processes was the development of 'community plans' which were intended to direct the delivery of NHI program funding according to the unique issues identified by individual municipalities. Development of community plans was largely supported under two NHI program components: the Supporting

1. HRDC was replaced by Human Resources and Skills Development Canada (HRSDC) in 2006 and subsequently renamed Employment and Social Development Canada (ESDC).

2. See Evaluation Directorate - Strategic Policy and Research Branch - HRSDC (2008). Summative Evaluation of the National Homelessness Initiative - May 2008 Report # SP-AH-693-05-08E. H. R. a. S. D. Canada. (Ottawa, HRSDC). Accessed April 21, 2015 at http://publications.gc.ca/collections/collection_2013/rhdcc-hrsdc/HS28-149-2008-eng.pdf

Communities Partnership Initiative (SCPI) and the Regional Homelessness Fund (RHF). The other NHI program components consisted of: Urban Aboriginal Homelessness, National Research Program, Homeless Individuals and Families Information System and Surplus Federal Real Property for Homelessness Initiative. Evaluation of the NHI program in 2008 used document reviews, administrative data, key informant interviews and surveys from a convenience sample which lauded its success and encouraged continued funding (Evaluation Directorate, 2008). In this report the agency noted that it could not readily locate membership contacts and information for all CABs, a disconcerting problem for federal policy makers and funders. This examination was also limited by its inability to include informants from all CABs (58% representation), and the notable exclusion of Quebec entities in its survey and interviews. This omission of a Quebec voice continues to impact understanding of CABs in the francophone context. The report can provide a picture of the functioning and impact of some CABs but falls far short of a fulsome examination of their various strengths and challenges.

Communities were given latitude in developing local priorities and some control in the delivery of NHI program components. SCPI was a major program component of the NHI. Through SCPI, 61 communities were designated to develop projects and deliver funding to address priorities identified in community plans. Each locality was given a choice between two program delivery models: the Community Entity (CE) model or the Shared Delivery (SD) model. Under the CE model, the community (in consultation with HRDC) would designate responsibility for development and delivery of the community plan to a community organization. Under the SD model, HRDC[3] would work in partnership with a cross-section of community representatives to implement community plans through selecting, funding and monitoring projects. In most instances both of these approaches resulted in the eventual establishment of community advisory boards (CABs) to undertake this mission.

3. The federal government has changed the name of this department several times in the last 15 years. We have used the acronyms current at the time that relevant policies and practices were enacted. At the present time the department is known as EDSC (Employment and Development Services Canada, or Services Canada)

The Homelessness Partnering Strategy and CABs

In April of 2007, the NHI was replaced by the Homelessness Partnering Strategy (HPS). While many components of the NHI remained intact, the focus shifted strongly towards concepts of collaboration and community ownership. HPS describes itself as "a community-based program that relies on communities to determine their own needs and to develop appropriate projects" (Human Resources and Skills Development Canada, 2011: para. 1). The mandate of HPS focused on the 61 designated communities as well as provisions for some rural, northern and off-reserve Aboriginal communities.[4] While most communities were defined municipal entities, a few larger areas were designated as 'community and developed Regional Advisory Boards' (RABs). Within its structure, HPS collapsed the multiple NHI programs into three main components: Homelessness Partnership Initiative (HPI), Homelessness Accountability Network and Surplus Federal Real Property for Homelessness Initiative. The HPI essentially replaced SCPI in terms of supporting development of the CABs, community plans and community implementation. HPI created a standardized and formalized approach to systems-level[5] homelessness collaboration which is unique to Canada. Under the program, each designated community was expected to create and maintain a CAB which would supervise the creation of its own community plan. In some communities, this board came under the umbrella of the municipal government, in others it consisted of a group of representatives of local services providers. Under HPI, the 61 designated communities receive a pot of funding to distribute in support of developing and implementing community plans. This funding was also usually contingent on matching dollars from provincial and local authorities. CABs then utilized community plans to determine how to deliver the available HPI funding in their community in order to meet the objectives of their plan.

CABs in Designated and Non-designated Communities

HPI continues to be the federal program that drives initiatives to address homelessness and to funnel federal dollars into local designated communities for this purpose. It also provides some limited funding for municipalities that are not included in the 61 designated communities. These non-designated communities were initially referred to as Aboriginal (off-reserve) and Outreach communities. In 2011, they became referred to by HPS as 'Rural and Remote' communities. Some non - designated communities have also developed CABs to guide the development and implementation of community plans. A primary difference between the 61 designated CABs and Rural and Remote CABs is that the latter do not receive an annually renewable, dedicated pot of funding to implement their plans. CABs in rural and northern non-designated communities do not have access to or responsibility for delivering an ongoing stream of funding as do those in designated communities. Instead, they must apply to HPS for funding on an as-needed basis through the Rural and Remote funding stream. Although funding is limited for implementing community plans, due to their role as strategic coordinators of homelessness services in their communities, northern and rural CABs do have some ability to influence funding priorities from federal, provincial, municipal and private funding sources (Schiff, 2014; Schiff & Brunger, 2015). As such they are similar, although more limited, in mandate and function to CABs in designated communities.

More recently, CABs have begun to communicate with each other to advocate for needs and issues as a collective. Over two-thirds of the 61 designated communities have participated in one of two national meetings (2013–2014) which were independent of

4. Explanation of the process utilized for selecting designated communities can be found at http://www.hrsdc.gc.ca/eng/homelessness/funding/designated_communities/index.shtml and a list of designated communities at http://www.hrsdc.gc.ca/eng/success_stories/homelessness/01/page03.shtml

5. 'Service-level' coordination focuses on cross-sectoral (or inter-professional) collaboration with the explicit aim of coordinating service delivery. By contrast, 'systems-level' coordination focuses on planning, or creating the conditions, for service level coordination to occur. Systems-level coordination occurs, for example, through homelessness coalitions and committees focusing on community-wide analysis and planning.

federal government and HPS activities (CHRA, 2013). In this formative process they began to urge HPS to face lack of housing as the primary cause of homelessness and to examine other housing approaches that have been successful across various Canadian municipalities for many years. However, a number of CABs have not participated and there is no representation from Quebec. Recently, HPS has posted summaries of community plans for large and small communities, but has not made public the community plans for any of the CABs. It can be difficult to determine the extent to which they have developed a comprehensive plan to address homelessness in their communities. Although many have reportedly submitted plans, it is also unclear as to how many of these communities have operating CABs and the extent to which they have been able to implement programs to address local issues of homelessness. This again raises questions about the need for independent formative and structural evaluation to help improve implementation, operating conditions and outcomes for these groups.

Evaluations of HPS CABs

In 2008, HRSDC acknowledged the need for guidance in terms of governance structures and processes for CABs (2008) and it began with some consultation with selected CABs to produce a set of guidelines for elements of a well-functioning CAB (ESDC, 2013). Further consultation with some of the 61 designated communities in 2011 produced a series of recommendations on main aspects of a well-functioning board. The 2008 self-evaluation concluded that CABs have been successful in developing community plans, delivering HPS funding and "improving the coordination of services and supports in their communities" (Evaluation Directorate, 2008:19). However, this report lacked a substantive Quebec presence in the interviews and surveys used to assemble data, and was vague about the actual number of CABs contacted and included in the evaluation. This makes it limited in its applicability to entities across the country. The consultations also fell far short of a fulsome evaluation by trained and independent evaluators on what works and in what context. This echoes what Backer (2003) reported: that many collaborative approaches lack evaluative studies, which leaves them as celebrated but not validated initiatives.

A few other studies have investigated issues related to homelessness collaboratives in Canada. A PhD dissertation by Doberstein (2014) examined the structure and dynamics of Toronto and Vancouver CABs and concluded that the more institutionalized and inclusive Vancouver organization was a key factor in its effectiveness in implementing a homelessness policy and programs that have reduced Vancouver's homelessness. Schiff (2014; 2015) and Schiff and Brunger (2015) examine issues related to challenges and successes of CABs in northern and non-designated communities. The Greater Vancouver CAB was the focus of an independent study that looked at the collaborative process and the impact of representatives of service organizations in decision making regarding HPS funding allocations (Doberstein, 2015). It concluded that their process showed considerable collaborative efforts (Doberstein, 2015). Results of that study suggest that collaborative approaches in the form of CABs might create particular impact in terms of policy development and implementation.

The only truly comprehensive and independent outcome evaluation of a CAB (examining impact and effectiveness) is that of the St. John's (NL & LAB) group which was completed in 2012 as part of its first 10 years of operation (Goss Gilroy Inc., 2012). This

evaluation included key informant interviews, a focus group, survey of members, case studies and a document review covering the CAB's history. It noted that the CAB had made a marked impact in several areas: building partnerships and leveraging other monies to increase infrastructure, facilitating data collection, providing planning support, supporting research, and increasing community awareness of homelessness. Among outcome indicators the evaluation examined the CAB's (positive) impact on its ability to meet clients' needs, on member organizations and other community organizations, the community and government.

Apart from this report and the Doberstein report on the collaborative funding process of the Vancouver CAB (2015), there is a near absence of literature examining impact, effectiveness and challenges experienced by Canadian homelessness collaboratives. Less than half of the known community plans are readily accessible for public discussion and little is known about communities that have been unable to produce a comprehensive plan or to effectively implement a plan's recommendations. This is in sharp contrast to HPS directives that CABs need to be open and accountable (HPS, 2013). Implicit in this is the conclusion that some communities are unable to find adequate ways to implement an effective CAB to address homelessness and that there is no effective mechanism for addressing this lack.

These reports all indicate that homelessness coalitions in Canada might experience challenges related to effective collaboration and governance. In addition to issues of accountability for government initiatives, the wide literature base on evaluating the impact and effectiveness of community collaborations recognizes that, although collaborative entities might be organized and successful in many ways (Provan & Kenis, 2008), there is always a need for ongoing structural evaluation (Backer, 2003). While homelessness collaboratives in the U.S. and UK have benefited from formal, independent evaluation, there could be valuable lessons learned from their experiences and findings.

EVALUATING THE IMPACT AND EFFECTIVENESS OF HOMELESSNESS COLLABORATIVES

Evaluating Community Collaborations

When formal collaborations involve multiple organizations with diverse missions and the individual styles of multiple players, the task of identifying evaluation foci, strategies and outcomes becomes complex and often difficult to navigate. System-level coordination through community collaborative processes operate across a diversity of focal areas (e.g. healthy living, policing, homelessness and food security, among others) and share many structural similarities.

Over the past several decades, initiatives to evaluate these types of entities have been slowly emerging as they find themselves accountable for a variety of outcomes (Sowa, 2008). Foster-Fishman et al (2001) synthesized the literature on various types of community-based collaborations and articulated a detailed list of individual, group and organizational competencies and capacities that need to be considered in examining the structure and functions of collaborative entities. They include on an individual level

knowledge, skills and attitudes that allow for effective interpersonal and group work; the capacity of the organization (collaborative) with respect to leadership, internal and external communication, resources and mandates; and the ability of the collaborative to arrive at unique, innovative (not duplicative) programs and initiatives.

Evaluation of collaboratives is a complex task that includes individual-, group- and system-level analysis. A synthesis of previous research by Mattessich & Monsey (1992) identified factors related to characteristics of membership, communication, process and structure as well as the environment that all had direct influence on building and sustaining successful coalitions and collaborative initiatives. A further review by Taylor-Powell & Rossing (2009) elaborated on the previous work and noted that "the level of organizational and/or community 'readiness' to undertake collaborative work, including such factors as awareness of need for an integrated approach, resource availability, flexibility in organizational structure and communication, history of collaborative work, favourable political and social climate…" (5) is critical to success. It may be important to first help establish the community's capacity for change as well as the potential of a collaborative to foster change" (6). Thus the evaluation process cannot be measured solely in outcomes, as the extent to which it becomes a formative process that readies a community for change is an important pre-determinant of ultimate outcomes.

A different perspective on evaluating collaboratives comes from the social policy field where it is encompassed in discourse around network governance. When viewed from a policy perspective (rather than the social psychology views of Foster-Fishman et al), the analysis and outcomes are more likely to be put in systems and government policy development terminology (Provan & Milward, 2001). Notwithstanding the change in focus, researchers from both perspectives, as well as those in social services administration, concur on the need for more robust understanding of the various forms of these collaboratives and a deeper inquiry on the models that lead to effective outcomes (Foster-Fishman et al, 2001; Provan & Kenis, 2008; Snavely & Tracy, 2000) .

Recently, some literature on evaluating community collaborations has emerged out of the U.S. which focuses specifically on homelessness 'coalitions' and collaborative entities in that country. Hambrick and Rog (2000) published one of the earliest comprehensive examinations of coordination in the U.S homeless sector. They argue that coordination "has been a (if not the) dominant theme at all levels" of government in the U.S. (353). They identify service-level coordination (as appears in the form of various case management and service provider team approaches) as well as systems-level coordination occurring through homeless coalitions and councils. Much of the subsequent literature discusses homeless coalitions or 'councils' in the context of the Continuum of Care (CoC) funding stream in the Department of Housing and Urban Development (HUD) which, in 1994, began to mandate development of networks among agencies as a pre-requisite for funding (Macgill, 2011).

Macgill (2011) provides an overview of much of this emerging but limited body of literature through an examination of compiled applications to the HUD CoC funding stream from 2008. Out of the 457 CoC mandated networks in existence at the time, a random sample of 30 were selected to evaluate organizational structure and process. The results confirm previous findings about the elements which create challenge and success in these organizations.

- Lewis et al. (2009) and Ivery (2008) find that larger organizations, due to greater human and resource capital, have more capacity to participate in collaborative processes. This may disadvantage smaller and more specialized programs that serve unique populations of homeless persons, and leave them out of funding or policy making decisions.
- Provan & Milward (2001) identify issues created when networks become "too large" in that the capacity for the coalition to create meaningful collaborations declines.
- Ivery (2010) indicates the importance of stable leadership and points to the significance of governance structures in creating effective collaborative processes. This also underscores the vulnerability of coalition stability in times of changing leadership. The extent to which leadership changes are also impacted by political leadership changes further amplifies the importance of strong and continued leadership.

Magill (2011) indicates a further finding: that clarity in structure and process creates a more engaging environment for maintaining members' interest and bringing new participants to the table. This is reminiscent of theory on cross-sectoral collaboration in general (Backer, 2003; Butterfoss et al, 1993; Fishman et al, 2006).

One study out of the UK focuses specifically on rural systems-level collaboration in the homeless sector and identifies some issues not found in the U.S. literature (Cloke et al, 2000). In this work, the authors discuss the significance of pre-existing discourses on homelessness in dictating the strategies used to address issues. Those with little social or political power who espoused contrary discourses were unable to rework social relations to have their ideas respected in the collaborative process. This meant that those individuals or organizations with power could manipulate the agenda of a coalition to their own interests and understanding of the issues surrounding homelessness. Cloke et al. (2000) conclude that merely repackaging existing resources and social relations will not fulfill goals of creating more pluralist forms of governance. They also point to the need for government investment of human and capital resources as important to make partnerships work. This study was set in a rural context and may have particular relevance in areas where there are more limited resources, fewer key players in the collaboration and where local attitudes may be shaped by a few powerful individuals. While these dynamics will also factor in larger urban settings, their relative importance may vary with the addition of multiple stakeholders and various political voices.

DISCUSSION: VALUE AND CHALLENGE IN THE CAB MODEL

The existing literature on evaluating community collaborations and the few evaluations of Canadian CABs provide some insight into some of the challenges experienced by these groups. We point to three particular challenges: issues related to funding for CABs and their funding priorities; autonomy in decision making processes; and need for formal, independent evaluation.

Funding

CABs were initially promoted by HPS as the local organizations that would provide analysis of homeless problems in a given municipality or region, and then determine how the problems would be addressed. They were expected to develop a community plan that would identify issues and prioritize solutions. They were also charged with determining which housing proposals should receive federal HPS funding with the contingency that federal dollars needed to be matched with local and provincial funding. This was meant to assure the integration and collaboration of local and provincial efforts. CABs were expected to establish mechanisms for determining the size of the homeless population in each region and quantify the demographics through a homeless management information system that would eventually be linked to a national database. Under the guise of local control and responsibility, the devolution of housing responsibility to a partnership between CABs and provincial ministries in charge of housing, concomitant with federal cost sharing, effectively put the responsibility for housing on the local rather than federal level. This was not followed with revenue sharing or revenue generating mechanisms that would allow local entities to implement plans without additional burden on municipalities. Effectively, CABs became a political mechanism that released the federal government from being the major financial contributor to social housing or a national housing policy. There was promise, with the original directives that local boards identify community priorities, that the delegation of authority and responsibility would accompany the devolution of fiscal input. Sadly, this has not happened.

Autonomy and Local Decision Making

Another challenge is that CABs are not always in charge of determining the direction of their initiatives and programs. Schiff and Brunger (2015) point to some specific concerns in northern, non-designated community contexts. While historically the implementation of and identification of homeless issues and planning was devolved to the community level, recently HPS has shifted its expectations of local plans and their enactment. When the boards were established they were charged with finding local solutions to local problems. In the last couple of years, HPS has taken a firm command of the direction in which communities must move to address its problems housing homeless people. What began in 2012 as a directive to implement a "housing first" approach to ending homelessness, has escalated to a set of directives that places the housing of the most chronically homeless as the first priority of all communities.

With the release in 2012 of the preliminary results and in 2014 of the final results from the Mental Health Commission's study, At Home/Chez Soi (Goering et al, 2014), which focused on a "housing first" approach to sheltering chronically homeless individuals with mental illnesses and concurrent addictions, HPS moved to adopt this philosophy as a national mandate to housing. Despite the fact that this study only focused on one sector of the homeless population, lacks comparison with other supportive housing initiatives existing in some Canadian cities and had outcomes that are less robust than reported in previous American studies using the same "Housing First" model, HPS established a policy to apply housing first as an approach across all populations. Effectively, this has once again shifted the dynamics as the federal government has actively stepped in to mandate that "Housing First" is the preferred national housing model and has instructed CABs to place priority on those initiatives that use this approach. The mandate is reinforced by the requirement that 65% of all funding be allocated to "housing first" initiatives. This recent directive reinforces the position that HPS sets the policy while expecting local CABs to comply, often with little or no prior consultation.

When placement of a target of 90% of chronically homeless, those with the longest and most persistent length of homelessness, termed 'housing first individuals,' has been met, the community may move on to a second set of less seriously displaced. HPS also provides a long list of directives as to what is admissible as a program qualifying for "Housing First" funding and which programs and services constitute acceptable initiatives. It also mandates a plan to move people rapidly to permanent supports that are not part of the HPS effort and must come from existing local and provincial programs. Finally, while the Housing First model requires ACT or ICM teams to provide supports, HPS deems the ACT team to fall under the purview of the health care system and will not allow for their funding. This further hobbles the work of the CABs, especially since homelessness and health are intricately related (Hwang, 2001).

These directives have resulted in considerable turmoil for CABs around the country. On the one hand, they have been mandated to complete and execute plans to end homelessness. On the other hand, HPS has taken control of housing priorities and approaches by unilaterally assigning the priority group and its approved methods for housing. Notwithstanding the fact that the Housing First approach has been shown to be effective with one group (those with a mental illness and co-occurring substance use, and not with all people in the homeless population) and that the evidence is modest but not overwhelming (Goering, 2012; Rog, 2013), it has removed local control and input in the decision and execution of this mandate. This is a complete reversal of

the intent of CABs as originally envisioned, but does not remove them as significant actors as they are still responsible for raising matching funding for all programs and designating which programs will obtain funding. Finally, HPS has directed that all Housing First persons should be housed and shifted to other programs by the end of its current funding cycle in 2019, again with no evidence that this is possible or feasible in many instances of chronic homelessness. Essentially CABs have been allocated considerable responsibility but have moved from quasi-independence to federal control of their mission and mandates.

Process and Effect Evaluation

The broader literature on community collaboration and the evaluative studies out of the U.S. and UK point to the value of formal, independent process and effect evaluation. In the context of HPS CABs, for municipalities and designated regions to qualify for funding to address homelessness and to extend the impact of meagre resources, the additional task of evaluating their process and outcomes is often tabled in favour of allocating funds and resources to achieve the aims of the collaborations. While HPS has developed a report on "Elements of a Well-functioning CAB/RAB" (2013), which includes a number of recommendations of CAB/RAB recognition of accountability for its organization, functions and products, there is no mention of the need to evaluate individual CABs or how the accountability should be operationalized. As Backer (2003) suggests, in order to continue to operate effectively, collaborative entities have a need for ongoing process and outcome evaluations.

CONCLUSIONS

The CAB model has significantly affected systems-level strategic planning to address homelessness in urban and rural areas across Canada. Despite these impacts, there has been little research examining the nature and effectiveness of these organizations. Due to the Homelessness Partnering Strategy's focus on designated communities for their own internal evaluations of CABs, there is even less known about systems-level homelessness collaboratives in in rural, northern, and other non-designated communities. There is evidence that points to challenges experienced by CABs related to funding, autonomy and structural evaluation. Systems-level homelessness collaborations in Canadian communities might need more support for formative evaluation, organizational structuring, coordination and research. There is also a need to understand the relative effectiveness of different approaches through comparative analysis at regional, national and international levels.

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Inter-sectoral Collaborations

3.6

"WHAT IS NEEDED IS THE MORTAR THAT HOLDS THESE BLOCKS TOGETHER": COORDINATING LOCAL SERVICES THROUGH COMMUNITY-BASED MANAGERIALISM

Josh EVANS & Robert WILTON

INTRODUCTION

Historically speaking, responses to homelessness in Canada have been formed most directly at the local level, most often led by faith-based, volunteer-driven charitable organizations with long histories of serving low-income and unhoused individuals and families. These local and informal voluntary landscapes typically provided basic stopgap services such as emergency shelter and meal programs to homeless populations. Until the late 1980s, these voluntary landscapes operated largely outside the purview of provincial and federal governments (Wolfe & Jay, 1993); however, during the 1990s, as housing crises worsened and shelters became overburdened by a growing and increasingly diverse homeless population and as funding regimes evolved, these voluntary landscapes of care underwent a significant re-configuration shifting from a 'patchwork' of crisis-relief programs largely operating in isolation to a more 'seamless' network of outcome-orientated programs focused on moving individuals from the street to the shelter and into independent housing. An emergent priority in this re-configured system has been both increased inter-agency coordination and the targeting of services to chronically homeless individuals with complex needs living in the shelter system. In addition, this re-configuration has relied upon collaborative planning and local partnerships between local government and voluntary organizations.

In this chapter, we use a case study to conceptualize this form of local coordination, a form of governance we call community-based managerialism (CBM), and assess its impacts on the local voluntary sector. Our case study is based on research that chronicled how local actors (municipal officials, voluntary sector organizations) responded to the burgeoning crisis of homelessness in Hamilton, Ontario between 1999 and 2009. The research combined a number of qualitative methods, including interviews and document analysis, to gather multiple perspectives on the experience of homeless people, the experiences of government and voluntary sector actors involved in service provision and the evolution of social policies aimed at addressing homelessness in the city.

We use this case study to argue that efforts to coordinate local services proceeded through the scaffolding of 'soft' community arrangements over top 'hard' managerial arrangements (a form of governance we term

CBM) which more effectively focused services on the chronically homeless but also reconfigured the local voluntary landscape. Here we understand soft arrangements to refer to horizontal networks of collaborative decision making, social partnership and coordinated service delivery and hard arrangements to refer to linear top-down decision making, performance management and contractually organized service delivery (Craig & Cotterell, 2007).

In what follows we first review relevant literatures on state/voluntary sector relations and define some of the terminology used in this chapter. We then turn our attention to the coordination of homelessness services in Ontario before examining the Hamilton experience in more detail. This is followed by some concluding reflections on the governance of community services for homeless people through community-based managerialism.

INSTITUTIONAL ARRANGEMENTS, STATE/VOLUNTARY SECTOR RELATIONSHIPS AND THE VOLUNTARY LANDSCAPE

The voluntary sector has played a key role in responding to the crisis of homelessness in Canada. Generally speaking, the 'voluntary sector' refers to a collection of independent, self-governing, non-profit organizations that are constitutionally independent of the state but which often work closely with the public sector and for the public good. The neoliberal restructuring of welfare states in countries such as Canada has assigned more formal responsibility to the voluntary sector for the delivery of public services (Evans & Shields, 2001). In the process, voluntary sector organizations have developed closer relationships with the state, relationships shaped through various institutional arrangements joining the voluntary sector to the state. In this chapter, we consider two types of arrangements: hard managerial arrangements and soft community arrangements (Craig & Cotterell, 2007). Each of these arrangements has featured in scholarly literatures on the voluntary sector. Each has also been associated with a particular type of voluntary landscape: the shadow state and the partnering state, respectively. These literatures are reviewed next.

The neoliberal restructuring of welfare states in countries such as Canada has assigned more formal responsibility to the voluntary sector for the delivery of public services (Evans & Shields, 2001)

Hard Arrangements and the Shadow State

Hard arrangements pertain to public management reforms in the early 1990s marked by the proliferation of contractual relationships, accountability controls and performance measures that accompanied privatization strategies in the neoliberal era (Craig & Cotterell, 2007). This form of public administration has been labeled the New Public Management (NPM) (Clarke & Newman, 1997). Craig and Cotterell (2007) label these arrangements hard because they facilitate, in a hierarchical fashion, the bureaucratic and administrative control of welfare services and, by extension, local voluntary organizations.

One of the primary administrative devices of NPM is contracting between the state and voluntary sector organizations for public services. The shift towards NPM strategies in the 1980s and early 1990s ushered in a 'contractual regime' consisting of purchaser-provider splits between the state and the voluntary sector (Smith & Lipsky, 1993). An important element of this 'contract culture' has been the creation of quasi-markets through 'managed competition' (e.g. state-coordinated competitive bidding processes) among voluntary sector organizations for service contracts (Cloutier-Fisher & Skinner, 2006). Principles of accountability and efficiency have also guided NPM strategies manifesting as output-orientated and target-based measures of performance and accountability that are pegged to the contractual regime (Clarke & Newman, 1997).

Literature in the social sciences (e.g. Baines, 2004; Gibson et al., 2007; Phillips & Levasseur, 2004; Shields & Evans, 1998; Smith & Lipsky, 1993) and human geography in particular (e.g. Cloutier-Fisher & Skinner, 2006; Milligan & Conradson, 2006; Skinner & Rosenberg, 2006; Trudeau, 2008b) have examined the impacts of NPM reforms on the voluntary sector. On the whole this literature has shown how the ethos and structure of voluntary sector organizations changed as nonprofits are required to function more like entrepreneurs and 'do more for less' (Evans & Shields, 2001). By providing incentives for professional skills and training, competitive bidding processes have encouraged professionalization (Smith & Lipsky 1993). In many cases this has altered the types of services voluntary sector organizations deliver. As a result, many nonprofits have evolved from small grassroots organizations to large bureaucratic, corporatist organizations (Milligan & Fyfe, 2005).

By providing incentives for professional skills and training, competitive bidding processes have encouraged professionalization (Smith & Lipsky 1993).

Many of these themes are captured in the shadow state concept developed by Jennifer Wolch (1989, 1990). Wolch coined the shadow state concept, in the context of welfare state devolution and privatization in the 1980s, to describe a quasi-state apparatus created through the contracting of voluntary sector organizations by the state for public service delivery (see DeVerteuil et al., 2002; Lake & Newman, 2002; Mitchell, 2001; Trudeau, 2008a). This shadow state apparatus is bureaucratically administered in a hierarchical fashion outside of democratic oversight. As this apparatus develops, the voluntary sector becomes increasingly dependent on state funding and in turn is subject to increased administrative control by the state. As a result the expansion of the shadow state apparatus facilitates the penetration of the state further into civil society and, by extension, into communities and the everyday lives of service users.

Soft Arrangements and the Partnering State

In the more recent period, new soft arrangements that emphasize "the strategic importance of civil society for social cohesion and economic vitality" (Fyfe, 2005: 539) have emerged. Rather than focus on transforming the voluntary sector into a market and nonprofits into entrepreneurial actors as NPM reforms aimed to do, soft arrangements seek to use voluntary organizations as instruments to reinvigorate civil society (Fyfe, 2005) by promoting community collaboration and partnership and fostering social capital and active citizenship (Milligan & Fyfe, 2005). Soft arrangements have typically been associated with local grassroots participation and a shift towards 'networked' and 'horizontal' forms of coordination (Phillips, 2004; Saint-Martin, 2004). Craig and Cotterell (2007) label these forms of coordination soft because they are premised on partnership, collaboration and interdependence as opposed to hierarchical command and control principles.

These soft arrangements have generated a stream of recent literature on voluntary sector experiences (e.g. Fyfe, 2005; Milligan & Conradson, 2006; Milligan & Fyfe, 2005; Trudeau, 2008a, 2008b). This research has re-examined voluntarism in the context of the repositioning of voluntary sector organizations from simple delivery agents to partners in a community governance paradigm (Edwards & Woods, 2006; Halseth & Ryser, 2007). These new spaces of governance have prompted some to rethink issues of cooptation and concepts such as the shadow state. Trudeau (2008a) has put forward the revised notion of a 'relational shadow state' which moves away from viewing voluntarism as the straightforward cooptation of voluntary sector organizations by state agendas and rationalities. Trudeau (2008a) instead directs attention to the multiple directionalities of influence and agenda setting that characterizes contemporary state-civil society relations. He argues that interactions between the state and civil society actors are better approached as relational in nature, reflecting the growing preference for soft institutional arrangements in social policy.

Much in the same vein, others have pointed to the notion of a partnering state (Larner & Craig, 2005; Larner & Butler, 2005). Central to the notion of the partnering state is what Larner and Butler (2005: 80) define as local partnerships: the "multi-level collaborative arrangements that aspire to 'join up' central government agencies, local institutions (e.g. local authorities, schools, hospitals) and/or community and voluntary sector groups." According to Larner and Butler (2005, 2007) the partnering state cannot be read as a straightforward top-down cooptation of the voluntary sector by the paternalistic state (as portrayed by the shadow state concept). Instead, local partnerships are characterized by processes of contestation through which community agendas penetrate the state.

Some, however, have identified problems with the partnering state. Milligan and Fyfe (2005, 2006), for example, suggest that voluntary sector agencies are forced down two strategic pathways: one, embrace the renewed state-voluntary sector compacts and sacrifice traditional voluntary ideals and independence in exchange for partnership working and empowerment strategies (e.g. renewal) or, two, maintain independence to pursue traditional ideals by de-centering to the margins away from state partnerships and by extension funding (e.g. relocation). Milligan and Fyfe (2006) suggest that these divergent pathways have contributed to a bifurcated voluntary landscape consisting of large, professionalized, hierarchical corporatist organizations and small, informal, non-hierarchical 'grassroots' organizations (Milligan & Fyfe, 2005; Fyfe & Milligan, 2005). Others have raised questions regarding the degree to which the more recent emphasis on partnerships are only skin deep in the sense that they conveniently outflank problems such as homelessness, deepening neoliberal ideals and market rationalities in the process (Graefe, 2007; MacMillan & Townsend, 2006).

These questions concerning the nature of soft institutional arrangements and the ways in which they are layered onto other harder institutional arrangements have implications for how we interpret the governance of community services for homeless populations. In the following section, we use a case study of homelessness policy in Hamilton, Ontario to examine the implications of efforts to coordinate local services through a combination of hard *and* soft institutional arrangements, a mode of governance we call CBM. Our case study draws upon 20 key informant interviews with representatives of voluntary sector service providers and municipal government officials from Hamilton. Interviews were digitally recorded, transcribed and analyzed alongside relevant policy documents and materials.

These questions concerning the nature of soft institutional arrangements and the ways in which they are layered onto other harder institutional arrangements have implications for how we interpret the governance of community services for homeless populations.

THE GOVERNANCE OF HOMELESS SERVICES: THE ONTARIO CONTEXT

Provincial policies have had enormous impacts on levels of homelessness and service responses. In Ontario, the intensification of homelessness in the late 1990s was profoundly shaped by cutbacks at the provincial level. From 1995–2002 Ontario was governed by an ultra-conservative political party that introduced a radical neoliberal policy agenda. These policies were particularly damaging to people living in poverty. Almost immediately upon taking control of government, then provincial Premier Mike Harris cut social assistance rates by 21.9%, eliminated rent controls and cancelled the construction of 17,000 social housing units (Hulchanski, 2004). In addition to rolling back key aspects of the welfare state, the government also rolled out transformative institutional reforms. First, the government introduced the *Ontario Works Act* (*OWA*) (1997) which converted the province's welfare program to a U.S.-modeled workfare program (Peck, 2001). Second, the government forced the amalgamation of several municipalities and downloaded social welfare responsibilities in areas such as social and community health services. During this 'local services realignment,' as it came to be called, the provincial government retained significant responsibilities such as setting overall program objectives and standards. Provincial involvement in homeless services was limited to five programs at the time, two of which were cost-shared (80/20) between the province and municipalities. After the re-alignment, municipalities assumed responsibility (and the added cost-burden) for administering and delivering these programs.

In Ontario, the intensification of homelessness in the late 1990s was profoundly shaped by cutbacks at the provincial level. From 1995–2002 Ontario was governed by an ultra-conservative political party that introduced a radical neoliberal policy agenda. These policies were particularly damaging to people living in poverty.

The restructuring of the late 1990s had far-reaching implications with regard to the governance of homeless services at the local level. While roll-backs exacerbated poverty and increased demands for welfare assistance, downloading shifted more responsibility and cost-burdens for welfare services to municipalities. These shifts created an austere fiscal predicament for municipal governments. To cope with these responsibilities and rising demand for services, services such as emergency shelter provision were contracted to local voluntary sector organizations. These services were funded through 'purchase-of-service' contracts, a model originating in the early 1980s (Laws, 1992). These contracts compensated voluntary sector organizations with a per diem, the value of which was set by the province, for each night a person stays at the shelter. The cost of this per diem was cost-shared by the province and municipality (80-20 respectively). The *OWA* legislation sets the general rules regarding what was expected from shelter providers under these purchase-of-service contracts. For example, under the *OWA* service providers have provided shelter, food and basic supervision. Under this funding regime, voluntary sector portfolios rapidly expanded to meet the demand for emergency accommodation. Under the broad mandate of the *OWA*, service providers had the freedom to craft their own shelter programs and these largely followed their organizational philosophies and missions leading to organizational 'silos' as well as underserviced populations.

In 2002, the provincial government changed over to the Liberal party and new Premier Dalton McGuinty (2002–2013) initiated an explicit 'Third Way' political agenda (Coulter, 2009). McGuinty's policies reflected a more inclusive agenda and programs were routinely wrapped in the language of social investment.

In the decade that followed, this state-voluntary sector relationship was transformed again by provincial and federal programs that introduced a number of hard and soft arrangements. In 2002, the provincial government changed over to the Liberal party and new Premier Dalton McGuinty (2002–2013) initiated an explicit 'Third Way' political agenda (Coulter, 2009). McGuinty's policies reflected a more inclusive agenda and programs were routinely wrapped in the language of social investment. In 2005, the five provincial homeless programs that survived the Harris era were merged into the *Consolidated Homelessness Prevention Program* (CHPP). While funding levels remained unchanged, the program itself was more ambitious in terms of how it sought to coordinate services at the local level. CHPP aimed to: create seamless service continuums to reconnect individuals and families and assist those at risk of homelessness; promote innovative and flexible client-centred approaches to service delivery; provide support for planning and management activities such as research and the development of community plans; and track client outcomes and performance measures. Municipalities were required to report regularly on six performance measures such as the number of homeless individuals served and the number of homeless individuals moved from the street to temporary accommodation and then to permanent accommodation. Nonetheless, much of the social policy and funding arrangements introduced under the previous government remained unchanged (e.g. elimination of rent controls, abandonment of social housing commitments, downloading of social service delivery).

The federal government, in introducing its own hard managerial and soft community arrangements, also played a significant role transforming state-voluntary sector relationships in Ontario. In the last decade, perhaps the most significant homeless program in Canada has been the federal government's *National Homelessness Initiative* (NHI), now called the *Homelessness Partnering Strategy* (HPS). Shortly after disentangling itself from the social housing sector in 1995, the federal government launched the three-year (2000–2003) NHI. The NHI was designed to assist local

communities in alleviating homelessness, which was widely perceived as a national crisis by the year 2000 (Graham et al., 2003). The underlying rationale of the NHI was to address the fragmented nature of community services at the local level. The NHI sought to promote a continuum of community-based supports by empowering local governments, community agencies and other partners to work collaboratively towards integrated strategies and community action plans.

The cornerstone of NHI was the Supporting Community Partnerships Initiative (SCPI). SCPI was conceived as a capacity-building program that would promote community-based partnerships among government, private and voluntary sectors and develop strategies to reduce street homelessness. These strategies were to be data driven and informed by tailored community plans. Investments were to be directed towards seamless and integrated service models that could be delivered in a collaborative manner. Decision making was carried out through a Community Entity (CE) model wherein a municipality or an incorporated body authorized to make decisions on behalf of the community makes project selection decisions. In light of the continued growth of homelessness, SCPI was later extended an additional three years (2003–2006). In 2006, the federal government changed hands from the Liberal Party of Canada to the Conservative Party of Canada. Initially the new Conservative government extended the SCPI program an additional year (2006–2007). The NHI and SCPI were then re-branded as the Homeless Partnering Strategy (HPS) and the Homeless Partnering Initiative (HPI) respectively. The HPI (2007–present) is similar to SCPI in its focus on community-based partnership. It differs, however, in its explicit adoption of a Housing First (HF) approach and a heavier emphasis on outcomes and performance management.

The HPI (2007–present) is similar to SCPI in its focus on community-based partnership. It differs, however, in its explicit adoption of a Housing First (HF) approach and a heavier emphasis on outcomes and performance management.

In summary, the governance of community services for homeless populations in Ontario has long been a local endeavor involving provincial and municipal governments and, most directly, voluntary sector organizations. Voluntary organizations have, until recently, operated rather autonomously under the vague prescriptions of the *OWA* and contractual terms defined by service agreements with the municipality. In recent years, however, provincial and federal homeless programs have encouraged the development of more seamless service systems delivered through soft community-based partnerships managed using hard performance evaluation tools. These latter programs have transformed the level and scope of service integration at the local level. The next section examines these transformations in more detail paying particular attention to the impacts on the voluntary sector, using Hamilton, Ontario as a case study.

COORDINATING THE LOCAL VOLUNTARY LANDSCAPE: COMMUNITY-BASED MANAGERIALISM IN HAMILTON, ONTARIO

Our case study is organized into three subsections. The first subsection describes the emergence of a managerial approach to homelessness structured by hard institutional arrangements. The second subsection describes the co-emergence of a complimentary and interlocking community approach to homelessness structured by soft institutional arrangements. The coexistence of these two forms of coordination constitutes a form of local governance we call CBM. The third subsection describes the impacts of CBM on the local voluntary sector.

The 'Managerial Turn'

In 1999, community services for homeless people in Hamilton, Ontario encompassed a network of emergency shelters operated by local voluntary sector organizations. Over the course of 10 years, the coordination of these services came to be reshaped by a 'managerial turn' towards outcome measurement and performance evaluation. The shift was rationalized in local policy documents and by local actors as a necessary response to the fragmented and crisis-orientated landscape of homelessness services, a landscape representing significant costs to the city and the province as poverty rose, housing affordability worsened and emergency shelters swelled (City of Hamilton, 2003, 2004, 2009). This encompassed a strategic shift away from disconnected program silos towards an integrated and proactive service system orientated around efficiency and sustainability. This emphasis on creating measurable and integrated service systems reflected the strategic focus of federal programs such as SCPI/HPI and Ontario's CHPP. Both programs required enumerating local homeless populations and tracking performance measures such as the number of homeless individuals served in shelters and moved into permanent accommodation. Both programs also emphasized the creation of integrated service systems.

By bringing local service providers together into a new service system city officials in Hamilton sought a more sustainable approach that could alleviate homelessness and address the rising costs associated with providing emergency shelter. Key components of this new system were funding mechanisms to reorient the shelter-based programs of independent voluntary agencies to move individuals out of the shelter system and into housing. As one Hamilton municipal official put it:

> *Funding agencies for folks in beds doesn't create an ability to move people out of the shelter system – which is where we want to get to, right? The shelters focus exclusively on that sort of emergency response when it's needed as opposed to longer-term housing, right (...) We want to, again, look at it from a system perspective and say, 'where's the best place to invest?' (Municipal Official 2)*

Programs implemented to monitor and measure changes in service usage were instrumental in identifying the best place to invest. The SCPI/HPI programs were particularly significant here. A major initiative launched through SCPI was the Homelessness Individual and Family Information System (HIFIS). HIFIS was a

database tool that was installed in shelters to collect data on individuals using shelter services. It permitted city managers to track shelter usage by facility and individual over time. This new analytical capacity revealed that the chronically homeless comprised a small proportion of the sheltered population but accounted for a disproportionately large proportion of costs (Culhane & Metraux, 2008).

In 2007, approximately 90% of shelter users stayed in Hamilton facilities for less than 42 days. Approximately 10% stayed for longer than 42 days (City of Hamilton, 2007b). This smaller group, it was believed, consumed a far greater amount of resources and thus represented a greater cost to the city and province. By providing these groups with immediate housing through a HF approach significant cost savings could be achieved. Based on this logic, the targeting of chronically homeless populations became a priority for the city, as did the eventual shrinking of the emergency shelter system (City of Hamilton, 2009). The same municipal official remarked on these priorities:

> *So I think clearly we now have a vision of what our priorities are currently. We know the funding streams that we have. We are consciously, consciously – I mean on this level we are consciously – trying to ensure that we are using our money to meet those priorities. (Municipal Official 2)*

Funding streams from the federal government's NHI/HPI and the provincial government's CHPP were instrumental in pursuing these new priorities. Both provided an assortment of time-limited, project-based grants to the city that facilitated a significant redesign of the shelter system. Designs came to emphasize HF over shelter-first approaches going as far as recommending the planned shrinkage of emergency shelters and even the closing of some facilities. It also recognized the need to replace the per diem system with base funding for agencies. In a city where shelter services were handled entirely by the voluntary sector this system redesign required community buy-in, a fact that was not lost on municipal officials:

> *I think there's a greater awareness of the need to look at a system of services rather than individual services or individual agencies, individual programs. There is still a lot of resistance to that because it does mean change. It could mean change in the way things are done. It could mean often there is a funding implication to changing the 'silo' approach or the program driven approach to a system of service and the impact could be significant for a particular agency (…) So there is that gap that still has to be breached I think in terms of how do we deal with sort of the autonomy and the local missions of local agencies that may or may not fit in with realignments of resources from a systems approach. (Municipal Official 1)*

Getting agencies, which had historically operated independently, to buy into a shared service system represented a challenge, particularly because working together as a system involved not only changing the way that services were to be funded but also shrinking programs. The challenge for the city and province was to find ways to run a more efficient system while insuring space remained for the autonomy (and by extension diversity and innovation) of voluntary sector agencies.

The 'Community Turn'

As the local voluntary sector was being reshaped by a managerial turn towards performance evaluation and financial management, it was simultaneously being reshaped by a 'community turn' towards collaborative planning and partnership. This turn was symbolized by a long and sometimes contentious period of community consultation and collaborative planning that produced numerous assessments, action plans, community plans and strategic plans. In this regard, federal programs such as the NHI and the HPS were instrumental in facilitating this turn. They provided many of the resources (personnel and funds) required to coordinate collaborative community planning. This community turn placed municipalities in a better position to take ownership of the homelessness problem, as they had been delegated by the province, and formulate a 'made in Hamilton' solution. One municipal official described this as follows:

> *We were reacting to [federal and provincial government] programs and their sort of policy framework so that's why we decided to say, as a community we should probably build a strategy of our own that isn't driven by the programs but that we would have the strategy and we would have the outcomes that we want to achieve and then we'll work out all our resources with their senior level government programs or our own stuff in terms of fulfilling those outcomes and so we try to turn things around a little bit and that's why we developed Everyone has a Home. (Municipal Official 1)*

Everyone Has A Home: A Strategic Plan to Address Homelessness (2007a) was developed through city-led consultation processes lasting several years. Among its priorities were to: engage the entire community on issues related to homelessness; establish and preserve affordable housing; increase supports to help people obtain and maintain housing; increase access to adequate income; and ensure efficient and effective use of community resources. One thread running through the strategic plan was the notion that enhanced collaboration with community organizations as well as planning and consultation with affected groups would contribute to more inclusive and healthier communities. While this sentiment was widely shared, from the City of Hamilton's perspective the value of partnership and collaboration was also in enhancing responsiveness, efficiencies and quality of service. As one municipal official put it:

> *The whole push for collaboration, I think that's really what we are very conscious of now. We want collaborative efforts because the more you can reach more people, it's more efficient in terms of flowing your dollars and affecting service for people. And I think it is much more comprehensive in the way that it is provided. (Municipal Official 2)*

Under SCPI/HPI, the City of Hamilton was expected to be a strategic enabler (Milligan & Fyfe, 2006) and broker these collaborations and partnerships. The real challenge for the City of Hamilton was in building project-based partnerships between community agencies, often with different missions and values, to support strategic, system-wide priorities. The strategic plan called for collaboration by community partners to expand evaluation and monitoring efforts of homelessness programming and to identify and reach chronically homeless people in the emergency shelter system. City officials cited a healthy civic culture when it came to collaboration but hinted at the need to go further.

> *And I would say we have some agencies that have totally bought into collaborative effort and collaborative responses. Then we have others that are having more difficulty playing in the sandbox and at some point in time we are going to have to wrestle with that – and it's coming. It's coming to a forefront with this because what we are talking about – funding – and I would say, this is exactly where we are going to go to with this funding pot – it is going to be a collaborative response and you are part of the collaborative response or you are not. You can provide whatever service you want – if you want to pay for it, go for it. (Municipal Official 2)*

Federal and provincial funding regimes did give city officials leverage. The push for collaboration was a central component of federal programs such as SCPI and HPI and as such was a prerequisite built into the aforementioned program's funding mechanisms. In their SCPI/HPI funding applications applicants were required to specify who they were partnering with and how. Regardless, the above comments about "playing in the sandbox" hint at tensions related to the funding requirement to partner and collaborate.

The findings summarized above describe how both hard arrangements in the form of a managerial turn towards performance-orientated systems and soft arrangements in the form of a community turn towards local collaboration and partnership came together at the local level in Hamilton to create a form of local governance we refer to as CBM. CBM was best exemplified in the service delivery framework adopted in Hamilton called the *Blueprint for Emergency Shelter Services* (City of Hamilton, 2009). This framework defined the specifications for a redesigned emergency shelter system including standardized intake procedures, common practices and protocols, information sharing and measurement of system-wide outcomes. It also established the Emergency Shelter Services Planning and Integration Committee as a structure for promoting integration and enhanced coordination. As the following quote demonstrates, the blueprint epitomized the blending of managerial and community imperatives:

> *With a clear vision, a new service delivery framework and a proposed funding model, many of the critical building blocks for a sound emergency shelter system are in place. What is needed is the mortar that holds these blocks together. The firm commitment and the consistency of a unifying systems-oriented group, is essential in order to create a strong and lasting structure (City of Hamilton, 2009: 17).*

This passage conveys how crucial community collaboration was for achieving managerial ends. From the perspective of voluntary sector organizations, however, CBM had significant impacts, which were not always positive. These are elucidated in the following section.

VOLUNTARY SECTOR TENSIONS

As previously noted, recent literatures on voluntarism have focused sustained attention on some of the tensions associated with both hard and soft institutional reforms. Many of these tensions were present in Hamilton. Three tensions in particular are described next.

First, horizontal tensions were evident within the voluntary sector as organizations were pushed to collaborate and simultaneously compete for funding. For example, one key informant shared the following:

> *So we're faced with a dilemma which is kind of a paradox because the government says, 'You should partner more closely with people.' And we try to do that – we meet with all these groups, women's shelter, men's shelter, etc. etc. the addiction, but as soon as you leave that building, we have to realize that we are competitors, money wise, so you have the social work side, cozying up to each other in your organization saying, 'We have to have more of a love in type of thing.' And then on the development side we have to face reality that we have to raise money to exist.*
> *(Social Services Agency, 9)*

The fact that project-based funding was contingent on collaboration led some agencies to refer to subsequent arrangements as forced partnerships. In the scramble to assemble project-funding applications, artificial partnerships were sometimes devised that more or less existed on paper for the sake of securing the funds.

Second, vertical tensions were evident between voluntary organizations and state funders. The greater emphasis on outcomes imposed additional burdens on already resource strapped agencies that now had to invest more resources into not only proposal writing but also reporting. Large agencies that had professionalized their organizations had few options other than to play the game and embrace the investment logic that was now guiding the distribution of state funding. One key informant stated:

> *Instead of just going, 'this is important we need to make this investment,' they want to go back with, 'this is how this investment has made a difference and we need to continue these results with more funding' (...) Just show that what you're doing is making that progress. Cut out the diatribe about you know all the social ills that are out there and just show the results and get some money there. (...) We've had to push back a little bit. Occasionally people want outcome measurement, like within eight months for people that are chronically homeless for 20 years, and like, 'okay now, come on here?'*
> *(Social Services Agency 13)*

Agencies in these situations found it necessary to invest time and resources in shaping and managing the expectations of state and community funders or to simply push back.

Third, a more complex internal tension was evident with regard to the perceived loss of the voluntary sector's traditional advocacy role, as agencies were compelled towards more professional organizational forms and more interventionist approaches. One particular example was the managerial imperative to target chronically homeless populations, a rationality that seemed to penetrate the missions of several service providers. For example, one key informant explained:

> *If you look at what the city is doing, is putting more emphasis on homelessness, but trying to eradicate the chronic shelter user (…) again the city and [us] are doing this, taking that individual, working with them one on one and supporting that person with everything that we can and getting that person off the street. Getting into an apartment as I said earlier or into a rooming house but not only that but helping them with the budget, with how they spend their money, with how they communicate almost on a daily basis, you know it's a one-on-one. You go to that person's apartment in the morning and say to them 'ok we need to do this today, do that today' to help them move along, (Social Service Agency 1).*

The voluntary sector, traditionally renowned for its responsiveness and its orientation towards social justice, was now expected to operate more professionally and less as the social advocates that the sector was traditionally known for. One key informant expressed this dynamic in terms of a sense of loss:

> *Things had changed where we were never going to be able to go back to those days of that really vibrant political activist. It was activists doing this job – this work 10, 12, 15 years ago and now it's sort of professionals and policy people and stuff (…) it is different and I'm not saying it's not effective but it's more professionals running the show now instead of community activists and I think that's how it's changed. (Advocacy Organization 6)*

The horizontal, vertical and internal tensions identified above roughly triangulate the impact of CBM at the local level. Refocusing the shelter system around financial efficiencies and targeting chronic shelter users involved changes to how local organizations related to each other and, in some cases, their own missions. Local voluntary sector organizations adapted: some worked with the system, becoming more professionalized and bureaucratic in the process, and others worked outside the system. The result was a bifurcated voluntary landscape at the local level consisting of large, professionalized, corporatist organizations closely aligned with the state and small, informal grassroots organizations operating largely on the periphery (Milligan & Fyfe, 2005).

This form of voluntary landscape should not be read as a straightforward top-down cooptation of the voluntary sector by the state (as portrayed by the shadow state concept). Local voluntary organizations did maintain some independence and community agendas were not completely lost on the state. Yet the practices and activities of some organizations were significantly reshaped by the managerial agenda of the municipal government and its desire to achieve a more sustainable approach to serving the homeless population. In this regard, CBM allowed a certain degree of freedom, in terms of what local organizations could do, but this freedom existed within certain managerial parameters (such as targeting chronic shelter users, for example).

CONCLUSION

The above case study demonstrates how the federal, provincial and municipal governments worked with and through the voluntary sector to address the crisis of homelessness in Hamilton, Ontario. In this regard, the local voluntary landscape was a critical site of investment, coordination and ultimately transformation. Without a doubt CBM, as a mode of governance, significantly reconfigured the voluntary landscape in Hamilton. The layering of soft community arrangements over top preexisting hard managerial arrangements transformed the orientation of some voluntary organizations and changed their relationship to the City of Hamilton. The resulting configuration was associated with a number of tensions traceable to competitive and performance-orientated reforms on one hand and collaborative and partnership-based imperatives on the other. These tensions are notable given the dual emphasis on cost-savings and community governance in homelessness policy.

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Inter-sectoral Collaborations

3.7

I'LL TELL YOU WHAT I WANT, WHAT I REALLY, REALLY WANT: INTEGRATED PUBLIC HEALTH CARE FOR HOMELESS INDIVIDUALS IN CANADA

Kristy BUCCIERI

Modern advancements in travel have led to an unprecedented number of pandemic outbreaks in recent years. As a global city, Toronto has been particularly affected by events such as SARS and H1N1. It is well documented that some individuals fare better than others in these kinds of crises, and that vulnerability is often rooted in pre-existing social inequities. Among the most marginalized and at-risk groups are those who are homeless and/or dependent on social services for subsistence. This chapter takes a critical look at the fragmentation of homelessness and public health services in Toronto, using a study of the H1N1 pandemic. Homelessness is often associated with negative health outcomes, but is less often recognized as being a crisis of public health. Many organizations within homelessness sectors are not designed with public health considerations in mind, meaning that clients are often in congregate settings for extended periods without adequate ventilation and disinfection practices in place. Through this chapter, I argue that the best way to prepare the homelessness sector in Toronto for a pandemic outbreak, such as H1N1, is to redesign it as an integrated public health and social care sector. This chapter examines the current barriers that prevent full public health applications in homeless agencies and reimagines an approach that foregrounds integrated care and the individual needs of service users.

In the mid-1990s the Spice Girls broke onto the international music scene with their catchy always-in-your-head song Wannabe. Even now, you can probably hear the refrain ringing in your ears: "Yo, I'll tell you what I want, what I really, really want. So tell me what you want, what you really, really want…" (Beckham et al., 1996). These two simple lines could be the anthem of integrated care, the increasingly popular idea that health and care sectors should be coordinated in order to provide the most comprehensive support for clients. The idea of integrated care is thought to be particularly important and useful for marginalized persons, such as those who are homeless and/or who have complex needs (Public Health England, 2015). While the term 'integrated care' is, to date, not well defined or universally used (Kodner, 2009), there is a common underpinning notion that in order for it to

be effective, integrated care needs to be built around the individual client and their particular set of needs (Dorrell, 2015). This chapter draws on research from two studies[1] on homelessness and health to highlight the existing gaps in the Toronto homelessness sector that expose homeless persons to unhealthy conditions.

I begin this chapter by discussing the findings of a study conducted of the Toronto homelessness sector's response to H1N1, a pandemic that affected the city in 2009 and 2010. I argue that this outbreak, while relatively mild in impact, served to highlight some key deficiencies in the homelessness sector resulting from its fragmented nature. Namely, the current separation of the homelessness and public health sectors means that homeless individuals must seek supports in various service agencies that are overcrowded, poorly ventilated and not operating on coordinated schedules. At present, homeless persons experience many communicable and chronic health conditions that are exacerbated by living on the street, in large part because public health considerations are not at the forefront of social service design or delivery in the homelessness sector. In the section that follows, I draw on integrated care literature and interviews conducted with staff of a local health authority to argue that integrated care offers new opportunities for service provision. While the definition of integrated care is contested (as will be discussed), in this paper I follow Kodner and Spreeuwenberg's (2002) proposed definition:

> *Integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long-term problems cutting across multiple services, providers and settings. The result of such multi-pronged efforts to promote integration for the benefit of these special patient groups is called 'integrated care' (3).*

Evolving past early conceptions of integration as being vertical or horizontal in nature, I argue that we need to rethink the homelessness and public health sectors as one holistic system. In the final section, I draw on Herklots' (2015) three levels of street, service and sector to offer a theoretical sketch of how this integrated care model of homelessness and public health could come into practice.

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HOMELESSNESS SECTOR FRAGMENTATION: THE H1N1 STUDY

In 2010 and 2011, the period following the H1N1 outbreak, researchers in Toronto, Calgary, Regina and Victoria undertook an analysis of the level of pandemic preparedness of homelessness sectors in their respective cities. Given that homelessness has been described as a health inequity cliff, where the health of homeless persons drops significantly on the street (Story, 2013), this project sought to examine how the health of homeless persons was impacted by homelessness sector responses. This chapter reports on some of the findings of the Toronto-based study[2], in which surveys and interviews were conducted with 149 homeless individuals, 15 social service providers working in frontline agencies and five key stakeholders involved in public health and/or homelessness policy.

It is well documented that the experience of homelessness often creates or contributes to a range of physical health problems...

As part of the study, homeless participants were asked to self-report the health conditions they experienced in the preceding year. Results indicated that the participants reported experiencing fatigue/tiredness (59.7%), coughing up phlegm (51.7%), shortness of breath (36.9%), night sweats (35.6%), chest pain (28.2%), unexplained weight changes (24.2%), chronic lung disease (21.5%), coughing up blood (16.8%), infection (16.2%), fever that persists (14.1%) and diabetes (8.1%). When asked about health conditions overall (not limited to the preceding year), participants also noted experiencing arthritis (13.4%), Hepatitis A, B, or C (12.8%), lung disease (7.4%), cancer (6.7%), HIV/AIDS (4%), tuberculosis (2%) and herpes (1.4%).

It is well documented that the experience of homelessness often creates or contributes to a range of physical health problems, including respiratory illness, fatigue, tuberculosis, traumatic brain and other injuries, sexually transmitted infections, hepatitis and HIV/AIDS (Daiski, 2007; Frankish, Hwang & Quantz, 2005; Haldenby, Berman & Forchuk, 2007; Hwang, 2001; Hwang et al., 2008; Topolovec-Vranic et al., 2012). In a study of 24 homeless participants from one Canadian city, Daiski (2007) found that physical health problems were often chronic, emerged decades earlier than typically expected in those who were younger and were reinforced through social and structural barriers such as living in poverty and having inconsistent access to health care. Food deprivation and/or inadequate nutrition are common problems among those who are homeless (Gaetz, Tarasuk, Dachner & Kirkpatrick, 2006; Tarasuk, Dachner & Li, 2005). Reliance on soup kitchens and other programs for food (Sager, 2011) combined with a poor diet that is high in processed foods, fats and sugars, create the conditions among homeless persons for the two seemingly contradictory health issues of hunger and obesity (Koh, Hoy, O'Connell & Montgomery, 2012).

Many of the chronic health conditions that homeless individuals experience may be unwittingly related to the design and operation of services within the homelessness sector. For instance, the high rates of coughing up phlegm, shortness of breath and chronic lung disease found in the H1N1 research study could be aggravated by – if not the result of – spending time in overcrowded congregate spaces with poor ventilation. The findings of interviews with key stakeholders in the H1N1 study supported the assertions that public health measures are not prioritized in many service agencies, largely due to a lack of adequate funding and resources. Figures provided by one of the stakeholders suggested that in 2011 (at the time of the interview), there were approximately 3,800 emergency beds

2. For the full report, please see Buccieri & Gaetz (2015).

available between City of Toronto-operated shelters and purchase-of-service shelters (not including violence against women shelters and domestic hostels). In the same year, the reported average nightly occupancy of emergency shelter beds, according to City of Toronto (n.d.) statistics, was 3,716, producing an average occupancy rate of 97.8%. The consistently high demand for services, combined with a lack of funding and resources, creates the conditions in which addressing public health issues like overcrowding, congregate living and poor ventilation become lower priorities.

According to one stakeholder in the H1N1 study with a background in public health medicine: "Anytime you have a congregate setting it's easier to spread anything. This is the case with drop-ins and shelters. Ideally you should have smaller groups, more rooms, more bathrooms – that would be better and reduce transmissions between groups." Communicable diseases are common in homeless service agencies, a phenomenon not limited to Canada. Researchers in Tokyo conducted a microscopic analysis of body lice from the discarded clothing of homeless persons and found the rates of nymphs and adults up to 643 specimens (Sasaki, Kobayashi & Agui, 2002). According to these researchers, "It is likely that factors such as overcrowding, malnutrition condition, and inadequate access to medical care affect the transmission and spread of louse-borne diseases among the homeless" (Sasaki et al., 2002: 429).

There are two particularly challenging aspects of homelessness from a public health perspective: the co-occurring factors of containment and mobility (Buccieri, 2014). Both of these issues stem largely from the system design. In regard to containment, many homeless individuals are reliant on services, leaving little choice but to put themselves in high density places like shelters and food-service programs. In the pandemic study, for instance, 61.7% of participants noted they go to drop-in centres for food and that while there, on average, there are more than 20 to 50 others in the room with them. Further, a substantial percentage (41.6%) reported that while in these agencies, it is common to have at least five other people within touching distance at any given time. The current system, in which homeless individuals are reliant on services for the necessities of life, forces them to enter unhealthy situations that contribute to poor health outcomes through overcrowding, exposure to others with communicable diseases and poor ventilation. Shantz (2010), a formerly homeless man, reflects on his own time in emergency shelters, writing:

> *Despite the images conjured up by names like vagabond, drifter, or hobo, being homeless is an experience of bodily and spatial confinement. Going to shelters can leave us beaten up… or contracting tuberculosis, supposedly a disease of the past that is rampant in contemporary shelters… our bodies are time travellers picking up ancient illnesses that the rest of the population only reads about in history books (182).*

The related factor of mobility is caused as service agencies open and close throughout the day, forcing clients into public spaces and/or other services. As Daiski (2007) found, most homeless agencies have restrictions such as early curfews that force people out at certain times of the day. Ali (2010) writes:

> *In the realm of homelessness the exercise of social control is seen in terms of the regulation of other particular forms of individual behaviour, most notably the mobility of the homeless persons, including the spaces they are allowed to occupy and the social relations and associations they are able to pursue (82).*

The politics of mobility is one that makes use of institutional cycling, to move homeless bodies through fragmented services despite the risk to their health (Ali, 2010).

In one Toronto-based study, researchers used shelter data to examine the number of shelter residents who would be potentially exposed to a communicable disease in the event of a public health outbreak (Hwang, Kiss, Gundlapalli, Ho & Leung, 2008). Their findings clearly indicate the inter-related public health challenges of containment and mobility when working with homeless populations. Among a sample of 4,565 shelter residents, they found that individuals had contact with a mean of 97 other shelter users over a one day period and that those who stayed at more than one shelter had contact with an average of 98 additional shelter residents (Hwang et al., 2008). This study highlights the current public health challenges of containment and mobility, as homeless individuals spend time in close proximity to many other service users while also cycling between agencies.

At present, the homelessness sector in Toronto is overburdened with high demands for service coupled with a lack of sufficient funding and resources, producing conditions that lead to chronic health conditions and communicable diseases for service users. According to one stakeholder interviewed in the H1N1 study:

> *The whole issue regarding community infection control in the homelessness sector needs to be addressed, with explicit resources for that. We're getting there. We're trying for funding for a public health infection control position to work with community agencies – someone to draw on in an emergency, pre-existing infrastructure. We already do that with seniors' homes, schools, etc. We need pre-existing infrastructure to carry this out, and the person responsible for infection control in the sector should have a direct line to high level people. That will happen.*

There is a pressing need to better coordinate efforts between the homelessness sector and public health officials. The success of one effort during the H1N1 outbreak, to hold vaccine clinics in shelters and drop-in centres, showed that there is a willingness and ability to bring these two sectors together (Buccieri & Gaetz, 2013).

The difficulty lies in the siloing of public health and social care. A large issue that many agencies faced during H1N1 was not only that budgets were low, but that there were restrictions on how they could spend the money. Agencies are mandated in particular ways and their funding is often tied to the operation of particular programs with limited (if any) discretion for its reallocation. As one stakeholder noted in the H1N1 study:

One of the things that struck me was the difficulty so many organizations had with organizational depth. They just didn't have the staff time to free up to think things through. They are funded in a very strict way that limits their mandate – this is really true in social services. The fact that health issues occur in the realm of social services becomes really difficult, and they are not always able to pick it up.

According to another stakeholder: "Living through H1N1, one of the biggest issues was that so many agencies had not even a generic emergency plan. So in dealing with H1N1, many were starting from scratch." Without the mandates, expertise, funds or resources to address public health issues in their agencies, it is perhaps not surprising (if not expected) that these gaps emerged. What currently exists is a systemic issue, in which service agencies require public health measures to protect their clients but lack the capacity to do so because of limited funding, resources and public health expertise.

The results of the H1N1 study highlighted many strengths of the homelessness sector in Toronto, such as a willingness to work collaboratively within the sector, the dedication of service providers and a keen understanding of the systemic barriers homeless persons experience. Yet, it also highlighted the public health challenges that are currently embedded in the system. Homeless individuals experience many chronic and communicable health conditions that are exacerbated by being contained in over-crowded services they depend on and by having to cycle to other agencies as they open and close throughout the day. The lack of discretionary funding in the homelessness sector means there is limited financial and human capital that can be put toward addressing these public health issues. What is needed is a new approach that builds capacity through holistic integrated care.

IT'S A BIRD, IT'S A PLANE, IT'S INTEGRATED CARE

Redesigning an integrated system-wide response to homelessness is no simple task. Yet, as the H1N1 study highlighted, the current fragmented nature of the homelessness sector may be contributing to the poor health of homeless clients. In the same way that Albert Einstein defines insanity as doing the same thing over and over and expecting different results, Dorrell (2015) notes that, "we run partitioned services and wonder why we fail to deliver integrated care" (13). Perhaps the complexity of planning and operating an integrated care model for high-needs clients, such as the homeless, seems too daunting a task to undertake. Van Laere and Withers (2008) counter this view when they write:

> *Services are organized and managed in such a complex manner that policy makers and managers tend to think that homeless people do have complex needs. This is not true. Needs are not complex at all. Tackling the health issues of the homeless requires a systematic approach by dedicated homeless health care professionals (5).*

Shifting the ideology to one that sees the homelessness and public health sectors not as separate and distinct but as one holistic system brings with it the prospect of adopting better ways of working together, of addressing the current gaps and of considering the needs of the service user in different ways.

In the United Kingdom, integrated care has been considered the holy grail of policy making for several decades (Burstow, 2015; Keohane, 2015). As such, the UK has formulated a nationally agreed upon definition of what integrated care means for an individual, which is that, "I can plan my care with people who work together to understand me and my carer(s), allow me to control, and bring together services to achieve the outcomes important to me" (Public Health England, 2015: 4). This definition indicates a strong, collaborative relationship between care and cure sectors, while emphasizing the client's ability to formulate their own service needs.

In Canada, to date, there is no comparably recognized national definition of what integrated care means. Canada is not alone in this definitional ambiguity. Even within the UK, integrated care is known by several names, including 'personalized care,' 'patient-centered care,' 'joined-up care,' and 'whole person care' (Keohane, 2015). "Like a Rorschach test, integrated care has many meanings;" Kodner and Spreeuwenberg (2002) note, "it is often used by different people to mean different things" (1). Integrated care may be considered the Superman of service provision. Not only is it lauded as a saviour, but it is an entity that appears in shapeshifting forms. In a recent conceptual analysis of integrated care, Kodner (2009) highlights its ambiguity by comparing it to a tree, a precise surgical procedure, a country and the proverbial elephant that everyone touches but no one can fully grasp. Reading this article brings to mind the old line, "It's a bird, it's a plane, it's Superman!" Only now, it has been changed to (the much less catchy), "It's a tree, it's a country, it's an elephant, it's integrated care!" Over time the concept of integrated care has changed and developed, leaving it under-defined and open to interpretation.

As part of a larger study, in the summer of 2015 interviews were conducted with three staff members of a local health authority in Ontario pertaining to issues of health, homelessness and integrated care. The research participants were senior level officials who

work in health systems policy and planning with a focus on marginalized populations. When asked what integrated care means to them, one participant stated:

> *Well, I see it as, as integrated around the client. So I think you look at what people who use services need from a holistic perspective and then those services should be integrated around that person. To varying degrees I think people that have very high needs, need a higher level of the same services but I think generally speaking looking at anyone from a holistic perspective should provide that integrated system. I think what's really important… is that it shouldn't be a series of systems, it should be one system that works together.*

Despite this definition of integrated care as being one holistic system, it was also noted that this understanding has evolved slowly over time. One interview participant stated:

> *In the beginning within integration it was, "Are we talking horizontal integration like hospital to hospital to hospital? Or are you talking vertical integration… that would move through… home and community, to hospital, to tertiary care?" So there's a bit of both, and I mean there's still both but now increasingly we have less of the conversations about this being a horizontal or vertical integration and more about it being a system integration for the client's needs.*

Dorrell (2015) has noted that our current systems are inherited from history, creating institutional boundaries that partition services in ways that can be highly disruptive to users. He continues by stating: "Above all we must ensure that we develop a care sector which delivers services which are built around the needs of the individual rather than inviting individuals to mould their needs to the services available from the inherited institutions" (Dorrell, 2015: 14). A lack of integrated services may be particularly problematic for homeless individuals. One health authority staff member agrees with Dorrell by stating:

> *I think often times people are homeless because they haven't had that integrated system around them to support them. And for lots of reasons they're not the customers that the system wants to serve and so I think that that's the notion that really needs to be turned on its end. Is it's not about the people providing the service; it's about the person who needs the service. And the work should be in making that adapt to the individual, not the individual having to make that adapt. So I think that those people who are homeless are those who are the most in need who just simply have not been able to have their needs addressed for reasons that don't relate to them specifically.*

As integrated care becomes more recognized and implemented at the higher system planning levels, it will require an equal shift in mindset from front line workers in the care and cure sectors. This is a task many are willing to take on, as one health authority staff noted:

> *Certainly the service providers want to be able to meet the needs of such high-needs clients. They recognize it's a drop in the system, it's a weakness, it's high potential for a fail in the system when the full needs of folks are not addressed. Ending up on the street homeless is a fail, it's just not easy to address in the health system alone.*

However, there exist many structural barriers that must be addressed before full integrated care is possible. Among the most pressing of issues to be sorted is the original question of how to define integrated care. As a tree, surgical procedure, country and elephant (Kodner, 2009), integrated care is not universally conceptualized or enacted. Reflecting on conversations about how to best use integrated care for complex-needs clients, one health authority member stated:

> *Those hardest-to-service clients have been the ones that are most tricky for our service providers to serve in a coordinated and integrated fashion because they're looking for, in my opinion, "It would be nice if there were an easy answer, an easy fix." And what we've learned over time is that it's not that. And then when we started with discussions about complex clients and high-needs clients, service providers would gravitate towards the most medically complex individuals. When we'd talk complexity they would say, "Are these the folks who are in our ICU, that are intubated and you know, end of life… all resources on hand? That kind of thing. And [what] we've learned over time is, those aren't the ones that are as hard to serve. There are systems to support, and protocols, and resources to support those individuals. It's the ones that are socially complex that are challenging the system response the most.*

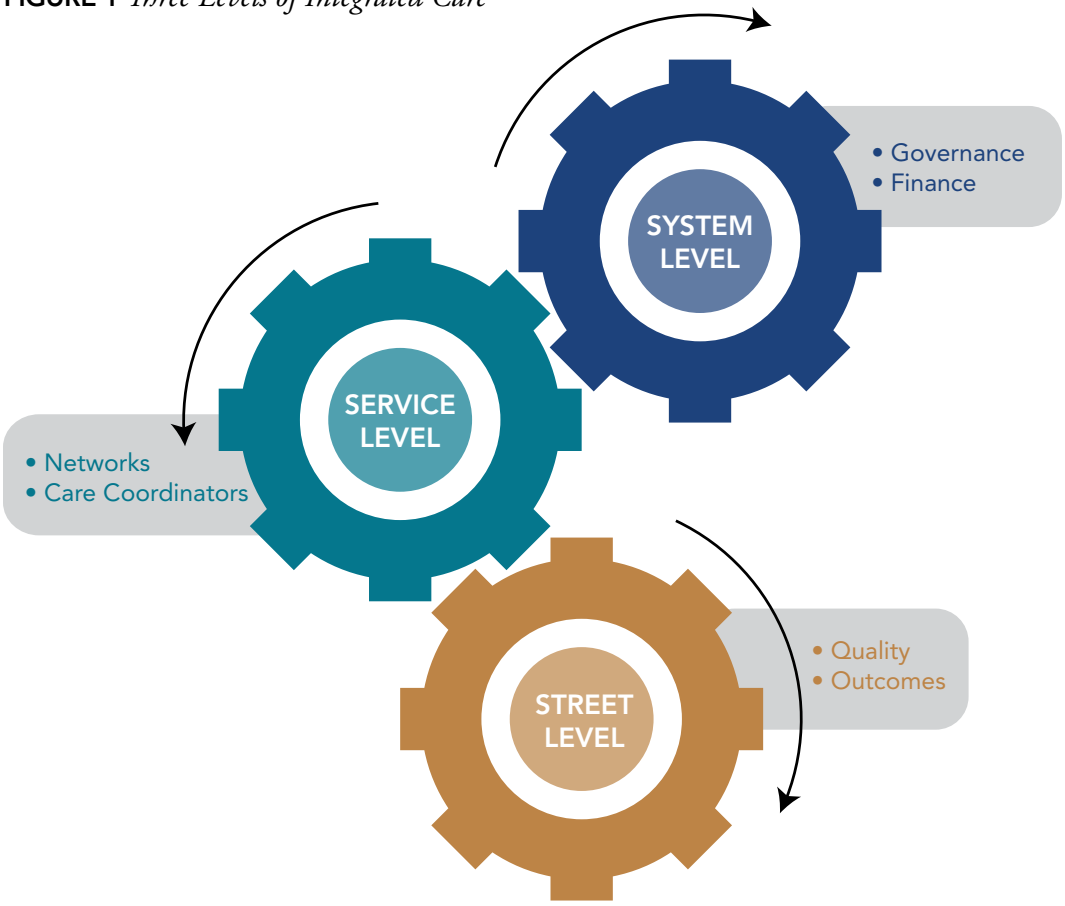
In Canada we are witnessing a promising ideological shift toward integrated care that builds from the service user's perspective. This uptake may be particularly important for meeting the cure and care needs of homeless individuals through one holistic system. The Calgary Homelessness Foundation (2012), is one such example of progress, as in its system planning framework it acknowledged that, "when a client's complexity is not assessed, or when the programmatic intervention chosen does not match their risk and resiliency factors, there is a higher likelihood of poor outcomes" (2). The movement toward integrated care is likely to continue to grow in the years to come. "Tell me what you want, what you really, really want" (Beckham et al., 1996) will not just be a Spice Girls lyric, but a mantra for integrated care providers all over. The final section of this chapter imagines how a holistic system of integrated public health care could be developed in line with homelessness sectors, from the ground up.

A THEORETICAL SKETCH OF INTEGRATED PUBLIC HEALTH AND SOCIAL CARE FOR HOMELESS PERSONS

An integrated care approach is one that brings together the system, service and street levels to advance the health and social support of individual service users (Herklots, 2015). Dividing these levels is in no way meant to suggest that they are distinct mutually exclusive categories. To the contrary, successful integration at any level depends on successful integration at every level. The discussion that follows is not meant to be an exhaustive guide on how to implement integrated public health and social care in homelessness sectors in Canada. Rather, it highlights the key features that need to be considered and addressed on each of these levels before integrated care can be achieved. For each level below, the discussion focuses on what needs to be considered for improved public health measures in the social service provision offered to homeless persons.

Successful integration at any level depends on successful integration at every level.

FIGURE 1 *Three Levels of Integrated Care*



Street Level

The level of the street encompasses the service user and their caregivers, such as family members and/or significant others. There are two key considerations at this level – quality and meaningful outcomes. Public Health England (2015) writes, "ultimately, it will be people who use the services who will decide whether partnerships are working and are relevant to their needs" (20). As such, the quality of the services and supports being integrated is essential to their success (Herklots, 2015). The intent of integrated care is to enhance the quality of services and provide a more comprehensive level of support, particularly for those with complex and multiple service needs (Kodner & Spreeuwenberg, 2002).

At the street level, the emphasis is on the quality of service provision for the user with effectiveness being demonstrated by meaningful and measureable outcomes. There is considerable literature that shows there are high rates of chronic and communicable illness among homeless populations. Further evidence suggests that many homeless individuals do not actively seek health care until a medical issue is at an advanced stage (Homeless Link, 2014). Participation is key, as having a sense of control over one's own health care has been shown to be an important factor in improving outcomes (Kelsey, 2015). Measureable outcomes of integrated public health and social care for individuals would include an improvement in self-reported health and wellness, reduction of chronic and/or communicable illness and earlier help-seeking behaviour. Starting with the needs of the individual service user and aiming for quality of services and meaningful outcomes is the goal of the street level. It also sets the foundation for both the service and system levels to be built upon.

At the street level, the emphasis is on the quality of service provision for the user with effectiveness being demonstrated by meaningful and measureable outcomes.

Service Level

The service level focuses on professionals and agencies that work with homeless individuals to provide care. It is these individuals who are responsible for working directly with homeless persons to achieve the best possible outcomes, such as improved health and well-being. The factors that need to be addressed at the service level for successful integrated care are those of networks and care coordinators. The notion of networks builds upon existing relations within the sector and aims to strengthen and enhance them through digital strategies. The service level is perhaps where there exists the most promise for an integrated care system that prioritizes public health. This is evident in the Calgary Homeless Foundation's (2012) system planning framework which includes key elements such as having eligibility criteria for homeless-serving programs and formalized eligibility criteria to support streamlined referral and the matching of clients to services. The coordinated intake and referral of clients through the system and between agencies means that individuals may be less likely to seek assistance from multiple sources. Among the findings of the H1N1 study was that homeless individuals spend a great deal of time seeking to have their care needs met in various social service agencies (where they are in congregate settings with poor ventilation and at risk of exposure to communicable diseases). Streamlined coordination around intake and referral has the potential to reduce these public health risks by ensuring homeless individuals do not have to wander between agencies in search of appropriate care.

Working across the sector between agencies is not a new idea. In the H1N1 study it was found that many service providers already have informal networks with colleagues working in other organizations. Integrated care seeks to build upon these relationships by making them more formal and standardized. Best practices that have been shown to be effective in this regard include communication between service providers, practitioner familiarization with the range of homeless services in the community (Hwang & Burns, 2014),

single point of entry for all homeless services and multiservice centres where services can be accessed by homeless persons in one area without the need to travel extensively (Hambrick & Rog, 2000). Integrated care at the service level has the potential to improve public health outcomes for homeless individuals by reducing the number of clients who are mobile in search of care and through the streamlining of institutional practices like intake and referral. As Public Health England (2015) notes, there is something incredibly powerful about different professionals being linked into each other's services.

In today's digital age, perhaps among the most important tools are electronic data collection and record sharing. A study of 28 homeless agencies in North America, conducted by Cavacuiti and Svoboda (2008), found that nine used electronic medical records for outreach and that they were important for providers to access medical information and to collect aggregated client data for the purposes of planning, evaluation and advocacy. Further, this study showed that having these records available at multiple locations could be a powerful tool for improving coordination, safety, efficiency and the quality of care provided to homeless clients (Cavacuiti & Svoboda, 2008). Electronic records can help to provide common intake, assessment, referrals and service coordination (Calgary Homeless Foundation, 2012), while sharing information through electronic networks can allow different locations and services to communicate and coordinate (Hambrick & Rog, 2000). The comprehensive adoption of data and digital strategies may have a significant impact on the productivity and effectiveness of service agencies by streamlining the process, although issues of transparency, privacy and access need to be considered and addressed (Kelsey, 2015).

The comprehensive adoption of data and digital strategies may have a significant impact on the productivity and effectiveness of service agencies by streamlining the process, although issues of transparency, privacy and access need to be considered and addressed (Kelsey, 2015).

Navigating an integrated system in which intake and referral processes are coordinated across the sector through electronic records is perhaps a daunting task. The Calgary Homeless Foundation (2012) notes in its systems planning framework that technical support will be made available for their service providers to assist them in using the software. While this is certainly essential, supports also must be put in place to help service users navigate a high-tech integrated system as well. Here the notion of care coordinators (borrowed from the UK model for elderly person care) offers some promise. Care coordinators work one-on-one with an individual to help them identify their goals and then broker a wide range of supports to achieve them, working intensively with the client for three or more months to connect them to ongoing sources of support, so they can sustain any advances made (Abrahams, 2015). This notion is not unlike case management, which is a staple of homeless service provision in Canada as well. The key here is that the care coordinator would not be affiliated with any particular service agency but instead would work as a liaison across the sector to help individual service users understand how the services are integrated and coordinated.

Through enhanced networks and the use of care coordinators, the service level holds many opportunities for reducing communicable disease and chronic illness among the homeless. While many of these initiatives – such as coordinated intake and referral – may not on the surface seem like public health initiatives, they do have an impact on critical factors such as service capacity, who is admitted into a shelter or agency and how long that person stays. These measures are particularly important when public health issues, like outbreaks of influenza or tuberculosis, arise. For instance, having access to this information can prevent the discharge of a person who is ill into another agency. Addressing public health issues at the service level is key, but depends on support from above and below.

System Level

The system level is the overarching structure that operates, governs and funds the homelessness sector. At present, the results of the H1N1 study indicate that public health is not a top priority within the sector, given the high rates of chronic and communicable illness, overcrowding of many agencies, poor ventilation and the twin conditions of containment and mobility. An ideological shift toward integrated care at the system level is needed in order to identify the public health risks to homeless service users and begin to address them in a systemic way. For integrated care to happen there needs to be strong governance that prioritizes public health, coupled with a shared finance strategy that supports these aims.

Within the context of public health and homelessness, this means that those in positions of power, such as agency executive directors, city directors and public health leaders, need to come together to put public health issues at the forefront of social and public policy agendas.

Research by Pearson (2015) indicates that there are four critical factors for success, that include: one, a clearly articulated and widely shared vision of why, how and for what benefits; two, a medium- to long-term financial strategy that is realistic about costs; three, flexible organizational arrangements that support a common purpose; and four, attention to matters of culture through effective leadership. This research shows the importance of having strong commitment from system leaders and the backing of financial support. Within the context of public health and homelessness, this means that those in positions of power, such as agency executive directors, city directors and public health leaders, need to come together to put public health issues at the forefront of social and public policy agendas.

In reality, Hughes (2015) notes, implementing integrated care requires the highest level of commitment from the system leaders such that it filters down to all levels of staff and becomes an organizational goal in itself. This mental shift in putting public health at the forefront of service design and provision is an ideological necessity. While most individuals who work in the care sector do so because they want to be involved in caring for the vulnerable (Dorrell, 2015), it must be recognized that change does not happen simply because the right sorts of structures are in place, but requires the imagination of those who can see how structures can be improved upon (Public Health England, 2015). To that end, an integrated care system level approach to public health and homelessness is one in which a common governance structure regulates the opening and closing of agencies throughout the day and service hours are coordinated such that individuals are not forced out of agencies and into a cycle of service-seeking mobility. This goal of common oversight does not require that agencies dispense with control over their own governance, but that they are held to a high legally binding standard of collaboration, such as through the creation of a sector-wide oversight board that would hold responsibility for ensuring accountability, coordination and transparency. Given the unique positions of each agency, a coordinating board or council is one proven best practice approach that can serve as a deliberative body that provides policy and provision advice across the sector (Hambrick & Rog, 2000). A board of this nature would include members of the homelessness sector, as well as public health officials providing a key opportunity for cross-sector learning and collaboration.

In order to achieve a goal of integrated public health and social care, financial support will be imperative. Bowden (2015) notes that a funding challenge exists in designing long-term services around the needs of individual service users, but that the answer lies in joined-up budgets that care for people's care regardless of what part of the system the care comes from. Within the homelessness sector, the reality of

underfunding is reflected in the results of the H1N1 study. High demands for service mean that many agencies are operating at or beyond capacity and have little control over discretionary funds. Expecting individual agencies to take on the challenge of funding coordination outside their own agency is unrealistic.

The UK offers one promising model and example of funding for integrated care that could be adopted elsewhere. In May 2013 the UK government announced an investment of £10 million for a national Homeless Hospital Discharge Fund in which voluntary sector organizations, working in partnership with the National Health Service and local authorities, could bid for capital and review funding to improve hospital discharge procedures for people who were homeless. Subsequent program evaluations showed this integrated care approach to be highly effective at improving health and care outcomes (Homeless Link, 2014). The approach of funding integrated care initiatives at a higher governmental level is one that could be considered in Canada, such as through the Homelessness Partnering Strategy. This is not to suggest that any program or initiative can be directly implanted from one location to another seamlessly. A program of this nature would require a rethinking of funding and partnerships at the federal, provincial/territorial and municipal levels of government, but may offer new ways of working collaboratively that the existing model does not allow for.

Decreasing the rates of communicable and chronic illness among homeless individuals is a goal that can be achieved through integrated care. Creating a board of public health officials and homelessness sector workers is one way to improve collaboration, not only within the sector but between the sectors as well. Offering shared funding sources that depend on collaboration could improve the quality of services put forth, while also providing an opportunity to invest in improving the physical design of shelters and other agencies. The UK example shows that having a joint funding strategy that depends upon service coordination is an effective approach. Further, given findings of Toronto-based research that showed that within shelters indirect health care costs, such as personnel and supplies, are consistently much greater than the direct cost of providing health care (Hoch, Dewa, Hwang & Goering, 2008) – having a unified funding approach could serve to reduce the financial burden on individual agencies through cost and resource sharing.

CONCLUSION

Integrated care is a promising approach for meeting the complex needs of homeless individuals. While it is becoming increasingly popular among health planning authorities, the term remains ambiguous and lacks a clear definition. How to best understand and apply integrated care is a valuable discussion that Canada's cure and care sectors need to continue to engage in for the benefit of system clients. For those who are homeless, an ideological and operational shift of this nature has the potential to greatly improve their health and wellness. Public health issues are, at present, not given enough priority in a homelessness sector that is strained and constantly operating at capacity. Changes at the street, service and system level are needed in order to create a holistic system of public health and social care that is based on the needs of the individual. While full system integration may be a challenge (Midgley & Richardson, 2007), we must strive for a culture in which boundaries are sought to be overcome (Herklots, 2015). Or, as the Spice Girls would say, "tell me what you want, what you really, really want…"

Decreasing the rates of communicable and chronic illness among homeless individuals is a goal that can be achieved through integrated care.

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Inter-sectoral Collaborations

3.8

VIGNETTE: ADDRESSING HOMELESSNESS AMONG CANADIAN VETERANS

Cheryl FORCHUK, Jan RICHARDSON
& Heather ATYEO

ADDRESSING HOMELESSNESS AMONG CANADIAN VETERANS

The range of experiences and differing needs among specific homeless subgroups is not well understood. This is especially true for Canadian veterans—a subpopulation gaining increasing recognition among homeless communities across Canada. While it is clear that the needs of Canadian veterans who are homeless differ from the general homeless population, there is little research within the Canadian context to guide housing interventions and related support for this group. Furthermore, individuals may not self-identify as veterans for a variety of reasons and, thus, innovative approaches are necessary to reach this target population.

The Canadian Model for Housing and Support for Veterans Experiencing Homelessness was a two-year evaluation project (2012–2014) funded through the federal Homelessness Partnering Strategy, with in-kind support from Veterans Affairs Canada (VAC) and the City of London and housing through support agencies across four Canadian cities. This participatory action research project developed and evaluated a model of housing and individualized programming to best meet the unique needs of Canadian veterans experiencing homelessness. The project used principles identified previously by veterans who were homeless (Milroy, 2009; Ray & Forchuk, 2011), such as peer support from someone with experience in the military and support for alcohol abuse and related issues. Local community partners experienced in working within the homeless-serving sector collaborated with federal partners, veteran specific organizations (the Royal Canadian Legion, Operational Stress Injury Clinic [OSIC] and Operational Stress Injury Support Services [OSISS]) and other community-based services to provide 56 units of housing with support to veterans who were experiencing homeless. Each site adhered to similar principles with emphasis on providing veteran-specific support and worked to enable pathways that support long-term housing-with-support solutions. Housing models differed across sites and included varying levels of on-site case management, clinical support and peer mentorship, allowing for examination of the strengths and limitations of each approach and an opportunity to compare unique adaptations that evolved within each community.

TABLE 1 *Overview of the Four Housing First Providers*

Location	Capacity	Staffing	Housing Model	Housing & Supports	Peer Support
Toronto	20	Weekday support plus 24/7 on call	Two-bedroom units in one building owned and operated by site	Combined landlord and programs	Mental Health Peer Support
London	10	Seven-day daily support plus 24/7 on call	Scattered sites: private sector apartments	Private landlord and supports by program	OSSIS
Calgary	15	On site 24/7	One-bedroom units in one building owned and operated by site	Combined landlord and programs	Informal
Victoria	11	Weekday volunteer support, no paid staff	Shared accommodations and some private sector	Combined landlord and programs	Veteran volunteers; OSSIS

Housing Model and Housing Specific Supports

One site offered transitional housing though allowed flexibility as to the length of stay, whereas the remaining three sites provided permanent housing. Tenants were able to come and go freely at three of the four sites while one site maintained a controlled entry model where tenants/guests checked in with staff as they entered or left the building. Staffing levels varied by site from daily with or without after-hours on-call support to a 24/7 staffing presence. Across sites, housing staff served as the primary case manager while working closely in partnership with a locally appointed Veteran Affairs Canada case manager, OSIC clinician and peer support counselor(s) to ensure that each veteran's housing, social, cultural and health-related needs were seamlessly addressed. The exception to this was Victoria, where the overall approach was similar; however, supports were overseen and delivered by peer veteran volunteers. Support was individualized such that veteran-identified needs (social and health) were considered a priority.

Key Principles

The following principles based on the work of Milroy (2009) and Ray and Forchuk (2011) formed the basis of the Evaluation Project. Each project site was consistent in applying these principles while creating strategies to match local conditions and variability:

TABLE 2 *Key Principles for Addressing Homelessness Among Canadian Veterans*

• Providing housing with support
• Peer support: by vets for vets
• Provision of services separate from the general shelter/homeless population
• Emphasis on promoting self-respect
• Providing structure through the day
• Addressing co-occurring mental illness, addiction and trauma-related issues
• Providing a transition process to housing

Veteran Specific Supports

Once enrolled in veteran specific housing, veterans were assigned a local Veteran Affairs Canada (VAC) case manager for assistance and support regarding service-related benefits. An OSIC clinician addressed care for mental health, addictions and/or medical concerns arising as a result of military service. Following assessment by VAC/OSIC, veterans dealing with health or social issues that did not relate to military service were formally referred by way of a warm transfer process to appropriate community-based services and supports within public and non-profit sectors. The VAC case manager and OSIC clinician collaborated with housing staff to ensure that recommendations regarding social and health-related needs aligned with housing-specific goals and housing support staff then provided ongoing support that allowed veterans to initiate and maintain a connection to community-based treatment programs.

Peer Support

Efforts to link veterans with peer support services were made at all sites. In some cases, this involved formal peer support through veteran-affiliated organizations (e.g. OSISS, Royal Canadian Legion). Community volunteers who had served in the military offered informal peer support at one site; these individuals were not affiliated with any specific agency and had not received formal training yet shared an interest in supporting this population. One site employed a mental health peer support worker as staff.

Housing First and Harm Reduction

A Housing First approach served as the cornerstone of this project; along with provisions to support attainment of permanent housing, veterans were offered intensive case planning and support aimed at improving health, independent living skills, well-being and social interests. This was based on the foundational principle that individuals experiencing homelessness are better able to address addiction, mental health, trauma and other health issues from the stability of their own home (Mead, 2003).

Harm reduction practices were observed and combined with assessment and safety planning. Frequent in-home visits by qualified staff and peers were integrated within the housing support model across sites. In-home visits are a key element of a Housing First approach and in this context offered a more accurate assessment of housing stability and an opportunity to negotiate "in the moment" solutions to issues that arose. As well, staff and peers were better able to engage with veterans

on a more personal level, to advocate (where necessary) and to provide a wraparound service able to mitigate system navigation issues as well as generally support veterans in working toward their individualized goals as they made the transition from street life to home life. Veterans were not required to observe abstinence rules within their own housing unit at three sites; however, substance use was prohibited in communal areas (shared patio, hallways or lounge) in order to respect fellow residents who may be in different stages of recovery. In Victoria, veterans were discouraged from using substances on site, this was largely due to the absence of paid staff or after-hours support. Housing tenure for veterans struggling with addiction at this site frequently relied on active involvement with addiction counseling and/or rehabilitation.

RESEARCH FINDINGS

Evaluation of this project included a mixed-methods approach. Quantitative analysis was derived from a standardized set of valid reliable questionnaires administered to veterans at baseline, three, nine and 15 months. Questionnaires included demographic and housing histories, Quality of Life Enjoyment and Satisfaction—Short Form (Endicott, 1993), and the Health, Social, Justice Service Use form. Qualitative analysis was based on three cycles of focus group interviews conducted with veterans, staff and stakeholders at each site (2012–2014).

Analysis revealed a pattern of chronic homelessness with tremendous physical and mental health consequences occurring many years following release from active military service.

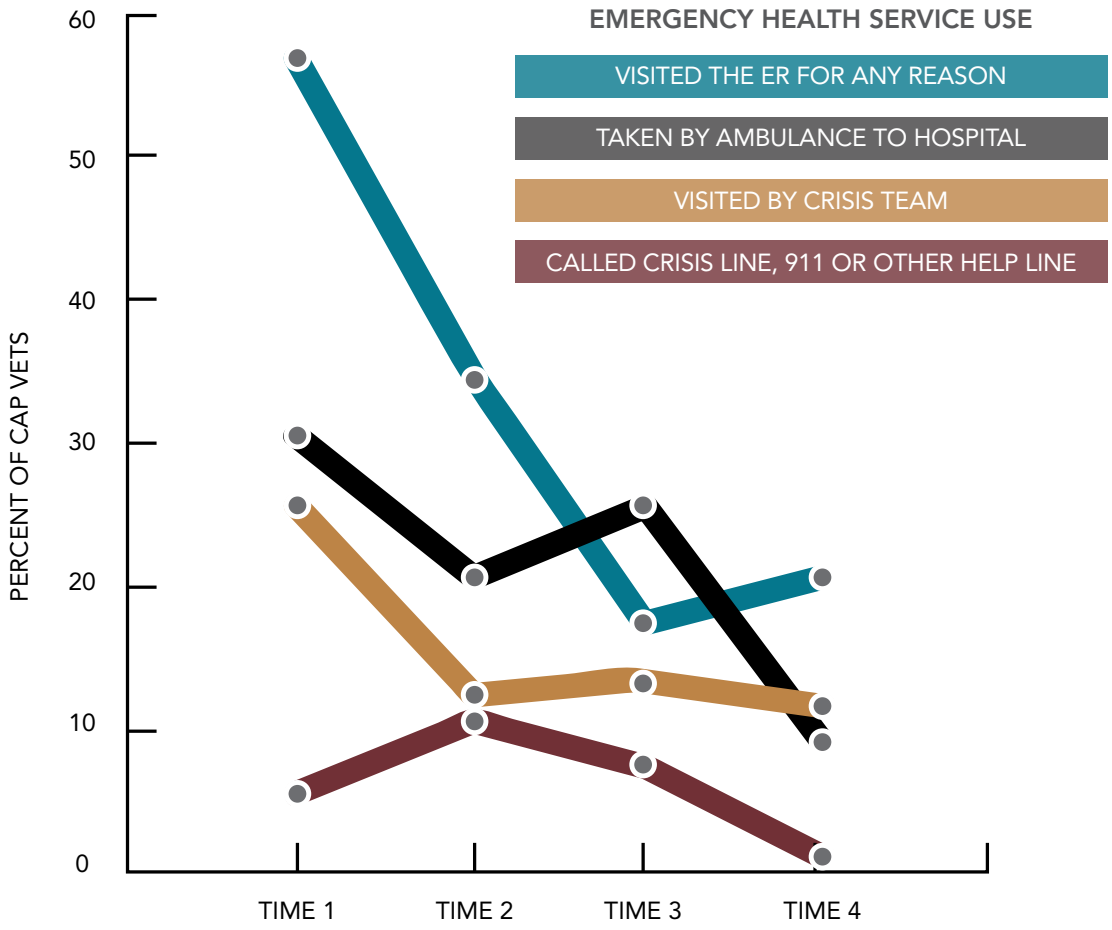
Analysis revealed a pattern of chronic homelessness with tremendous physical and mental health consequences occurring many years following release from active military service. The majority of participants were white English Canadian (79%) and male (92.1%) with an average age of 52.8 years. Only 9.7% were Aboriginal or Métis. While 66% of the sample reported having children, the pilot study housed only one single parent family. The average total time spent homeless for veterans in this study was 5.8 years (range 0–30 years). At enrolment 69.8% of participants reported situations of absolute homelessness while the remainder were at imminent risk of homelessness. The average number of years served in the Canadian Forces was 8.1 years with 39.7% having served in overseas deployments. Participants reported an average of 28.4 years since release from military service. The total time-lapse since first episode of homelessness averaged 9.7 years prior to enrolment (range 0–47 years) suggesting that for many veterans, homelessness followed a period of prolonged destabilization.

Veterans consistently voiced a desire to re-engage with military culture. Peer support services afforded many veterans an opportunity to reconnect with the camaraderie and sense of pride they once felt while serving their country. However, not all participants regarded their military experiences in a positive light and, therefore, the majority's preference was to access veteran peer support on their own terms and at their own pace. The level of street entrenchment and ongoing substance use among participants proved challenging for veteran peer supporters at one site. Sites where peer support staff and/or volunteers had more experience in working with homeless populations were better able to integrate peer support as a consistent and ongoing aspect of housing with support.

Shifting Needs Once Housed

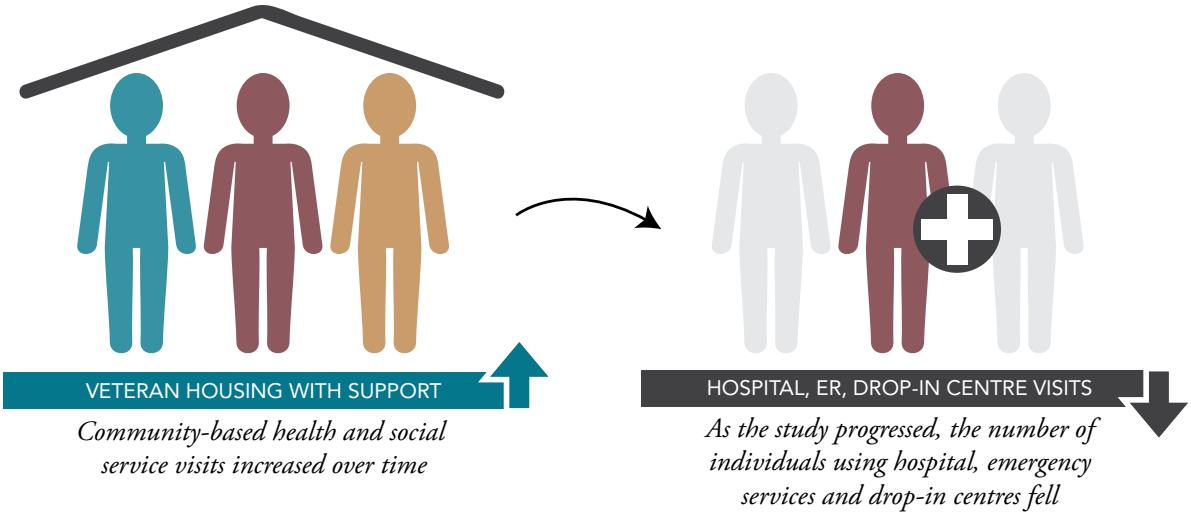
The sample size of this pilot project was insufficient to support formal analysis of service-use patterns over time. A general trend toward increased community-based care (social service and health) was observed, along with decreased hospital and emergency-room visits.

FIGURE 1 *Service-Utilization Across Data Collection Points (0,3,9 and 15 months)*



Food bank use increased over the period of study while drop-in centre visits decreased overall.

FIGURE 2 *Shift Toward Community-Based Preventative Care*



These service-use trends resulted in cost savings to the system and suggest a shift in the manner in which the veterans were able to respond to challenges from a crisis and emergency response toward more preventative supports. The provision of permanent stable housing and support contributed to cost savings of up to $536,600 in the first year following enrolment into veteran-specific housing; this figure is based on reduced reliance on emergency shelter and drop-in centre services. The immediate costs of emergency housing and related services far exceed the costs of permanent supportive housing (Calgary Homeless Foundation, 2008; Gaetz, 2012; Pomeroy, 2005); continued cost savings are therefore anticipated over time in light of the chronicity of homelessness observed among veterans involved in this study sample. Comprehensive tracking and accounting processes are integral to supporting meaningful cost-benefit analyses that illustrate how increased expenditures in one sector—in this case, a housing intervention with support—translates into significant cost savings in other sectors. Such processes should therefore be integrated as a component of program evaluation for evolving interventions that seek to address the issue of homelessness, particularly those targeted at specific subpopulations of the homeless, as this will enhance overall understanding of the true impact of targeted interventions across various systems and sectors.

Local System Collaboration and Networking

Collaboration at the local level between a range of sectors and service providers allowed for insight into site-specific strengths and challenges as veterans transitioned from a state of homelessness to being housed. All sites agreed that a concerted effort to establish regular meetings and case conferences to support individual veteran needs was important and provided a forum to address ongoing issues or conflicts. The success of outreach efforts to identify participants often depended upon the knowledge of street-level/ homeless-serving programs and other community-based mental health or addiction programs. Once established within the housing program, veteran services and other community support services were instrumental in supporting continued success. The local Housing First agency served as the primary case manager responsible for coordinating services; these agencies were familiar with the housing/homeless-serving sector and were well established in their relationships with community services, mental health and addiction treatment programs thus enhancing access to community-based resources if/when these were deemed a necessary component of veteran-specific care. Regular teleconference meetings between housing supports, VAC, OSIC and peer supports provided an opportunity to consider site-specific obstacles, identify common challenges and develop shared problem solving strategies. Sharing of information and ideas improved consistency across sites, thus improving timely access to housing and service delivery generally.

Regular teleconference meetings between housing supports, VAC, OSIC and peer supports provided an opportunity to consider site-specific obstacles, identify common challenges and develop shared problem solving strategies.

KEY AREAS OF CONSIDERATION FOR PROVIDING HOUSING WITH SUPPORT FOR CANADIAN VETERANS:

- Veterans have unique needs within the broader homeless population;
- Structure and routine, including leisure, are important;
- Peer support requires an understanding of both military service and homelessness-related issues;
- Collaboration includes an integrated and shared response with both homeless-serving and veteran-serving organizations;
- Permanent long-term housing solutions with support are preferred over transitional housing models;
- Housing First and harm reduction philosophies and interventions must drive programming;
- Choice in housing and living arrangements is important. In particular, the needs of women and families are unlikely to be met by single-site housing models; and
- Programs need to be outcome-focused with housing stability a primary goal. Secondary goals include diversion from emergency services such as shelters, police and emergency departments.

CONCLUSION

By providing veteran-specific housing and support to homeless veterans, this Canadian Evaluation Project created an opportunity for veterans, many of whom had spent years on the streets or on the verge of homelessness, to achieve new stability in their lives. This required coordinated and intensive efforts on the part of participating organizations within housing/homelessness- and veteran-serving sectors. This encompassed development of formal service agreements between agencies and a clear understanding of organizational mandates that govern service delivery. At times, this also required a shift in care delivery to conform to the primary housing agency's core philosophy or approach (i.e. adopting a harm reduction approach to support a Housing First mandate). The initial key principles for addressing homelessness among Canadian veterans remained relevant and were supported throughout the study. However, the depth and scope pertaining to the understanding of these principles increased in complexity over time. The exception from the original list of principles is that permanent rather than transitional housing is needed.

For the veterans who were housed as part of this study, this integrated approach improved access to much needed resources including income supports, medical, mental health and addiction treatments and provided an opportunity for psychosocial healing and reconnection to military culture and family supports. Ensuring pathways for open and clear communication between partner organizations serving the homeless veteran population was critical to the success of the program. Mutual problem solving required all parties keep an open mind in the face of conflict or tension and be prepared to listen, explain and/or compromise to ensure the ultimate goals of providing safe, affordable and stable housing in accordance with the core philosophies. Continued collaboration between sectors and between organizations serving the veteran population is needed, along with further research to validate long-term benefits and impacts associated with veteran-specific housing and support programs such as these.

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Inter-sectoral Collaborations

3.9

AN EVALUATION OF THE LONDON COMMUNITY ADDICTION RESPONSE STRATEGY (LONDON CARES): FACILITATING SERVICE INTEGRATION THROUGH COLLABORATIVE BEST PRACTICES

Cheryl FORCHUK, Jan RICHARDSON,
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INTRODUCTION

Homelessness in Canada has been on the rise since the 1980s. In 2006, the United Nations Committee on Economic, Social and Cultural Rights made a number of recommendations for the federal, provincial and territorial governments of Canada to address homelessness and inadequate housing as a "national emergency"(United Nations, 2006). Research has repeatedly found that individuals with addictions and mental illnesses are overrepresented among those experiencing homelessness (Argintaru et al., 2013; Bharel et al., 2012; Draine, Salzer, Culhane & Hadley, 2002; Drake & Wallach, 1999; Forchuk, Csiernik & Jensen, 2011; Goering, Tolomiczenko, Sheldon, Boydell & Wasylenki, 2002; Hwang et al., 2013; Khandor et al., 2011), with approximately two-thirds to three-quarters of the homeless population experiencing mental health challenges. This chapter describes the evaluation of a municipal strategy which focused on the housing needs and health outcomes of individuals experiencing addiction, poor mental health and poverty.

Priority populations identified in London's Community Plan on Homelessness (City of London, 2010) and Homeless Prevention System (City of London, 2013) include those who are experiencing persistent or chronic homelessness or at immediate risk of becoming homeless as a result of having to live on the street for the first time as well as youth, street-involved sex workers and Aboriginal populations. An objective of London CAReS is increasing community integration while decreasing the costs to and demands on emergency, health, social and justice systems.

London CAReS is a highly flexible service collaboration established to address the needs of particular priority populations experiencing persistent and chronic homelessness. The efforts to assist individuals served through London CAReS exist within a context of considerable systemic barriers to long-term housing stability. London CAReS participants are offered access to private market and subsidized scattered-site independent housing, along with intensive in-home and

community-based supports necessary to achieve housing stability. Their choice of neighbourhood and community is a primary determinant when selecting their housing.

Similar to other Housing First initiatives, London CAReS is a recovery-oriented model driven by participant choice and strengths. Specifically, London CAReS participants are supported with interventions and other support including health, community services and justice remedies along with social, recreational, educational, occupational and vocational activities. Interventions and supports are voluntary, culturally appropriate, individualized and, most importantly, participant driven. The program is based on respect and inclusion and encourages social and community integration through employment, vocational and recreational activities (Gaetz et al., 2013; Tsemberis et al., 2003).

London CAReS participants are supported with interventions and other support including health, community services and justice remedies along with social, recreational, educational, occupational and vocational activities. Interventions and supports are voluntary, culturally appropriate, individualized and, most importantly, participant driven.

London CAReS applies a Housing First approach which was developed through Pathways to Housing in New York in the early 1990s. This approach considers housing as a basic human right and the model offers access to permanent immediate housing of varying types to individuals experiencing homelessness, based on their unique circumstances and with appropriate and dedicated in-home support. Gaetz, Scott and Gulliver (2013) reviewed Housing First approaches and outlined common core principles in order to clearly articulate this approach. These principles include:

1. Immediate access to permanent housing with no housing readiness requirement;
2. Consumer choice and self-determination;
3. Recovery orientation;
4. Individualized and client-driven supports; and
5. Social and community integration.

The Housing First approach is considered a best practice to ending homelessness and has been proven to address homelessness by supporting individuals in obtaining and maintaining homes without increasing poor mental health symptoms or substance use (City of Toronto, 2007; Collins et al., 2012; Goering et al., 2014; Kirst, Zerger, Misir, Hwang & Stergiopoulos, 2015; Metraux, Marcus & Culhane, 2003; Padgett, Gulcur & Tsemberis, 2006; Palepu, Patterson, Moniruzzamen, Frankish & Somers, 2013; Toronto Shelter, Support & Housing Administration, 2009; Tsemberis, 1999; Tsemberis & Eisenberg, 2000; Tsemberis, Moran, Shinn, Asmussen & Shern, 2003; Tsemberis, Gulcur & Nakae, 2004; Tsemberis, Kent & Respress, 2012). In contrast to the traditional 'treatment first' approach that believes individuals experiencing homelessness must address their addictions and mental health issues prior to being deemed suitable candidates for housing (Padgett, Gulcur & Tsemberis, 2006), Housing First does not believe independent housing should be based on sobriety or acceptance of treatment. Housing First programs promote harm reduction strategies and support respectful environments and interventions that meet individuals 'where they are at' with their current substance use and treatment goals (Tsemberis & Eisenberg, 2000).

LONDON CAReS BACKGROUND

London CAReS began as an innovative City of London council-approved strategy focused on a community-based systems approach to improving the health and housing outcomes of individuals experiencing homelessness and who live with the complex and co-occurring challenges associated with addictions, poor mental health and poverty. The first five years of the integrated strategy commenced in 2008 and focused on individuals with these complex and often co-occurring challenges residing in or relying on the downtown and core neighbourhoods. This first stage of London CAReS was designed and delivered through a range of street-level services aimed at engaging individuals and families experiencing homelessness while liaising with neighbourhood residents, businesses and other community organizations. In 2011, based on experiences and the results of an evaluation which took place between 2008–2010, along with the approval of the London Community Plan on Homelessness, London CAReS re-focused its objectives to build on community integration and housing outcomes for the targeted populations. These recommendations were further supported through the development of London's Homeless Prevention System, which focused attention on prioritized action plans associated with homelessness services, including London CAReS. London CAReS shifted its focus to align with Housing First principles and strengthen service collaboration. The restructured London CAReS model of service was based on the cooperation of community services, business and neighbourhood associations, the London Police Service, individuals and all orders of government with specific leadership by the City of London.

FIGURE 1 *London CAReS Model of Collaboration*

The following components form the comprehensive service collaboration:

1. System governance, accountability and managing director;
2. Street outreach;
3. Housing selection;
4. Housing stability;
5. Syringe recovery; and
6. Administrative space.

Component 1: London CAReS Coordinator, System Governance, Accountability and Leadership

London CAReS is a voluntary service collaboration. It is comprised of three funded organizations: Addiction Services of Thames Valley, Regional HIV/AIDS Connection and Unity Project for Relief of Homelessness. The three funded agencies, through the participation of their executive directors, along with the London CAReS managing director and the City of London designate, act as the administration committee for the London CAReS strategy.

The administration committee oversees the conduct, outcome, objectives and evaluation of the London CAReS strategy. These community leaders and their organizations possess a strong commitment to the collaboration, unique expertise, knowledge and resources that contribute to the overall guidance and success of London CAReS. The London CAReS managing director administers and oversees all of the program components, including street outreach, housing stability, housing selection and syringe recovery, to ensure a focused, integrated and collaborative response to priority groups. The London CAReS managing director is employed by one of the funded agencies and is accountable to the London CAReS administration committee. On a quarterly basis, the London CAReS managing director and administration committee report on the program activities and outcomes to representatives of management from key community stakeholder groups and organizations directly or indirectly serving individuals experiencing homelessness.

Component 2: London CAReS Street Outreach

The London CAReS Street Outreach Team establish and maintain relationships with individuals at risk of persistent homelessness and individuals at imminent risk of homelessness as a result of their 'first time' street presence. Provision of services on a 24 hour a day, seven day a week basis supports active contact with street-involved individuals. This allows street outreach staff to monitor circumstances and emerging concerns. These issues could include individuals and families who might be new to living on the street residing outdoors unsheltered, situations requiring crisis response and diversion, assistance with warm transfers or creating community linkages with other services or at-risk situations due to use of contaminated street drugs. The team supports individuals 'in the moment' in an effort to initiate a rapid exit from the street and into a sustainable housing plan. All Street Outreach Team services are focused on creating opportunities for the individuals or families to transition off the streets or out of emergency shelters and into a home and neighbourhood of their choice. The Street Outreach Team assists individuals and families to connect with services and resources through warm transfers. Depending on participant needs, services can include more immediate basic needs such as a meal, survival gear, harm reduction supplies or an emergency shelter bed. However, when individuals indicate readiness to move to housing, immediate opportunities will be offered such as quickly available housing. The team also provides crisis response, meeting participants where they are in an effort to support diversion from emergency services when these services are not necessary. Housing options can be offered rapidly or at times immediately to a participant due to available housing stock secured through London CAReS housing selection services.

Component 3: Housing Selection

The housing selection component assists London CAReS to provide housing stability by finding private sector and subsidized housing units scattered throughout the city, recruiting landlords and developing relationships and effective working partnerships with landlords, property owners and/or property management, and the City of London's Housing Division. Housing Selection staff have a unique skill set that requires them to have an understanding of the needs of housing providers as well as provide analysis of housing market trends to assist with housing stock search and acquisition. The primary role of housing selection services is to support the landlord. A 24-hour crisis response is available to landlords and tenants to prevent eviction and build positive tenancy.

Component 4: Housing Stability Team

The Housing Stability Team provides a participant-driven approach aimed at supporting participants as they transition to housing stability. Housing Stability Workers establish and maintain a relationship with individuals and families who have experienced persistent and chronic homelessness and focus their efforts on supporting housing stability and prevention of homelessness. Housing Stability Workers offer intensive in-home and community-based ongoing support, as directed by the needs and interests of the participant, connecting the participant to other services and assisting participants to transition into their housing and communities. London CAReS participants that are housed and supported by a Housing Stability Worker have access to a 24-hour crisis support service. The crisis and after-hours support is provided by Street Outreach and Housing Stability Workers on a scheduled on-call basis.

Component 5: Syringe Recovery

The London CAReS Street Outreach Team provides syringe and drug paraphernalia recovery within the geographical boundaries of London CAReS. They assist with responding to calls received by the London CAReS telephone service, record messages from this service and assist with all relevant data collection. Data collected assists with identifying and mapping 'hot spots.' Identifying hot spots creates more efficient responses to recovery allowing for safer public space and reduces the risk of biohazardous material being found in public spaces. Stationary needle collection bins, located in strategic locations, are maintained by the Street Outreach Team as part of a community service to reduce the amount of discarded drug-using equipment on the streets and assist in overall community safety.

Housing Stability Workers offer intensive in-home and community-based ongoing support, as directed by the needs and interests of the participant, connecting the participant to other services and assisting participants to transition into their housing and communities.

Component 6: London CAReS Administrative Space

London CAReS maintains its own secure space used solely for administrative purposes by London CAReS Staff and the administration committee. The London CAReS managing director works on-site and manages the office space in cooperation with the funded agency. The office space is not meant for face-to-face meetings with participants. Participants are supported in the community (i.e. on the street, in coffee shops, libraries, drop-in centres, their homes, hospitals, community agencies, the police station, etc.).

In 2013, London CAReS moved from a strategy to an annualized funded service under the London Homeless Prevention System. The London CAReS continuum of care is aimed at improving housing and health outcomes for those living with addiction and mental illness and experiencing homelessness, reducing the incidence of homelessness in London and enhancing the quality of life in the downtown core areas.

This unique approach applies the highly successful Four Pillar Approach (City of Vancouver, 2015), which incorporates treatment, prevention, justice response and harm reduction, to respond to addictions. London CAReS has created a fifth pillar of 'collaboration and integration.' This unifying pillar engages individuals with lived experience, businesses and residents in the design and delivery of London CAReS.

STUDY OBJECTIVES

The main objective of this study was to evaluate a unique Five Pillar Community Addiction Response Strategy that uses a Housing First approach to improve the housing and health outcomes of individuals experiencing homelessness and the challenges associated with addictions, poor mental health and poverty. This evaluation addressed two levels of enquiry: individual (i.e. impact of the service on consumers) and community (i.e. an exploration of London CAReS implementation and service/agency collaboration). This paper focuses primarily on the individual level outcomes across time to compare the year prior to entering the program to the year after. The study explored health and housing outcomes as well as health care utilization and emergency shelter use by London CAReS participants before and after enrollment in London CAReS.

RESEARCH QUESTIONS

The central research questions were:

Question 1: What changes in health, including housing stability, are reported by individuals accessing London CAReS?

Question 2: What is the difference in the use of emergency health services, emergency response and emergency community services when comparing the year after enrollment in the London CAReS program to the year prior?

Question 3: Is there an increase in the use of addiction and poor mental health prevention and treatment services in comparing the year after London CAReS enrollment to the year prior?

METHODOLOGY

The research team received ethics approval from Western University in March 2013.

The study utilized a mixed method (i.e. qualitative and quantitative measures) using interviews, focus groups and service databases. Qualitative data was obtained by incorporating open-ended questions into the interviews and by conducting focus groups. Open ended interview questions focused on the specific housing, health and health care needs of the individual clients and how these changed before and after enrollment in London CAReS. Focus group questions sought to explore common experiences of clients during their involvement with London CAReS and challenges faced in terms of maintaining their housing on a broader policy level (e.g. discussing rules that helped or hindered). CAReS service provider and other stakeholder focus groups examined the positive aspects and challenges of implementing the London CAReS model and experiences of collaboration between London CAReS and other involved agencies. Opportunities for improving the London CAReS service were also discussed.

Qualitative data were obtained from focus groups with 18 London CAReS staff and 28 other key community stakeholders at baseline and 10 months. In order to incorporate as many key stakeholders' views as possible, arrangements were made to meet separately with those key stakeholders unable to make the set focus group times. Key community stakeholders included individuals from a wide range of programs and agencies who interact with London CAReS or London CAReS participants. As such, these key stakeholders provide direct or indirect services to individuals experiencing homelessness. Information elicited through the focus groups included: benefits and breakthroughs of implementing London CAReS; collaboration of London CAReS with other community services; changes in health and housing of individuals accessing services through London CAReS; and challenges and areas of improvement for the London CAReS initiative.

Enrollment of client participants focused on those individuals receiving intensive housing stability support from a housing stability worker, along with some individuals identified through street outreach. The London CAReS participant sample was obtained by London CAReS staff mentioning the study to individuals accessing London CAReS services through the housing stability and street outreach programs. If individuals expressed interest a member of the research team met with them to explain the study and

obtain their informed consent to participate. The sample consisted of 65 London CAReS participants; 40 (61.5%) of whom enrolled from the housing stability program and 25 (38.5%) from the street outreach program.

London CAReS staff also aided in the retention of participants for follow-up; their consistent contact with many of the participants allowed researchers to connect with individuals at baseline and at two follow-up time points, five and 10 months post-baseline for interviews and focus groups. Numerous alternative contacts were obtained, such as family, friends and service providers at other agencies who also assisted with finding study participants for follow-up. As compensation for their time, all participants were given $20 in cash at the end of interviews and focus groups. All three interviews were completed with 56 (86.2%) of the 65 participants enrolled. Of the nine individuals who did not complete all interviews, four were lost to follow-up, one withdrew from the study, one no longer met inclusion criteria and three passed away. There were 33 participants in the focus groups, 20 of these also participated in individual interviews.

Leveraging the experience of and resources from leading community organizations, London CAReS is able to provide a seamless continuum of supports to participants from 24-hour street outreach and crisis support, intensive in-home case management from Housing Stability and actionable housing options from Housing Selection.

Leveraging the experience of and resources from leading community organizations, London CAReS is able to provide a seamless continuum of supports to participants from 24-hour street outreach and crisis support, intensive in-home case management from Housing Stability and actionable housing options from Housing Selection. This streamlined process allows for individuals to rapidly exit from the street into housing with identified supports oftentimes in under 30 days.

For qualitative analysis of both the interview open-ended question responses and focus group data, the research team used a matrix method (Leininger, 2002; Miles & Huberman,1994). Focus group discussions were audio-taped and later transcribed and validated. For the focus groups, the matrix consisted of three columns for participant groups (i.e. London CAReS participants, frontline London CAReS staff and other key stakeholders) and rows across for emergent themes. Groups were first analyzed separately using the phases of qualitative data analysis described by Leininger (2002). Research team members developed and validated a coding structure for emerging data to reveal patterns across and between groups and determine any similarities or differences in meanings. The matrix design allowed this direct comparison. Recurrent findings were then synthesized into unique concepts/themes. The data were analyzed until saturation occurred, meaning that no further unique themes arose (Leininger, 2002). The advantage of the matrix approach was that it provided a visual overview which captured all the major issues and allowed for connections to be made across data sets (Miles & Huberman, 1994).

Quantitative data used in this study came from several sources: records from four emergency shelters within the City of London; provincial records of participants' health service utilization prior to and after involvement with London CAReS (obtained through an analysis at the Institute for Clinical Evaluative Sciences (ICES) where provincial health data is held); and a final set of quantitative data were obtained during the research interviews conducted with London CAReS participants.

During the individual interviews a selection of previously used and/or validated quantitative research instruments were used to gather data of relevance to the demographic, health, housing and social integration characteristics of participants (see Table 1). To address the research questions explored in this chapter, the analyses focused on three of the tested instruments described in Table 1: the Demographics Form; the Health, Social, Justice Service Utilization Questionnaire; and the Housing History Form.

TABLE 1 *Research Instruments and Resources*

Research Instrument	Purpose	Source
ACCESS	Questionnaire assesses whether participant has a regular doctor, a regular place they go when they're sick (e.g. walk-in clinic, community health centre) and whether there has ever been a time they needed health care recently but could not access it.	MHCC
COMMUNITY INTEGRATION QUESTIONNAIRE (CIQ)	Uses 13 questions (summing to two scores) to assess the level of physical integration (community presence/participation) and psychological integration (sense of belonging).	Dijkers, 2000
CONSUMER HOUSING PREFERENCE SURVEY (MODIFIED SHORT VERSION)	Identifies current housing, preferred housing, preferred living companions and the supports needed.	Tanzman, 1990
DEMOGRAPHICS FORM	Collects basic demographic information including age, sex, marital status, education, current employment and presence of any psychiatric diagnoses.	Forchuk et al., 2011
GLOBAL ASSESSMENT OF INDIVIDUAL NEEDS SUBSTANCE PROBLEMS SCALE (GAIN-SPS)	Modified from the GAIN Short Screener (GAIN-SS); evaluates the probability an individual is currently experiencing or has previously experienced a substance issue.	Conrad et al., 2008
HEALTH, SOCIAL JUSTICE, SERVICE USE	Information collected includes the types and frequency of healthcare and social service utilization in the recent six months. Includes visits to service providers, visits to the ER and contact with community authorities (e.g. security, arrests and detentions by police).	Goering et al., 2011
HOUSING HISTORY SURVEY	Identifies types of residences lived in over the previous two years, length occupied, reasons for moving and housing satisfaction.	Forchuk et al., 2011
LEHMAN QUALITY OF LIFE: BRIEF VERSION	Used to evaluate clients in a number of areas including life in general, health, social relationships, family relationships, safety, finances and employment. Measurements include both the subjective (client's perceptions) and the objective (number of activities).	Lehman et al., 1994
MIGRATION FORM	Assesses the migration of individuals (recentness) and the reasons for it. Also includes an assessment of the situation under which the individual became homeless.	Kauppi et al., 2009
PERCEIVED HOUSING QUALITY	Examines the quality of current housing (e.g. safety, privacy, friendliness) as well as affordability and length of time in the current housing.	Tsemberis et al., 2003
SF-36 HEALTH SURVEY	This is a 36-item self-report checklist of the general physical and emotional health of the participant.	Ware & Sherbourne, 1992
WORKING ALLIANCE PARTICIPANT VERSION	Identifies the strength of relationship between the participant and main health care provider (e.g. London CAReS worker).	Horvath et al., 1989

Individual outcomes were evaluated across time as appropriate for the individual data sources utilized (i.e. interview data versus provincial health data). For individual interviews, data collected at the start of the evaluation (baseline) was compared to that collected at five and 10 months into the evaluation using a repeated measures ANOVA analysis. For provincial health care utilization data, data from six months pre-enrollment was compared to that of six months post-enrollment using paired t-tests for normally distributed data and Wilcoxon Signed Rank test for non-normally distributed data. Following this, data from 12 months pre-enrollment was compared to that of 12 months post-enrollment where data was available and using the paired t-tests and Wilcoxon Signed Rank test as described above.

FINDINGS

Sample Characteristics

Table 2 displays the demographic characteristics of the sample as reported via the demographic questionnaires. The average age of participants was 41.3 years and almost two-thirds were male (66.2%) and had never been married (64.6%). Most individuals self-identified as being Caucasian (75.4%). Just over a quarter of the sample (27.7%) stated having at least one child under 18 years of age.

With respect to mental health indicators, the most prevalent self-reported mental health diagnosis in the sample was a substance/addiction issue (55.4%), followed by mood disorders (47.7%) and anxiety disorders (33.8%). Furthermore, over half the sample had previously had a psychiatric admission (58.1%). Although 55.4% identified having a diagnosed substance-related disorder, 79.7% reported having a current substance/addiction issue. The most prevalent self-reported substance/addiction issues within the sample included tobacco (56.9%), alcohol (27.7%) and marijuana (24.6%). Almost the entire sample identified with having been homeless sometime in their lifetime (96.9%). On average, homelessness had occurred approximately 4.5 times during their lifetime, with the average age for first-time homelessness being 27.7 years.

TABLE 2 *Characteristics of the Sample (n=65)*

Characteristic	n (%)
AGE (YEARS) [MEAN (SD)]	**41.3 (14.40)**
GENDER	
Male	43 (66.2%)
Female	22 (33.8%)
ETHNIC GROUP	
European origins (i.e. Caucasian)	49 (75.4%)
Aboriginal	11 (16.9%)
Visible minority/mixed ethnicity	5 (7.7%)
LEVEL OF EDUCATION	
Grade school	26 (40.0%)
High school	27 (41.5%)
Community college/university	12 (18.5%)
MARITAL STATUS	
Single, never married	42 (64.6%)
Separated/divorced	17 (26.2%)
Married/common law	3 (4.6%)
Widowed	3 (4.6%)
Has children	38 (58.5%)
NUMBER OF CHILDREN UNDER 18 YEARS OF AGE (N=38)	
0 children	20 (52.6%)
1 child	10 (26.3%)
2 or more children	8 (21.0%)
Has custody of children (n=18)	1 (5.6%)
CURRENTLY EMPLOYED	**5 (7.7%)**
MENTAL HEALTH DIAGNOSES	
SUBSTANCE/ADDICTION ISSUES	**36 (55.4%)**
Mood disorder	31 (47.7%)
Anxiety disorder	22 (33.8%)
Disorder of childhood/adolescence	16 (24.6%)
Schizophrenia	11 (16.9%)
Post-traumatic stress disorder	9 (13.8%)
Personality disorder	6 (9.2%)
Other	1 (1.5%)
Mental health diagnosis present but type unknown	1 (1.5%)
Developmental handicap	0 (0%)
Organic disorder	0 (0%)
Has had a psychiatric admission (n=62)	36 (58.1%)
NUMBER OF PSYCHIATRIC ADMISSIONS IN PREVIOUS YEAR (N=35) [MEAN (SD)]	**0.7 (1.37)**
TOTAL NUMBER OF PSYCHIATRIC ADMISSIONS IN LIFETIME (N=30) [MEAN (SD)]	**5.5 (7.62)**
CURRENTLY HAS A SUBSTANCE/ADDICTION ISSUE (N=64)	**51 (79.7%)**
CURRENT SUBSTANCE/ADDICTION ISSUES	
Tobacco	37 (56.9%)
Alcohol	18 (27.7%)
Marijuana	16 (24.6%)
Prescription drugs	13 (20.0%)
Caffeine	12 (18.5%)
Other	11 (16.9%)
Cocaine/Crack	5 (7.7%)
Heroin	3 (4.6%)
Hallucinogens	2 (3.1%)
Has been homeless in lifetime	63 (96.9%)
AGE WHEN FIRST HOMELESS (YEARS) (N=61) [MEAN (SD)]	**27.7 (13.43)**
NUMBER OF TIMES HOMELESS (N=49) [MEAN (SD)]	**4.5 (5.72)**

QUESTION 1

The first question examined changes in health including housing stability as reported by individuals accessing London CAReS. Question 1 was explored through interview and focus group data. The findings from these are discussed separately.

London CAReS Participant Perceptions of Changes in Health and Housing Stability – Interview Findings Related to Question 1

While many (n=29, 50.8%) participants stated their needs were being met prior to engagement with London CAReS (e.g. "perfect"; "not bad" and "pretty good"), just as many (n=28, 49.1%) participants indicated their health care needs were not being met prior to engagement with London CAReS. Some attributed this to not having a family doctor (n=2), with being homeless (n=4) or with substance use (n=2), not being on medication (n=2) and not eating nutritious food or having access to enough food (n=2). Barriers to accessing health care included lack of transportation, difficulty getting a family doctor and "struggling with being able to get a health card."

Poor health was often associated with being homeless, "struggling" to live on the streets or "going from shelter to shelter" and difficulty finding "somewhere to rest." One individual stated "I have high blood pressure because of the lifestyle… [and I] don't sleep good." Others (n=2) associated poor health with their addiction/substance use. One participant reported "not using clean needles" and another was skipping scheduled appointments due to "use." Not visiting health care professionals was a common theme in the open-ended questions and often related to the effect of addictions on mental health: "I was a drug addict, I wasn't seeking help at all"; "I rarely went to the doctor"; "I was addicted to drugs a lot, I didn't care about myself." The stigma associated with addiction was also mentioned; one person found it "embarrassing" going to the hospital because they were labeled an "addict."

Some participants (n=3) indicated their health had not changed since being involved with London CAReS and a few mentioned that their health has generally gotten worse (n=7). Those who elaborated further stated this was due to substance use or mental health issues: "… some family things went down and I started using again… right now I'm just trying to get my stability back"; "my health has gotten worse. Not because of London CAReS though."

Overall, after involvement with London CAReS participants indicated their health had improved for a variety of reasons (n=48). For some (n=8), this was associated with obtaining housing; "after I met them, it improved. They got me a place. I slept on the streets for 10 years." For others better health was associated with reduced substance use, being "clean" or "no longer suffering from major addictions." Participants also spoke about eating better and having access to food. Responses also indicated London CAReS was aiding individuals in accessing health care (n=17) by connecting them to health care, providing transportation to appointments and advocating when working with health care professionals. For example, "London CAReS has advocated for me in situations… I've been in because of my addiction and people in health care actually listen now." Participants viewed London CAReS staff as a support system, offering encouragement for them to see a health care professional and being seen as approachable and always being "there" to talk to, specifically in relation

to having an "urge" to use substances. One participant mentioned their mental health has been "stabilized" and another noted "…I have a place. The depression is less now. My lifestyle is better."

The majority (n=51, 78.5%) of interview responses indicated housing needs were not being met before involvement with London CAReS; participants described themselves as: being "homeless"; "living off shelters"; "on the streets"; or "couch surfing." Some (n=5) participants described themselves as being in and out of homelessness or being homeless for long periods of time, as one participant noted "I was homeless for a decade." Participants described their housing needs as being met "poorly," "bad," or "barely at all." A few participants expanded upon their difficulties in finding and/or maintaining housing. Only a small number of participants (n=2) indicated their housing needs were being met before involvement with London CAReS. Participants explained that London CAReS helped them to find or access housing and, in some cases, homes they would not have been able to obtain on their own. Specifically, London CAReS' role in providing assistance with rent and advocating with landlords was discussed. For those who elaborated, this included rent subsidy, paying first and last month's rent and setting them up with direct payment methods to help secure and maintain homes as well as making the housing affordable.

Practical assistance, such as arrangements with moving, was also mentioned, including renting a moving truck and physically helping the participant move their belongings. Participant responses indicated housing was good quality, of their choice and met the needs/wants of individuals, such as "they worked with me to find a place based on what I needed"; "they really rally to find you appropriate housing, and not the bottom of the barrel. They're nice apartments with good landlords." A couple of participants described how London CAReS ensured they had housing set up before they were discharged/released from jail or the hospital, mitigating their risks of re-experiencing homelessness and ensuring there isn't a return to the streets or emergency shelter during this transition.

Participants commented how once they were housed, London CAReS staff worked with them to support their ongoing stability. One individual stated "they keep in contact with you to keep you stable." Responses indicated they assisted with basic needs, such as support accessing food banks or ensuring food was in the apartment, providing assistance applying for ODSP and assistance with furniture and homewares.

Most participants (n=51) indicated their housing needs are being met and supported by London CAReS. Some participants (n=4) indicated that after their involvement with London CAReS they had yet to receive support in finding housing. A couple of participants indicated that, although they had received housing support, their housing situation had not improved due to poor quality or conflicting views with their London CAReS staff.

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London CAReS Participant Perceptions of Changes in Health and Housing Stability – Focus Group Findings Related to Question 1

During focus groups responses were not counted since they were part of a discussion with many group members nodding heads or otherwise indicating agreement with issues raised. Where there was a divergence of opinion this was explored by the group facilitator. The discussions around this research topic tended to focus on the concrete help that was offered through London CAReS to address barriers and some of the ongoing challenges still faced.

Issues related to substance use and other mental health concerns were other major themes of discussion related to changes in health. Dependent on participant objective, London CAReS was viewed as providing support for individuals to reduce or abstain from substance use or ensuring they were using substances safely through harm reduction. Many participants reported not using substances anymore: "I had a seven year addiction and because of London CAReS I've made it a year straight." Feeling comfortable with their assigned London CAReS staff member and having a positive supportive relationship meant participants could work on their goals related to their substance use: "I'm also addict [sic] and alcoholic so they're helping me stay clean and good. Helping me with triggers and that" and "they don't put us down for our drug use, they bring us needles when we need them at bad times. We can't see anybody else bringing us needles."

Participants also described an improvement in their general health. In particular, indicators of improved health included discussions around better access to food. Focus group participants described how London CAReS helped them get groceries by taking them to a store or food bank, or by bringing groceries if they were unable to get them themselves. If necessary, it was reported that Meals on Wheels would be arranged, so meals are delivered regularly. A participant mentioned regularly having food now at home and no longer needing to access church or organization meal programs. One participant commented on having gained weight as "before I was so thin." This was mentioned in the context of a supportive relationship with London CAReS and a decrease in substance use. Lastly, participants in the focus groups also described how London CAReS assisted them to access health care, especially by providing transportation to appointments and picking up prescription medication.

In discussing changes related to housing stability, generally focus group participants reported London CAReS helped them in accessing housing and "getting off the streets." Assistance with maintaining housing was viewed as highly important in remaining stable: "I would have slipped, I would have gone right back to the streets... but she (London CAReS staff member) was there for me" and "bounced around place to place, foster homes, group homes, whatever. This is the longest time in my entire life I have ever stayed in one place." The barriers encountered related to housing support related to those with special needs and waiting lists. Gaining housing was commented upon as "slow," particularly for "wheelchair access" or "if you have a criminal record". Location of housing was an issue with "the only places they've shown me were remote." This was a concern due to the lack of transportation and bus passes. Challenges experienced after being housed by London CAReS included lack of furniture and being overcharged by a landlord who "said I damaged the place."

Participants described how addressing housing and substance use then helped improve quality of life more generally. Participants described how London CAReS has helped them or others gain control of their lives and increase their quality of life; "you get that little push, they can get you to where you couldn't get yourself" and now they [participants] "take care" of themselves. As one participant described, he "wouldn't be alive right now if it wasn't for London CAReS." Another said, "it's been about 15 months now I think with London CAReS. Before that I was a hopeless junkie on the streets and they saved my life."

QUESTION 2

The second question examined the difference in the use of emergency health services, emergency response and emergency community services before and after enrollment in the London CAReS program. The sources to address this question included the ICES provincial data, focus group data and the city's emergency shelter data.

Provincial-level Data

Provincial-level data showed no difference in the number of psychiatric-related ER visits for the sample group at six months post London CAReS involvement (1.8 vs. 2.5, p=0.889), but did show a reduction in psychiatric-related ER visits at 12 months post London CAReS involvement (6.4 vs. 4.9 visits, p=0.038), suggesting a longer-term positive impact. There were no significant changes in the number of all cause ER visits in the six month comparison (3.9 vs. 5.1, p=0.783) or the 12 month comparison (12.4 vs. 10.2, p=0.171).

The highest frequent visitor to the ER was reported as having had 276 ER visits during the previous fiscal year and the next highest had 260 ER visits; that particular individual had not visited the ER since being housed.

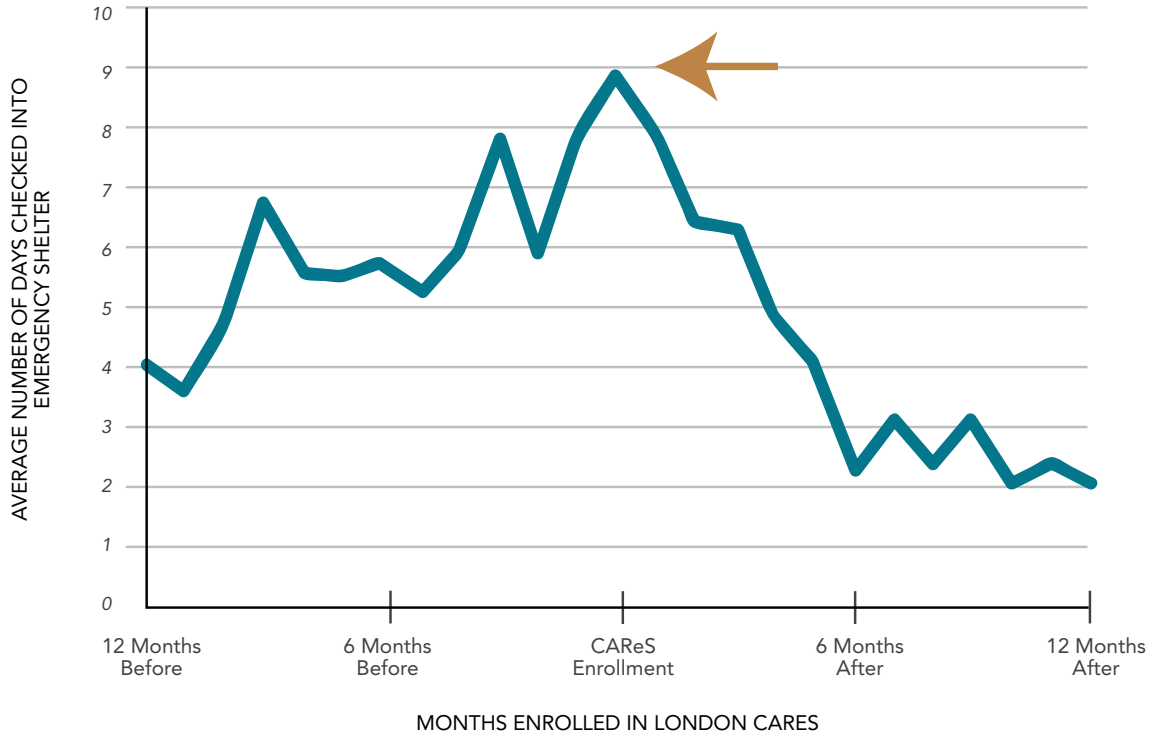
Focus Group Data

Focus group data was more optimistic about reduction in emergency services than what was reflected in the provincial dataset. Comments from London CAReS staff focus groups reflected that emergency room (ER) visits would have been far greater if London CAReS did not do crisis response, that both the police and ER services were appreciative of the diversion and that some London CAReS participants known to be ER frequent users were now housed. Some of the highest users were unfortunately not in the sample group. Refusal to participate in the evaluation process can be a limitation to reflecting results as accurately as possible. The difference between the qualitative and quantitative data on ER use may reflect that changes may have occurred with a few key individuals who were high users of ER services. London CAReS key stakeholder participants commented that reduced ER visits were noticed from those stably housed. The highest frequent visitor to the ER was reported as having had 276 ER visits during the previous fiscal year and the next highest had 260 ER visits; that particular individual had not visited the ER since being housed. There was a drastic reduction in emergency department visits with eight of 10 particular service users tracked and it was commented that considerable savings could be had by reduced ER visits. For example it costs $840 "just to register" and another $250 "if coming by ambulance" and "something like 74% of frequent flyers come to the hospital using ambulance services." Participants equated fewer ambulance responses with less police involvement. London CAReS staff facilitating home visits with primary care physicians also avoided ER visits. Key stakeholders observed London CAReS participants now attend the ER for more "medically appropriate reasons." The reduction in a few key individuals' use of the ER would create a reduction in health care costs, even if this small group was not statistically significant when added to the whole cohort.

Monthly Emergency Shelter Bed Data

Monthly emergency shelter bed data revealed a decrease in the average number of days spent in an emergency shelter after first contact with London CAReS (see Figure 2).

FIGURE 2 *Average Number of Days Spent in Emergency Shelter Before and After Enrollment in London CAReS*



A noticeable drop in shelter night use by London CAReS participants was also observed by the key stakeholder focus group participants, though they were not sure how much this might actually be due to being housed, as even when housed some individuals access crash beds because of issues such as loneliness or abuse.

QUESTION 3

The third question examined if there was an increase in the use of addiction and poor mental health prevention and treatment services after London CAReS enrollment compared to pre-intervention. Interviewed London CAReS participants indicated that prior to involvement with London CAReS they accessed a variety of services to meet their health needs, including visiting a physician (n=6), going to a drop-in centre or health care centre (n=8) or going to the hospital (n=5). Provincial agencies, such as Ontario Disability Support Program (ODSP) and Ontario Works were mentioned as services helping individuals meet their needs.

Initially, data from ICES was to be used to examine prevention and treatment services for addiction and mental illness. However, as treatment services for addiction are often community based and thus not attached to a person's OHIP (Ontario Health Insurance Plan) card, data on this aspect was not available through ICES. Consequently, the analysis focused on prevention and treatment for mental illness as defined by physician visits for psychiatric or any other reason.

The highest frequent visitor to the ER was reported as having had 276 ER visits during the previous fiscal year and the next highest had 260 ER visits; that particular individual had not visited the ER since being housed.

There were no significant changes in physician visits between the six months before and after enrollment with London CAReS for either the average number of psychiatric-related visits (8.0 vs. 8.4, p=0.889) or visits for all causes (9.8 vs.10.6, p=0.476). This observation remained true when comparing the numbers of physician visits both 12 months before and 12 months after enrollment with London CAReS for both the number of psychiatric-related visits (17.5 vs. 16.4, p=0.560) and visits for all causes (22.3 vs. 19.7, p=0.325). However, since the data that could be used for analysis through ICES was limited to physician visits this question could not be sufficiently answered.

Discussion

London CAReS is reducing homelessness in London, Ontario by offering a collaborative community-based Housing First strategy. Through the support of London CAReS, participants who once experienced chronic and persistent homelessness are now obtaining and maintaining quality homes. Consistent with Canadian homelessness literature, London CAReS participants experience high rates of health challenges including physical, mental and addiction issues (Bharel et al. 2012; Forchuk et al., 2011; Goering et al., 2002; Hwang et al., 2013; Khandor & Mason, 2007). Self reports of improved health, better access to food, use of harm reduction strategies and, in some cases, reduced substance use clearly outline the difference London CAReS has made in addressing health care challenges.

The decrease in psychiatric-related ER visits at 12 months after London CAReS involvement, but not at six months, suggests London CAReS' facilitation of service integration and community collaboration is effective at diverting individuals from psychiatric ER visits when introduced as a longer-term strategy. This diversion also suggests participants are having their mental health concerns addressed in the community and are avoiding unnecessary ER visits. The trend of increased physician visits at six months and decrease at 12

months post London CAReS involvement may suggest participants' health care needs are being addressed early on. It can be suggested that stabilization of health care needs is occurring 12 months after first receiving support from London CAReS, resulting in a trend of less physician visits.

Findings from emergency shelter data outline that with the focus on housing stability, London CAReS is supporting participants in obtaining and maintaining quality homes and decreasing time spent in emergency shelters. For example, one key stakeholder observed a direct link "between housing stability and London CAReS."

Diversion from the London Police Service was mentioned as London CAReS often responds to participants in crisis. This is beneficial to the London Police Service as their resources are freed up to focus on other matters. The prevention of an unnecessary police contact benefits the participant by allowing for higher number of supportive responses from London CAReS when considered more appropriate than enforcement.

A key component of the Housing First success is community integration (Gaetz et al., 2013). While participants did report increased stabilization and community involvement once housed, stigma was experienced by some and some reported experiencing difficulty "fitting in." This continued to act as a barrier to greater community integration and sense of neighbourhood belonging. Confronting stigma related to poverty, mental illness, addiction and homelessness continues to be an item to address. Increased community awareness and collaboration with agencies, neighbourhood associations and local businesses is helping to alleviate this. An additional effort taken by London CAReS was the inclusion of a full-time recreation and leisure support worker to work with participants in engaging in meaningful neighbourhood-based activities and ultimately promote greater connection to their new surroundings. As well, London CAReS has employed a recreational therapist to work with participants in engaging in meaningful activities to promote community integration. Another challenge has been the need to address a broad range of mental health issues in addition to substance-related concerns. This generally requires access to specialized services, which continues to be an issue for a number of participants and staff to navigate and gain access.

Limitations

Analyses conducted for this report were subject to several limitations. Firstly, the sample size meant that several of the quantitative analyses were underpowered (not sufficient information to be conclusive or to demonstrate significance). Only large effect sizes (i.e. drastic changes or differences) would have been able to achieve statistical significance (i.e. not just related to chance). Secondly, the information on emergency shelter bed usage was collected from a manual search through invoices received by the City of London. Thus, results are based only on individuals whose stay was paid for by the City and not those who were paying some room/board or staying at no charge such as crash beds and the Withdrawal Management Centre. Additionally, this analysis was based on the names and dates of birth of study participants, which may not be completely accurate due to individuals sometimes checking into emergency shelters with different names or dates of birth. Therefore, it is possible the number of days spent in emergency shelter is a conservative estimate for some individuals who may have checked in under a different name.

With respect to interview data, information collected was based on self-reporting, which may have led to underestimation of certain characteristics. For example, participants may not have accurately reported information pertaining to sensitive topics such as substance use, mental and physical diagnoses, and contacts with the justice system. This underestimation may also have occurred as a result of an inability to recall specific events as some questions asked the participant to think back in time. The open ended items on interviews were transcribed by the interview in situ and tended to be short answers.

Finally, as data at ICES often runs a year behind (i.e. October 2013 data became available for analysis in October 2014), only a six month comparison of data could be completed on all participants. Thus, the six months following enrollment in London CAReS was compared to the same period of time prior to enrollment. Although a 12-month window was completed where available, the sample size for this sub-analysis was severely reduced and subsequently the analyses were underpowered.

CONCLUSION

The results from this evaluation further support the growing literature that Housing First approaches reduce community homelessness and support individuals in maintaining their homes. Improved housing and self-reported improved health outcomes were achieved through the support of London CAReS. Diversion from psychiatric-related ER visits suggests participants are experiencing less mental health crises leading them to emergency services and greater contact with community-based supports. This decreases the strain on the health care system while supporting individuals in the community by preventing hospital visits. The decrease in visits 12 months after receiving support from London CAReS but not at six months suggests Housing First approaches are successful when implemented as a long-term strategy. It should be recognized that implementation of Housing First strategies require a long timeframe and intensive supports before changes in health and housing outcomes are seen. Future research should take this into account and set up longitudinal evaluations in order to capture these changes. This is consistent with other Housing First research demonstrating that when working with individuals identified as persistently homeless with complex and co-occurring challenges results require long-term supports to be in place in order to see indicators of stabilization and decreased experiences of crisis.

Results of this evaluation prove Housing First strategies can be implemented and be successful in mid-size Canadian cities. To the knowledge of the authors, there is no other Housing First four-pillar approach that has incorporated the additional fifth pillar of community collaboration.

Addressing homelessness requires a community collaborative response due to the complex challenges facing individuals and families experiencing chronic and/or persistent homelessness. The London CAReS approach outlines the need and success of facilitating a coordinated, unified strategy engaging various service providers, businesses, residents and individuals with lived experience in delivering the strategy. London CAReS is an example of successful implementation of a five-pillar Housing First approach, and can be a leader for other mid-size Canadian cities looking to develop and introduce a community response to homelessness.

Practitioners, such as London CAReS staff, often carry caseloads with individuals and families with quite complex and co-occurring issues which necessitate prioritizing needs. In some agencies a small number of individuals require a disproportionate amount of contact time with support staff. Interventions within a homeless prevention system can be based on assessing risk and prioritizing responses. Individuals and families with low risk of homelessness may receive less intensive interventions while those at higher risk may receive higher focus (Homeless Prevention System, City of London, 2013). This is particularly so in the area of addiction and poor mental health which affects many homeless individuals and where relapse is often an ongoing concern. The results of this study highlight the lack of stable housing as a major risk indicator for both relapse and the extensive use of limited social service and health resources. However, when individuals have a safe place to live and feel connected to their community, the ability for them to readily engage in a broader change process is more likely to occur than while in a state of homelessness.

In the evaluation of London CAReS, housing stability was a determinant which improved health issues,

including a reduction in substance use and helping participants to access health care professionals by providing information and resources. The reduction of costly ER visits impacts the cost effectiveness of the program. Furthermore, homelessness is associated with stigma and oppression. Having a fixed address is a substantive step toward re-establishing the dignity and self-worth that form the foundation of an individual's identity. Thus, individuals who have stable housing are more likely to be successful in achieving goals to address other life issues whereas those who remain homeless are more likely to require extensive services that produce little progress, impacting the ability to deliver service throughout the entire system. This then also necessitates the need for practitioners to advocate for programs like London CAReS in to order to be able to better meet individuals' needs.

The contribution of this evaluation to the literature on homelessness, poor mental health and addictions in Canada and, more particularly, to individuals, practitioners, health and social care agencies and society in general, is that as Housing First is proven to address and reduce homelessness, it would be prudent for all levels of government and municipalities to adopt this approach to ending homelessness in Canada.

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4.0

High-level Governance Challenges and Opportunities

High-level Governance
Challenges and Opportunities

4.1

SYSTEMS PLANNING AND GOVERNANCE: A CONCEPTUAL FRAMEWORK

Carey DOBERSTEIN

INTRODUCTION

Long before the homelessness sector started collecting comprehensive data on clients and their histories, it was widely known anecdotally that the policy failures or shortcomings of other sectors was a key contributor to the growing homeless population. Despite rarely being conceived as associated with homelessness, the policies (or lack thereof) of correctional facilities, mental health institutions and child and family services at times results in the discharging of individuals into homelessness. A service provider closely involved in system planning in Calgary recalls that "a couple of years into [executing] the [homelessness] plan we realized, 'Oh my God. All of these other systems are involved in it too.'"[1] Yet local policymakers and the homeless sector partners have little to no influence on these vast independent institutions of care, mainly situated at the provincial level of jurisdiction, which generally do not conceive of themselves as associated with the problem of homelessness.

To another service provider in Vancouver, "we [the traditional homeless serving sector] remain where people filter down to. We end up inheriting [who] no one else wants, [who] don't fit anyone else's mandate, or that they choose not to have them fit their mandate."[2] For example, when the child welfare system claims that they have a no-discharge (into homelessness) policy, yet skirt around that by allowing 'self-discharges,' the problem of non-compliant youth funnels into the homeless sector. Similarly, when resources for mental health services cover a mere fraction of those in need, the burden is felt most in the homelessness sector. Finally, when correctional institutions, Indian and North Affairs Canada (INAC) and even increasingly Citizenship and Immigration Canada (CIC) fail their most vulnerable populations, the burden falls on to the homelessness sector. Narratives such as the ones provided from Calgary and Vancouver abound in homelessness policy communities across Canada. Indeed, the data emerging from cities suggest that such associated sectors and institutions and their policy gaps are overwhelming homeless-serving agencies, such that, if left unchecked, threaten to overwhelm gains made within the traditionally defined homelessness sector in terms of coordination and integration.

1. Confidential interview. April 22, 2014.
2. Confidential interview. February 13, 2014.

Homelessness is thus a systemic public policy problem, involving numerous sectors, institutions and agencies and therefore requires integrated system responses in terms of governance and policy. This chapter responds to the need for a conceptual framework to understand and guide efforts towards system planning and integration from a governance and policy perspective. An integrated 'system' is characterized by a coordinated set of policies and programs aimed at aligning services to avoid redundancies, increase efficiency (e.g. reduce wait times), facilitate information sharing and learning in the policy community and provide an unbroken care experience for individuals and families facing homelessness or precarious housing. It is a significant governance challenge, but one that is necessary to tackle as a means towards ending homelessness in Canada. This chapter thus articulates a conceptual framework for collaborative governance focused on what is known as 'horizontal' system integration: a more centralized approach to planning, management and service delivery across a network of organizations and institutions within and across sectors.

I begin this chapter with a discussion of systems-oriented thinking. From here, I articulate three principal axes of integration: (i) the sectors to be integrated, (ii) the type of policy or service, and (iii) the source of authority or activity (Browne, G., Roberts, J., Gafni, A., Byrne, C., Kertyzia, J. & Loney, P., 2004). Following that, I consider collaborative governance as a means through which to achieve system integration, representing what some scholars call a 'collaborative advantage' – a result that could not be achieved by any organization working alone. The third section of the chapter articulates a conceptual framework to guide efforts towards system planning and integration via collaborative governance, identifying five key elements: (i) boundary identification and expansion, (ii) reconciling competing values in the system(s), (iii) leveraging interdependencies, (iv) leadership and external control and (v) system feedback loops. I also contemplate associated barriers and opportunities for each. The concluding section reflects on the challenges, but also the necessity, of collaborative governance for system planning and integration to end homelessness.

SYSTEM-ORIENTED THINKING

What does it mean when one refers to the 'homelessness sector'? Traditionally, this refers to homeless shelter providers, drop-in centres and outreach workers. Yet this conceptualization of what constitutes the homelessness sector is not only far too narrow, but is also temporally biased towards thinking about homelessness in reactive terms, at the expense of other proactive or preventative efforts. While numerous examples of such narrow conceptualizations of homelessness abound, the Government of Canada's Homelessness Partnering Strategy (HPS) (as well as its predecessor the National Homelessness Initiative) is an illustrative example. It is a nationwide, though small-scale, homelessness funding program for Canadian communities, yet one that prohibits the use of funds towards the construction or provision of affordable housing. Instead, funds must be used towards services or programs more narrowly defined as addressing chronic and episodic homelessness.

A broader 'system lens' breaks open this conceptualization of what constitutes homelessness policy and programs. A systems lens captures all relevant policy areas that touch on homelessness, including the systems of child welfare, criminal justice, health, employment and, of course, affordable housing.

A broader 'system lens' breaks open this conceptualization of what constitutes homelessness policy and programs. A systems lens captures all relevant policy areas that touch on homelessness, including the systems of child welfare, criminal justice, health, employment and, of course, affordable housing. It may not be obvious to some

how the child welfare system is related to homelessness until we understand that 20–45% of homeless youth were associated with that system and as many as 58% in some jurisdictions (Choca, M. J., Minoff, J., Angene, L., Byrnes, M., Kenneally, L., Norris, D., Pearn, D. & Rivers, M. M., 2004). Likewise the corrections system is associated with homelessness to the extent that discharge policies and reintegration programs are failing at their objectives. For example, research from New York City has identified that 11% of those released from incarceration experience post-release shelter stays, which amounts to over 4,000 shelter users in the 14-year period of study (Metraux & Culhane, 2004). Research in a Canadian context echoes these findings, revealing uneven supports for those discharged from correctional facilities across provinces, with many simply receiving a list of shelters for accommodation (Gaetz & O'Grady, 2009). And further, when mental health services cannot keep up with demand, this has significant implications for the stability of the lives of individuals who are precariously housed. Research across western countries continually shows that homeless individuals are disproportionately likely to suffer from personality disorders, with some estimates as high as 71% of the homeless population in some jurisdictions (Fazel, S., Khosla, V., Doll, H. & Geddes, J., 2008). Statistics like these are signifiers of a failure to diagnose, support and appropriately house those who struggle with mental illness. As such, these broader systems are in fact closely associated with homelessness and in fact the failures of these systems feed into the homelessness sector.

One of the major governance failures of homelessness is that there is a lack of ownership of this issue (Hambrick & Rog, 2000). A systems lens to the governance associated with homelessness therefore recognizes that policy changes in one area can have dramatic consequences – positive or negative – to other areas in the broader system. For example, child welfare policies and procedures that effectively discharge youth into homelessness when they are unable to place or retain youth into foster care creates significant pressures in the traditionally defined homelessness sector. Thus what are perceived as 'savings' or 'efficiencies' discovered and exploited in one system may in fact merely be pushing the problem into another sector at great consequence to the target population needing the support. Alternatively, when the corrections system develops (and faithfully implements) policies against discharging with no fixed address and effective programs to reintegrate individuals in society, this takes pressure off emergency shelters and drop-in centres. Yet these are big systems, the governance pressures of which are immense and often at odds with pressures in other systems and thus establishing coordination among them is a monumental, though necessary, task.

One of the major governance failures of homelessness is that there is a lack of ownership of this issue (Hambrick & Rog, 2000).

Thus the coordination of these various systems such that a coherent policy framework exists without major disjunctures or cracks through which vulnerable individuals and families fall is essential to improving policy outcomes (Foster-Fishman, P. G., Nowell, B. & Yang, H., 2007; Gaetz, 2013). Research on interagency collaboration by Bardach (1998) hypothesized that "substantial public value is being lost to insufficient collaboration in the public sector" (11). Peters (2007) likewise contends that "while individual programs must be made to work well, so too must the assembly of programs in government as a whole. At a minimum the programs within a particular area of policy should work together effectively" (74). Thus for implementation scholars like Peters, policy (or system) coordination is one of the important tasks of contemporary governance. Though many scholars espouse the claim that collaborative governance institutions or networks can 'solve' coordination problems, others warn that network structure and design also matters. To Thompson et al. (1991), "a possible disadvantage for networks is that very large-scale coordination via informal means becomes extremely difficult as the range of social actors expands" (15) (see also: Goldsmith & Eggers, 2001).

With a given policy context, system integration is a term used to describe a policy framework that covers the spectrum of needs of the target population as well as policies that work in a cohesive fashion (i.e. do not work at cross-purposes). An example of two homelessness-related policies working at cross-purposes would be (i) an aggressive outreach program to link street homeless persons to services and (ii) a bylaw that criminalizes sleeping in public squares and parks. They work at cross-purposes because the bylaw will drive the street homeless into the shadows (places they will not be discovered) and thus further away from accessing services. System integration and coordination is a feature of public policy that scholars and practitioners should care about not because of a desire to homogenize policy or reduce experimentation, but rather as a basic goal of competence and effectiveness in complex policy domains with many moving parts and institutional silos. Thus "coordination implies the bringing into a relationship other disparate activities and events" such that "disjunctures can be eliminated" (Thompson et al., 1991: 4). Coordination is about smoothing over potentially conflicting objectives and actions of agents and agencies in complex policy fields, not necessarily the imposition of a single policy instrument or philosophy. The public administration literature has long engaged with the pathologies associated with institutional silos (Aucoin, 1997; Pierre, 1998) and homelessness is a policy issue with several levels of government, even more bureaucratic agencies and departments as well as considerable role for the charitable sector and civil society.

WHAT NEEDS TO BE INTEGRATED?

As we think about governance frameworks that may lend themselves to more effective systems planning and integration, we must conceptualize what it is that needs to be integrated as it relates to homelessness. Browne et al. (2004) provide a helpful starting point by laying out a model and a means to measure such policy and service integration. To Browne et al. (2004), there are three principal axes to conceptualize: (i) the sectors to be integrated, (ii) the type of policy or service and (iii) the source of authority or activity.

The traditionally defined homelessness sector provides the starting point, which consists of the emergency shelter and support services such as drop-in centres and basic needs provisions. Yet the aforementioned associated sectors ... are the next most obviously related sectors to homelessness.

On the first axis, it is first critical to conceptualize which sectors are within the catchment zone of homelessness. The traditionally defined homelessness sector provides the starting point, which consists of the emergency shelter and support services such as drop-in centres and basic needs provisions. Yet the aforementioned associated sectors of mental health and addictions, other primary health care, child welfare, corrections, social assistance and affordable housing are the next most obviously related sectors to homelessness. Less often identified, though nonetheless critically important, sectors include education, employment and training, and enforcement and policing.

The second axis to conceptualize is the type of policy or service. For too long, many decision makers have conceptualized homelessness policy and services solely in terms of emergency services and basic supports. Yet there are also other types of interventions and policies that represent a more comprehensive and strategic response to homelessness, including early intervention and prevention. As a result, systems-oriented thinking demands a wider lens through which we conceptualize and execute homelessness policy and services, and in particular a rebalanced emphasis on prevention and early intervention as opposed to a heavy emphasis on reactive services after an individual experiences homelessness.

The third axis, and perhaps the most difficult to address through integration, is the axis pertaining to respective authorities and jurisdictional mandates. Included on this axis are organizations associated with the funding and regulation of activities related to homelessness, which can be public authorities, private market authorities and non-profit or community organizations. While not always the case in the past, and though certainly not universal across Canada, the non-profit sector associated with homelessness has become more integrated and less-siloed in recent decades, in part due to scarce resources but also due to networking and funding opportunities that incentivize partnerships and integration at the service level. The private sector authorities associated with homelessness are rarely part of the conversation as partners towards ending homelessness, but they (particularly private market landlords) are central actors towards generating a more comprehensive and effective suite of policies and programs. And finally the most essential governance challenge associated with systems planning and integration is with respect to the variety of public authorities whose policies, regulations and spending programs touch homelessness, and it is essential that they have more coherent alignment with the homelessness sector. All three levels of government have responsibilities that touch on the issue of homelessness, whether it is affordable housing and zoning, street bylaws and policing, mental health and addictions, child welfare, domestic violence or corrections. The respective public authorities across all three levels of government must jointly devise a cohesive policy framework such that service gaps and policy disjunctures are eliminated, otherwise spending and regulations risk being inefficient and interventions for homeless individuals are more likely to be unsuccessful.

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COLLABORATIVE GOVERNANCE IN PURSUIT OF A COLLABORATIVE ADVANTAGE

Systems planning and integration alone will not end homelessness. Adequate and sustained funding commitments from government in this regard are essential components on which all of this hinges. Canada is quite far from what many observers estimate is required in terms of investment from all levels of government to substantially address homelessness (Brownlee, 2014; Gaetz, Gulliver & Richter, 2014; Pomeroy, 2014). Experts and advocates argue that the affordable housing investment under Prime Minister Harper recently is not even half of what is required of the federal government in order to adequately address Canada's vast affordability deficit (Shapcott, 2014). Yet at the same time, simply allocating more money towards housing and homelessness alone will not be effective without a strategic orientation and policy framework that ensures that the various sectors and public authorities are working towards the same end goal. As such, scholars increasingly point towards collaborative or network governance as a key governance mechanism towards systems planning and integration (Peters, 2007).

Collaborative governance can be more precisely defined as "a method of collective decision making where public agencies and non-state stakeholders engage each other in a consensus-oriented deliberative process for inventing and implementing public policies and

procedures for managing public resources" (Johnston, Erik, Darrin Hicks, Ning Nan & Jennifer, C., 2011: 699). Collaborative governance is often justified, implicitly or explicitly, on the basis of what Huxham (1993) has termed the collaborative advantage – that they are created to resolve policy and coordination problems that could not be achieved by an organization or a government department acting alone (for a Canadian example in the context of homelessness, see Doberstein, 2015). There are so many moving parts and related sectors that touch the issue of homelessness that it is essential that there is not only interagency collaboration within the sector, but also inter-sectoral networks (e.g. homelessness, housing, mental health, corrections, child welfare, etc.), otherwise innovative solutions in one area will merely plug a single hole and the flow of the problem will simply become more intense elsewhere. Significant social change to end homelessness demands that we upset the status quo, which is maintained and constrained by the systems we live within (Seidman, 1988).

As such, there is broad agreement that some form of network governance or collaborative governance is essential to effectively address homelessness in our cities, in part because it will lead to achievements that would not otherwise be possible in a siloed organizational context. It is represents a "synergy that can be created through joint-working" (Vangen & Huxham, 2010: 163). Studies in collaborative governance literature have tended, until recently, to view this governance trend through a mostly positive lens and simply assume that a collaborative advantage is realized by virtue of a network's existence (McGuire, 2006). This is despite Huxham's (1993) early warnings and subsequent empirical studies (summarized in Huxham & Vangen, 2005) that the collaborative advantage is not always evidenced in practice given the difficulties of managing the complexity of the institutions, actors and their competing interests, leading instead to "collaborative inertia" (Vangen & Huxham, 2010: 163). Yet many suggest that collaborative governance networks hold promise to produce superior system coordination to that found in traditional, more siloed bureaucratic policy planning and decision making.

Systems Integration from a Governance Perspective

That is, despite its intuitive appeal, the outcomes of formal systems-level governance efforts towards coordination and integration are challenged by a lack of evidence (Hambrick & Rog, 2000).

Efforts towards systems planning and integration can occur at multiple levels, from the closest to the ground with service integration all the way up to the policy level from government. Systems integration at the service or program level is a critical piece and is the most likely to be achieved and sustained. There are numerous examples of system planning at the service level, including coordinated access and assessment, case management and other integrated models of service (Hambrick & Rog, 2000). Yet integration at the governance and policy level represents perhaps the steepest challenge, not only in terms of marshaling together the major players to act in a concerted fashion, but also in terms of demonstrating a tangible impact on services and outcomes. That is, despite its intuitive appeal, the outcomes of formal systems-level governance efforts towards coordination and integration are challenged by a lack of evidence (Hambrick & Rog, 2000). This is no doubt partly due to the fact that is it difficult to change these big systems, but also because many systems integration efforts have not fully conceptualized the dynamics and properties of the environments and contexts they are endeavoring to reform. Systemic change is both the most difficult to achieve and sustain, but also perhaps the most critical to grapple with in order to generate the transformative change that systems-thinking envisions (Foster-Fishman & Behrens, 2007).

There has been considerable research into systems-oriented thinking as it relates to social service provision, and in fact homelessness in particular, given the fragmentation of services and the lack of capacity of clients to navigate such a complex system. It is a sector that has evolved segmentally and thus is more often characterized as a patchwork system than a strategically planned suite of services. Most services and programs have been developed and have evolved incrementally: housing separate from social services, which is separate from health services, mental health and employment and each has a separate funding stream, different set of rules and usually a separate service location (Hambrick & Rog 2000). Given the expansive research in social services arenas in relation to system planning and integration (Ivery, 2010; Midgley & Richardson, 2007; Peirson, L. J., Boydell, K. M., Ferguson, H. B. & Ferris, L. E., 2011), we can distill a number of critical features of design and relationship management from a governance perspective, transforming and expanding on Browne's (2014) three axes specified earlier. Important features of systems integration from a governance perspective include: boundary identification and expansion, reconciling competing values in the system(s), leveraging interdependencies, leadership and external control and system feedback loops. Each are articulated and connected below.

Boundary Identification and Expansion

The first critical task of conceptualizing systems integration from a governance and policy perspective is to identify and expand the boundaries of the system. Boundaries determine the inclusion and exclusion of relevant government ministries and departments, stakeholders and issues that are considered connected to homelessness. The conceptualization and reconceptualization of boundaries, according to Midgley and Richardson (2007), is definitional to "systemic intervention," which they define as "purposeful action by agent[s] to create change in relation to a reflection upon boundaries" (171). The authors also suggest a "boundary critique" – that we critically reflect upon the boundaries we create, as they are associated with particular values and invoke different meanings (172). Foster-Fishman and Behrens (2007) likewise claim that it is fundamental to the efficacy of systems change endeavors that system boundaries are conceptualized and expanded. What Foster-Fishman et al. (2007) call "bounding the system" includes problem definition and specifying the "levels, niches, organizations and actors in the process" (202). The major gap in homelessness systems integration from a governance perspective is that the boundary is far too narrowly defined as to the issues associated with homelessness and therefore the governments, organizations and institutions implicated. In fact, systems-oriented governance ought to not even conceptualize boundaries before instead first discussing values and objectives, from which boundaries may then be formed. Otherwise, when starting with boundary specification we fall quickly into familiar notions of what is involved in generating and sustaining homelessness (Midgley & Richardson, 2007).

The major gap in homelessness systems integration from a governance perspective is that the boundary is far too narrowly defined as to the issues associated with homelessness and therefore the governments, organizations and institutions implicated.

Barriers to Boundary Identification and Expansion

The principal challenge for homelessness systems integration is the narrowly defined nature of homelessness policy and governance. Among the general public and even policy makers, the homelessness sector is generally perceived to consist of the emergency shelter system and support services such as drop-in centres and basic needs provisions. It is no surprise that this is the case. The first iteration of the federal homelessness program, the National Homelessness Initiative (2000–2007), was aimed principally at targeting emergency-based needs. Yet homeless counts across Canadian cities and subsequent research have identified very close links between homelessness and other sectors not traditionally conceptualized as part of the policy conversation. This includes the associated sectors of mental health and addictions, other primary health care, child welfare, corrections, social assistance and of course the affordable housing sector. When we talk about boundary expansion as an initial objective related to systems change, identifying the links between these associated sectors and homelessness is essential. Increasingly as well, additional sectors have been identified from research and the testimony of those with lived experience drawing in education, employment, training and enforcement and policing sectors.

Despite research to support the expansion of boundaries of the homelessness system, there are barriers to drawing these sectors into a broader policy discussion. First, many in the associated sectors do not perceive their primary, or even secondary, mandate to be associated with homelessness and thus resist being lured into this policy community. For example, the corrections and justice system would likely claim that their primary mandate is to detain and rehabilitate criminal offenders, and they are therefore not focused on the policy environment that exists once they are released. Second, time, expertise and financial resources represent significant barriers to their engagement in terms of policy and programs, as the corrections system, for example, cannot alone be everything to every client. Third, jurisdictional and legal barriers exist across sectors that may harden boundaries between obviously related sectors. Canada is a federal system, with constitutionally protected provinces with autonomy from the federal government, many of which jealously guard their jurisdiction and resist definitional slippage or backdoor attempts to legislate within – or even share information across – one level of government's boundary.

For example, since the first iteration of the National Homelessness Initiative, now called the HPS, the federal government prohibited local communities that prioritize and allocate their funds from investing in affordable housing units, as this is in their view a provincial government mandate. The federal government did not want local communities to use this money to allow the provincial governments to back off their own affordable housing investments. Thus a boundary is legally erected and reinforced through policy and programs, even if it makes little sense from a systems perspective. As communities become more mindful of system disjunctures like the examples above, they must make compelling arguments to eliminate arbitrary boundary distinctions within the system and expand the sectors that research and experience demonstrate are related to homelessness. In some contexts where the constitutional division of powers represent hardened boundaries unlikely to be overcome easily by relationship building among bureaucratic leaders (e.g. Quebec-Canada relationship), the task becomes one of managing the politics of power sharing within preserved boundary distinctions (e.g. special Quebec-Canada agreement on HPS).

Reconciling Competing Values and Knowledge

The second critical feature of systems integration from a governance perspective are the values and beliefs that undergird our social imaginaries associated with homelessness. To many systems theorists, this must be the starting point, even before boundaries are specified, as values and beliefs frame the objectives and understandings of the issue and thus ultimately are what subsequent policies, collaborations and interactions stem from. One point of resistance around systems integration is based on a perception that this implies a single rationality dominating and being imposed on sector elements. This was, in fact, the agenda of the earliest systems thinkers in the 1960s, who envisioned centrally planned and engineered systems from the top down. Yet this movement died when the limits of rational planning were exposed by such attempts. As a point of contrast, contemporary systems thinking demands that we acknowledge and work through the multiple rationalities rather than try to achieve a single 'objective rational policy' (Midgley & Richardson, 2007).

Though counter-intuitive, contemporary systems thinking involves less emphasis on top-down engineered collaboration and integration, and is instead conceived fundamentally as "a discourse that has a community of people who are engaged with it, with fuzzy boundaries on the edges" (Midgley & Richardson, 2007: 170). This implies engaging with multiple stakeholders in developing "rich pictures" of a problem definition and system solution, reflective of the diversity of knowledge and values rather than imposing an objective reality (Checkland, 2000: 22). This is not inconsistent with a simultaneous drive towards more and better data to inform understandings of the homelessness experience and service system, provided the interpretation of that data is an open and deliberative process. Research in public administration is conclusive that top-down imposed integration inattentive to the multitude of values and beliefs in the sector invariably results in failure because front line workers will often reject or evade policy mandates that conflict with their values (Klein & Sorra, 1996). Thus a framework of shared beliefs across the system is an essential ingredient in collaborative system integration efforts (Smith & Wilson, 2008). Thus before the system can be shifted and status quo upset towards transformative change, we must understand different perspectives on the problem's definition, and acknowledge the subjective nature of system conceptualizations around problem definition, system boundaries and solutions (Foster-Fishman et al., 2007).

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BARRIERS TO RECONCILING COMPETING VALUES & KNOWLEDGE

It is one thing to say that in order to be successful in systems change efforts towards ending homelessness that we need to better incorporate competing values and knowledge from across systems, and a whole other matter to actually do this and have something coherent and feasible emerge from such collaborative problem definition efforts. Consultations, networking events and collaborative problem solving efforts are good at generating a long list of different perspectives, values and solutions, but less frequently is there a coherent distillation of ideas resulting from it. The reconciliation of competing values and knowledge is the key challenge in system change efforts – it is not about achieving consensus, but rather finding ways for different ways of conceptualizing issues associated with homelessness to fit into the broader policy framework.

Key objectives in this context, therefore, are to locate and deliberate root causes of systemic problems by identifying system parts and their patterns of interdependency that explain the status quo, and use this collated information to identify leverage points that will cultivate major change (Foster-Fishman et al., 2007). This does not imply that all belief systems are equally valid or must be incorporated, but rather serves as a starting point in a discursive process that engages system members in "ongoing opportunities to discover and alter their worldviews," thus providing the mechanisms for "shifting mindsets and fostering system change" (Foster-Fishman & Behrens, 2007: 195). Such attention to the normative basis for understanding homelessness and the governance and policy response across levels, within niches and among actors, is essential to identify areas of support for and resistance to system change. That this is a difficult step is indeed an understatement but it is a necessary step, as we know that policy actors and service providers on the ground who do not buy into the values embedded in the system will find ways to evade it. As such, credible and sustained efforts must be made through institutionalized committees and networks to share knowledge and contemplate values, such that they can collectively identify areas of agreement and contention and reconcile them to the fullest possible extent in order to move forward towards systems change (Concordora, 2008).

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LEVERAGING INTERDEPENDENCIES

One of the central tenants of organizational theory as it relates to systems integration is the notion of interdependency. That is, organizations and institutions are interdependent pieces within a broader system; the actions of one will impact the conditions in other components of the system (Foster-Fishman & Behrens, 2007). Current understandings of systems highlight that most systems contain a complex web of interdependent parts. Thus systems-oriented thinking rejects conceptualizations of sectoral autonomy to the extent that that allows for narrow visions of goals and accountabilities. As such, all systems integration efforts must identify the component pieces of the system, thereby defining its boundaries, but also appreciate and conceptualize the interdependencies and relationships among the various elements of the system. Thus mapping the system is only a first step – drawing the various pathways and connections and interdependencies is what generates a system-oriented framework. What is essential to appreciate at this stage are the implications of truly understanding interdependency in the context of homelessness. It means that an intervention that is effective in one element must not necessarily be assumed to be effective in another element. Indeed, Provan and Milward (2001) explain that certain effectiveness criteria in a particular category or intervention may have an inverse relationship with effectiveness at another level. The implication of this is that leveraging change in one part will lead to the desired outcome only if concurrent and appropriate shifts happen in the other elements of the system (Foster-Fishmann et al. 2007).

BARRIERS TO LEVERAGING INTERDEPENDENCIES

Once system boundaries are identified (and ideally expanded, thereby capturing more elements related to homelessness), considerable work must be devoted to mapping out the respective interdependencies in the broader system. That is, once the respective sectors associated with homelessness are brought into the policy community, their specific relationship to other sectors in relation to policy, program and populations must be articulated. This is challenging work that is bound to result in disagreement, conflict and perhaps even resentment. For example, many youth homeless shelter providers identify the failures of the child welfare system as a key driver of the problem of youth homelessness that they attempt to address. Yet at the same time, members of the child welfare system may refer to the criminal justice or K–12 educational system as the true root of the problem. Likewise the addictions sector will often point to their interdependent relationship to the mental health sector, pointing to inadequate mental health services and programs that lead to self-medication and abuse of illicit and unsafe street drugs. This is not principally a story of blame avoidance – though that may be present to some degree – but rather a reflection of the layers of complexity in society and our institutions that contribute to homelessness, thus demanding more strategic and integrated policy responses.

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Yet for each of these examples of interdependencies articulated above as challenges, there are also positive interdependencies or relationship features. For example, from a purely cost savings lens, many of these interdependent features of the homelessness system would find efficiencies – and thus improved effectiveness of their interventions – through cooperation and establishing policy coherence that counteract trends of reciprocal 'dumping' of problems into other sectors. Yet the question of cost savings in the context of a federation like Canada is a difficult one to conceptualize, as the cost savings from actions in particular sectors may be realized in other sectors and thus the incentives to act are less direct. For example, a municipal government investing in affordable housing for chronically homeless individuals may ultimately save the health care system money, but that is a provincial expenditure and policy domain. Changing incentive structures from a sectoral or institutional-specific lens to a systems lens requires high-level leadership, detailed in the section below.

LEADERSHIP AND EXTERNAL CONTROL

Systems change and integration cannot occur without leadership. As mentioned above, one of the central problems in homelessness governance and policy is a lack of ownership of the issue. Ministries and departments in government with narrow mandates can too easily evade fundamental responsibility. At the same time, however, there is good reason in some respects to retain the traditional idea of bureaucratic autonomy, as it promotes accountability and responsibility for their particular mandate in the broader system. Both dynamics can be true at the same time. Yet what this implies is that there is a need for a central brokering institution and leadership that can bring coherence to the system. Thus even though organizations and institutions may recognize interdependencies, self-coordination at a policy level is unlikely to occur naturally. Administratively, this is simply very difficult to do and to maintain without sustained and empowered leadership. Institutional scholars have long noted that organizations can be incentivized to collaborate even without tangible gain if they face leadership mandates or pressures to conform to norms in their environment (DiMaggio & Powell, 1983).

Larger scale systems change can be envisioned to also mean consolidation of federal or provincial funding programs, thus truly leveraging the unrivaled authoritative role of the state to direct tax dollars and regulate the behaviour of agencies and actors.

Generally speaking, senior governments – provincial or federal – are best equipped to use their authoritative policy levers, in addition to persuasion and inspiration, to assume the leadership and brokering role. This has been the case in the United States, in which the federal government includes a requirement that coordination (in the form of planning) occur at the local level in order to access funds (Hambrick & Rog, 2000). Similar, though weaker, incentives are in place by the Canadian federal government via the HPS, but it is a vague – and therefore unenforced – mandate of cooperation and one that leaves far too many sectors untouched. Larger scale systems change can be envisioned to also mean consolidation of federal or provincial funding programs, thus truly leveraging the unrivaled authoritative role of the state to direct tax dollars and regulate the behaviour of agencies and actors. Yet norms of ministerial responsibility and bureaucratic autonomy within governments, not to speak of across governments, represent challenges to joint policymaking and investments and thus needs strong leadership to push sectoral fiefdoms towards system change efforts.

BARRIERS TO LEADERSHIP AND EXTERNAL CONTROL

Appropriate and stable leadership is therefore an essential feature (and challenge) of systems change and integration (Doberstein, 2013; Ivery, 2010). If not present, the capacity of organizations and institutions downstream will be limited and the priority may revert to maintaining organizational capacity for survival rather than the collective goals of the systems effort. Thus a brokering organization – which may be a central agency of government, a ministry or even a community foundation with wide legitimacy – must reside at the centre of the collaborative governance effort to link the overlapping elements and interdependencies to generate a coherent system, and must possess key sources of legal and jurisdictional authority to drive change. This is critical for systems change efforts, as research has identified legal and policy issues as the biggest barriers to change (CWLA, 2006). Systems leadership must have access to important governance and policy levers to drive change, including legislation, policy, regulations and resources to be deployed across levels and elements within the targeted system (Foster-Fishmann & Behrens, 2007). While shared understandings of problem definition are fundamental, legislative frameworks and incentives assist in framing the mandate and act as powerful tools to motivate agency and organizational engagement and compliance (Horwath & Morrison, 2011). Such mandates from leadership are necessary, but not sufficient, as articulated above. The mandates must be workable, reflect agency and organizational purposes and represent jointly held values.

Broker organizations also assume responsibility for bringing together the segments of the system, facilitating collaborative development and generating mechanisms for communication and learning. The sustainability of collaborative governance efforts towards systems change is essential to ensure progress, but is inherently challenged by (i) often relying on voluntary participation by government and community partners, (ii) the diversity of actors that have different conceptions and norms of decision making, which can lead to misunderstanding and conflict and (iii) the time required to build trust (Ivery, 2010). Strong, authoritative leadership is therefore required to serve as the backbone of such collaborative governance, but service agencies also need to be co-owners of the system change efforts (Horwath & Morrison, 2011). Bottom-up driven change is indeed part of this story of systems planning in Calgary, for example – agencies have stepped up, changed or enhanced their mandates and agreed to work together to solve complex issues – but to try to create a coherent system of autonomous agencies, interview respondents suggest that you also "need the core centralized… like the Calgary Homeless Foundation or some sort of governing body to push the plan [with] consistent messaging. You need that core [coordinating body] to put that together."[3] Systems change and integration is premised on stable leadership, but that does not imply an unchanging leadership structure. In fact, Alexander, J. A., Comfort, M. E., Weiner, B. J. and Bogue, R. (2001) argue that while continuity helps foster the stability necessary to move forward toward long-term goal achievement, leadership renewal and change can infuse a system with fresh ideas and new energy.

3. Confidential interview. April 25, 2014.

SYSTEM FEEDBACK LOOPS

Consistent with the notion of interdependency is the conceptualization of feedback loops in the design and management of a system. It is helpful to conceive of a homelessness system in ecological terms, meaning holistically and with an appreciation for the interconnectedness of constituent elements (Peirson et al., 2011). Once interdependencies are identified, collaborative policy making must model the impacts of system refinements, appreciating the successive impacts of policy and program changes throughout the system. Also critical to identify in the context of interdependencies are relationships and patterns in the system that reinforce the status quo or prevent system change. Foster-Fishman and Behrens (2007) warn us that a shift in one part of the system, such as a policy or regulatory change, will only transform the status quo of the broader system if that change prompts or leverages necessary changes in other parts of the system. This involves appreciating the potential for delayed reactions to actions and their consequences throughout the system, as well as anticipating unexpected consequences from actions that can create new conditions or problems (Foster-Fishman et al., 2007). Thus ecological principles of interdependence, cycling of resources, adaptation and anticipating future change are central to system-oriented governance design and management (Peirson et al., 2011).

BARRIERS TO SYSTEM FEEDBACK LOOPS

Promoting a shift towards an ecological conceptualization of homelessness policy and governance represents a challenge because traditional governance rules and norms of responsibility, autonomy and accountability are designed to resist such efforts. The fragmentation of policy and governance emerged as a solution to the increased complexity of government action and responsibility, and the bureaucracy was designed as the most effective means to perform such tasks (Wilson, 1989). Yet the fragmented bureaucracy may have outlived its function, particularly given more modern expectations of inclusive and collaborative policy planning and decision making. But we reside in a context with new governance problems, like homelessness, using old governance solutions like fragmented bureaucracies and this represents a barrier to harnessing positive system feedback loops.

Despite rhetoric that suggests otherwise, government ministries and departments largely reside in traditional bureaucratic norms that privilege autonomy and thus remain heavily siloed. Sectoral or ministerial silos in the context of homelessness are reinforced in part due to legitimate concerns over confidentiality and the privacy of individuals experiencing homelessness. Systems integration demands sharing information about clients and the involvement of large institutions such as police and hospitals in this context makes information and data sharing an especially difficult, though essential, task. The methodical implementation of the Homeless Management Information System (HMIS) in cities across Canada points to the opportunities and challenges associated with sharing information about clients among agencies and departments for the purposes of tracking client experience across the system, while also protecting their identity from wide exposure (see for example, Calgary Homeless Foundation, 2011).

At a higher level of collaboration, there are encouraging examples in a number of jurisdictions when bureaucracies engage in joint planning, data sharing and shared responsibilities such that system feedback loops can be harnessed. The Alberta Interagency Council on Homelessness is one such example featured in this volume. The Quebec government's policy framework on homelessness and poverty is another example of one that integrates 10 provincial ministries, including health and social services, immigration, justice and corrections, and education to drive system change. Yet consistent with claims made above of the necessity of a central backbone or brokering organization, there is a clear leader among them – the Minister of Social Services – to coordinate the effort and hold primary accountability.

One strategy to encourage this type of collaboration is a 'small wins' approach, breaking down the larger systems change task into smaller achievements, from which system members can build trust and demonstrate that progress can be made (Johnston et al., 2011). It is thus important to build an environment of trust and cooperation such that when areas of more intense disagreement or controversy are broached, there is a foundation of small wins or policy gains. Howarth and Morrison (2011) also emphasize that "double-loop learning" is a key aim of collaborative governance efforts, such that it is not simply agencies receiving top-down directives to integrate and establish productive feedback loops, but on the ground experience feeding up to change those very directives (371).

Table 1, below, summarizes the conceptual framework articulated in the previous sections, which specified the features of systems integration and the respective potential barriers.

TABLE 1 *A Conceptual Framework for a Systems Lens to Homelessness Governance*

Features of Systems Integration	Barriers
Boundary identification and expansion	1. Primary vs. secondary mandates 2. Lack of cross-sectoral expertise 3. Legal and administrative rules
Reconciling competing values	1. Shifting mindsets 2. Mollifying resistance to new ideas
Leveraging interdependencies	1. Mapping the layers of complexity of institutions and policy 2. Shifting incentive structures to avoid sectoral 'dumping'
Leadership and external control	1. Securing appropriate, stable, empowered leadership 2. Establishing a brokering organization with legitimacy across sectors 3. Managing conflict and trust in collaborative governance
System feedback loops	1. Information sharing across sectors while respecting privacy 2. Balancing 'top-down' and 'bottom-up' feedback loops

DISCUSSION

Systems planning for homelessness on a grand scale – from the macro policy level, through to the institutional level and down to the ground level of organizational coordination – is not widely practiced in Canada. Yet to the extent that systems planning in this context exists, it is mostly focused on horizontal integration, meaning using a centralized approach to planning, management and service delivery across organizations within a sector (e.g. traditionally defined homelessness sector) or between other relevant sectors (e.g. corrections, mental health, child welfare, etc.). Put simply, it means repositioning the (mostly) autonomous agencies and institutions that engage with the homeless population toward a common framework and strategy, such that none are working at cross-purposes or making the problem worse for each other.

This means not only thinking about how services within the traditionally conceived homelessness sector are coordinated and aligned, but also how the failure of large institutional systems of corrections, mental health and child and family services to serve their most vulnerable clients in part fuels the homelessness crisis. A helpful metaphor used by one respondent in Calgary to describe the theory behind system planning is to "think of it almost ecologically in terms of conceptualizing a number of components that work together in a holistic fashion. One thing feeds into another."[4]

Reflecting on the historical experience of Calgary within the homelessness sector, there were hundreds of millions of dollars being invested, but "they were just disconnected… like a chaotic road system," according to former Calgary Homeless Foundation CEO Tim Richter (Scott, 2012: 177–178). It is no wonder why homeless individuals were at times unable to navigate their way to support and stability. To Richter, decision makers needed a clearer map of the 'road system' to more effectively serve clients, but also a better sense of the bottlenecks and dead-ends and ultimately "a 'system of care'… [meaning] clearly defined roads home" (Scott, 2012: 177). And an essential quality of leadership and transformative change is that "you have to be willing to say doing better means that you [previously] did something that wasn't as good… and that you have to let go of what [you were] doing."[5] This is a lesson that ought to be internalized across the broader homelessness system.

Building bridges within the homeless serving sector requires more than charismatic leadership and a willingness to admit and correct past failures, but also strategically seizing on windows of opportunity to create change. Often this means taking advantage of leadership turnover in non-profit agencies or government ministries to make a case for change. And while waiting for leadership turnover does not amount to a grand strategy, others suggest that it is more about learning who are your natural advocates in large complex institutions or bureaucracies and leveraging them to create change in the system. One policy maker confirmed that "when you meet those people in this field and there are those opportunities, you want to grab them because [there are] a lot of people who are stagnant and don't want to take risks and aren't willing to change."[6] Careful to emphasize that diverse perspectives are essential to good policy planning, this respondent also stressed that the key task is "just balancing [inclusion], because we're reinvigorating [the system]."

4. Confidential interview. April 24, 2014.
5. Confidential interview. April 25, 2014.
6. Confidential interview. April 22, 2014

One homelessness service provider interviewed said that even ostensibly positive policy change at the top is often not enough: "Health Services has a zero discharge into homelessness [policy], but [for that to] trickle down to the social workers in each hospital is just a very, very complex thing".[7] So part of the challenge for those in the homeless-serving sector is to make the case to the other feeder systems that "we are there dealing with the same people around similar issues, so how can we collaborate and communicate better and work alongside each other instead of against each other?"[8] Many are sympathetic to this argument, but some are more skeptical that there is an easy solution, because the solutions that will be effective involve a fundamental reconceptualization of some of the ways we think about mental health, corrections, child welfare, social assistance rates, affordable housing and even poverty. To some respondents, these are conversations that political and policy elites have limited interest in entertaining, yet are key to ending homelessness.

"Health Services has a zero discharge into homelessness [policy], but [for that to] trickle down to the social workers in each hospital is just a very, very complex thing"

To one respondent, "the crux of it is: who benefits? The reality is right now I think the benefit of being able to dump this [problem] into non-profit settings is really cheap, compared to system [reform] costs. There's nothing cheaper [in the short-term] than keeping people in a shelter. I think until the benefit to perpetuating the status quo shifts, we're not going to get cooperation. Why? Because the reality is most of these systems are to a large extent being driven by the Treasury. It's hard to convince the average taxpayer that we should put a higher burden on you in the short term in order to change this".[9]

7. Confidential interview. April 25, 2014.
8. Confidential interview. April 22, 2014.
9. Confidential interview. April 22, 2014.

CONCLUSION

"The social services world always has to do Band-Aid solutions and quick fixes to make up for other systems and their dysfunction."[10]

Affordable housing is undoubtedly the most significant barrier in the system, and despite efforts by some municipalities and provincial governments to enhance investments with their more limited revenue sources, thus far it is not a conversation that the Government of Canada appears willing to seriously entertain with sufficient long-term financial support – in fact, the federal government has been incrementally reducing its investment in affordable housing in recent decades. Gaetz, Gulliver and Richter (2014) estimate that 100,000 units of affordable housing have not been built in the last 20 years due to cancelation of or reduction in affordable housing investments.

In summary, the important features of systems integration from the homelessness governance perspective articulated include: boundary identification and expansion, reconciling competing values in the system(s), leveraging interdependencies, leadership and external control, and generating system feedback loops. Systems change efforts must be collaborative across sectors, and collaborative governance is often justified on the basis of what Huxham (1993) has termed the collaborative advantage – that they are created to resolve policy and coordination problems that could not be achieved by an organization or a government department acting alone. Systems change towards ending homelessness is fundamentally dependent upon leveraging that collaborative advantage. The conceptual framework articulated in these pages offers a way of thinking about the opportunities and challenges associated with systems change efforts from a governance lens.

10. Confidential interview. April 21, 2014.

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4.2

THE STRATEGIC RESPONSE TO HOMELESSNESS IN FINLAND: EXPLORING INNOVATION & COORDINATION WITHIN A NATIONAL PLAN TO REDUCE & PREVENT HOMELESSNESS

Nicholas PLEACE, Marcus KNUTAGÅRD,
Dennis P. CULHANE & Riitta GRANFELT

INTRODUCTION

This chapter explores the results of an international review of the Finnish Homelessness Strategy covering the period from 2008–2015. The chapter discusses the development of the Finnish strategy, explores the results that have been achieved and considers some lessons for transferring policy and service models between different contexts. Alongside discussing the successes that have been delivered, the chapter also looks at the challenges that Finland still faces. The final section considers the challenges that Finland continues to face as it seeks to sustainably reduce all forms of homelessness and to end the experience of long-term homelessness.

The Development of the Finnish Strategy

As in Canada, the U.S., Denmark and the UK (Aubry et al., 2012; Benjaminsen and Andrade, 2015; Jones and Pleace, 2010; Kuhn and Culhane, 1998), it had become apparent by the 2000s that Finland was experiencing several distinct forms of homelessness (Busch-Geertsema, 2010; Tainio and Fredriksson, 2009). Of particular concern was growing evidence of long-term homelessness. A significant proportion of the homeless population, perhaps as much as 45%, were people who had both a sustained experience of homelessness and often very high support needs, including comorbidity of severe mental illness and problematic drug and alcohol use (Pleace et al., 2015; Tainio and Fredriksson, 2009). There were also associations between long-term homelessness and crime or nuisance behaviour and long-term homeless people were very rarely in employment, education or training (Tainio and Fredriksson, 2009).

This population of long-term homeless people represented a series of costs to Finnish society. The first cost was the damage that long-term homelessness could cause to the people who experienced it. The second cost centred on risks to Finnish social cohesion arising from Finnish citizens who were often vulnerable, living in situations of long-term homelessness. The third cost, because their homelessness was not being resolved by existing homelessness services, centred on the implications for public expenditure. Long-term homeless people may make disproportionately high and sustained use of emergency accommodation and emergency health services and have high rates of financially expensive contact with the criminal justice system (Culhane, 2008; Pleace et al., 2013).

A political consensus was sought to reduce overall levels of homelessness in Finland, with a specific intent to focus on reducing long-term homelessness. The result was to be a national program, with two stages, Paavo I (2008–2011) and Paavo II (2012–2015), designed to drastically reduce long-term homelessness by reducing it by 50% by 2011. Paavo I, administered by the Ministry of the Environment, involved the Ministry of Social Affairs, the Criminal Sanctions Agency, the Housing Finance and Development Centre of Finland (ARA) and Finland's slot machine association (RAY, Raha-automaattiyhdistys, which helps fund NGO housing services). Elected local governments from 10 cities, including the capital Helsinki which had the highest levels of homelessness, signed letters of intent which committed them into the Paavo I program and had them working in coordination with central government[1]. This created a context in which all levels of government in Finland and all major administrative bodies that were required for a coherent integrated national strategy were in place. The subsequent Paavo II program used the same administrative arrangements. Achieving this degree of consensus and coordination was a major achievement of the Finnish Homelessness Strategy.

Long-term homeless people may make disproportionately high and sustained use of emergency accommodation and emergency health services and have high rates of financially expensive contact with the criminal justice system (Culhane, 2008; Pleace et al., 2013).

Significant resources were made available to support the strategy. Approximately €21 million in subsidies were granted for housing construction during 2012–2013, with a further €13.6 million being granted for developing and delivering services – a total of €34.6 million (equivalent to CAD $46.4 million at mid-2013 exchange rates). The cities participating in implementing the program also provided significant investment.

Paavo I sought to halve long-term homelessness by 2011, while Paavo II sought to *eliminate* long-term homelessness by 2015. Paavo I concentrated mainly on long-term homelessness, but the remit of Paavo II, while still heavily focused on ending long-term homelessness, was somewhat wider. Paavo II included further development of preventative services and low-intensity support services focused on scattered ordinary housing. Paavo II also saw an attempt to ensure more effective use of the social housing supply to reduce homelessness.

Preventative services in Finland concentrate on strengthening housing skills, i.e. the knowledge people need to run their own homes and the coordination of support services (case management or service brokering) to prevent homelessness from occurring as a result of unmet support needs. Preventative services also arrange housing when someone is about to leave an institution or care, such as a psychiatric ward, prison or when young people leave social services' care. Housing advice is also provided, which can include support if a landlord tries to evict someone illegally or negotiating with a landlord if someone is threatened with eviction due to rent arrears. Finnish practice in homelessness prevention closely reflects that

1. The cities of Helsinki, Espoo, Vantaa, Tampere, Turku, Lahti, Jyväskylä, Kuopio, Joensuu, and Oulu took part in the Paavo programs. An eleventh city, Pori, joined Paavo II in 2013.

seen in other contexts where homelessness prevention services are viewed as relatively highly developed, such as in the UK (Pawson, 2007).

Under Paavo II, Finland began to focus more attention on the presence of concealed or doubled-up households. This group of individuals, couples and families are housed, but they are sharing housing with acquaintances, friends or relatives because they have no access to adequate and affordable housing. This population includes people in precarious situations, who are 'sofa surfing' from one short-term arrangement to another, as well as those in more stable situations who lack the privacy, room and control over their own living space that is associated with having their own home. Using ETHOS (the European Typology of Homelessness) as a reference point, this group of concealed households lack their own living space over which they exercise control (the physical domain of housing), cannot maintain privacy or social relationships because they lack their own living space (the social domain of housing) and lack a legal title of occupation (the legal domain) (Edgar et al., 2004).

Whether or not concealed households in these situations are regarded as homeless is often a question of interpretation in different European countries. In Finland, concealed households are counted as part of the homeless population. In some European countries these individuals, couples and families may be defined as living in inadequate housing, *not* as experiencing homelessness, which may be defined only in terms of living rough and using homelessness services (Baptista et al., 2012). The UK, U.S. and Canada all regard some households without security of tenure, living in temporary situations as being homeless[2], but their definitions are narrower. In Finland, efforts to reduce the number of concealed households who are viewed as experiencing homelessness have centred on increasing preventative services, including advice, information and support services, and ongoing efforts to increase the affordable housing supply. Alongside continued building of affordable social housing for rent, innovative means of accessing the private rented sector are also being considered (Pleace et al., 2015).

New services were developed as the Paavo II program (2012–2015) got underway. Paavo II had a particular emphasis on developing scattered forms of supported housing, on furthering the development of preventative services and increasing efficiency in the use of social housing to reduce homelessness. By 2013, Helsinki City had 2,086 supported apartments which were mainly individual apartments scattered across its housing stock, with an additional 905 apartments sublet from the Y Foundation, a quasi-governmental body that is a major provider of social housing in Finland (Pleace et al., 2015).

Social housing, in the Finnish sense, parallels public housing in North America in some respects, but it is comparatively far more widespread (13% of total housing stock[3]). Finnish social housing represents a significant element of the total housing stock and offers adequate affordable housing, not just for formerly homeless people, but for low-income households more generally. Increasing access to this resource for homeless people therefore meant balancing the needs of homeless people with the multiple roles that social housing has to fulfil. Various forms of social housing are widespread in much of Northern Europe though, as in Finland, social housing is not designed specifically to just meet the needs of homeless people, but has a much wider role including promoting access to adequate, affordable homes, urban regeneration and enabling key workers, such as teachers, to live and work in otherwise unaffordable areas (Pleace et al., 2012). Alongside an increased emphasis on developing more scattered forms of supported housing, the Paavo II program also had a greater focus on community integration.

2. UK: http://england.shelter.org.uk/get_advice/homelessness/homelessness_-_an_introduction/what_is_homelessness U.S.: https://www.nhchc.org/faq/official-definition-homelessness/ Canada: http://www.homelesshub.ca/sites/default/files/COHhomelessdefinition.pdf

3. In 2014, 337,791 units of social housing existed in Finland out of a total housing stock of 2,599,613 units (Statistics Finland).

Preventative services centred on housing advice, enhancement of cooperation between health and social services and specialist services for groups such as young people experiencing homelessness and former prisoners who were experiencing homelessness when released from jail. Housing advice services had brought down evictions in Helsinki by 32% between 2001–2008 and by 2012/13 16,000 people were supported by housing advice services in the capital city (Pleace et al., 2015).

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As Paavo II drew to a close in 2015, Finland had developed a national strategy which included several elements:

1. Administrative agreements to reduce homelessness between central government departments and key agencies, including the Y Foundation as a major provider of social housing. Letters of intent were secured from local governments, including the major cities, which created a political consensus at all levels of government in Finland;
2. Programs centred on increasing support for long-term homeless people, using a mix of communal models of Housing First and scattered, supported housing with mobile support;
3. An increased emphasis on homelessness prevention, including widespread use of housing advice services; and
4. A goal to increase the efficiency of the use of social housing to counteract homelessness.

While there was increasing emphasis on homelessness in a broader sense as the national homelessness strategy developed, goals for reducing long-term homelessness were at the core of both Paavo I and Paavo II. As noted, a central goal of Paavo II was to end long-term homelessness, building on the progress made under Paavo I to attempt to halve long-term homelessness. The specific focus on long-term homelessness at the centre of Paavo I and Paavo II has been described as unusual in the European context. While many regional and municipal strategies and some national-level strategies focus on reducing visible levels of people living rough, the Finnish focus on the sustained experience of homelessness is unusual (Busch-Geertsema, 2010).

The sustained strategic focus on long-term homelessness in Finland needs to be contextualised in order to be fully understood. Homelessness is not a common social problem in Finland. Homelessness was never widespread, as social protection (e.g. welfare and health) systems are extensive, generous and universally accessible and there is relatively extensive provision of social housing in the major cities. At its peak in the late 1980s, almost 20,000 people in Finland were homeless at any one point in time, in a population of 4.96 million (0.40% of population). By 2008, as a result of measures to expand the housing supply and the development of preventative services, total homelessness had fallen to 8,000 (0.15% of a population of 5.31 million)[4]. Long-term homelessness, i.e. homelessness that was sustained or recurrent, became central to the national strategy because it was the key aspect of the social problem of homelessness that was seen as not having been addressed. Levels of long-term homelessness were not high in numerical terms, but the problem was persistent, with long-term homelessness estimated as being some 45% of total homelessness as of 2008 (Busch-Geertsema, 2010).

4. Source: ARA http://www.ara.fi/en-us/About_ARA

The Focus on Long-Term Homelessness

At the core of the Finnish strategy was the development of a Housing First program that was specifically adapted to the Finnish situation and targeted on long-term homelessness. This was the most controversial and the most widely debated aspect of the strategic response to homelessness in Finland during the period of 2008–2015.

Housing First centres on the ideas of housing as a human right, with flexible non-judgemental services delivered with an emphasis on consumer choice, separation of housing from support (housing not being conditional on compliance with a treatment plan), harm reduction, person-centred planning and an active but non-coercive focus on recovery (Tsemberis 2010). Unlike some earlier models of homelessness services, housing is not offered after a series of steps or targets have been met by a homeless person with high support needs. Instead housing is provided immediately alongside support. Housing First also provides support for as long as is needed (Tsemberis, 2010).

Housing First, as almost every academic report, article or review on the subject points out, has become highly influential in homelessness policy in many countries, while being simultaneously characterised by an apparently high degree of program drift (Pleace and Bretherton, 2013; Tsai and Rosenheck, 2012). The original Pathways Housing First model[5], which was developed in New York in 1992 and which operated there until its recent closure, has been closely replicated in Canada, Ireland and France (Estecahandy, 2014; Goering et al., 2014; Greenwood et al., 2013; Houard, 2011); however, other forms of Housing First, which use Pathways as a reference point but which operate in different ways, far outnumber Housing First services which replicate the original Pathways model in the U.S., Canada and in Europe (Busch-Geertsema, 2013; Gaetz et al., 2013; Knutagård and Kristiansen, 2013; Pearson et al., 2007; Pleace and Bretherton, 2013). Housing First is increasingly widespread, but Housing First that replicates the original Pathways model is unusual. A majority of Housing First services reflect the ideas and cultures of the people providing them and are specifically adapted to the particular context they operate within (Pleace and Bretherton, 2013).

Housing First is increasingly widespread, but Housing First that replicates the original Pathways model is unusual. A majority of Housing First services reflect the ideas and cultures of the people providing them and are specifically adapted to the particular context they operate within (Pleace and Bretherton, 2013).

From some perspectives, this divergence in Housing First services operating in different contexts reflects a lack of clarity and coherence at the core of the Housing First approach (Pleace, 2011; Rosenheck, 2010). At present, however, research findings appear to indicate that these different versions of Housing First all appear effective in ending long-term homelessness *providing* they share the core philosophy of the Pathways model. The recovery orientation, harm reduction, client-led approach and separation of housing and support found in the Pathways model are widespread, but are best described as providing a framework for services that can differ markedly in the detail of their operation.

5. https://pathwaystohousing.org

There is North American and European evidence that Housing First services operating within this framework, which differ considerably in the detail of their operation, generally either replicate and occasionally exceed the housing sustainment levels achieved by the original Pathways service in New York (Busch-Geertsema, 2013; Pleace and Bretherton, 2013; Tsemberis, 2010). Policy transfer always involves adaptation to differing cultures and contexts. As Australian researchers have pointed out, trying to precisely replicate the original Pathways model designed for the U.S. in general and New York in particular, in Lisbon, Helsinki or Amsterdam, or indeed Sydney or Brisbane, without any real allowance for the major and highly varied differences in context, would be illogical (Johnson *et al.*, 2012).

Housing First as it exists in Europe and North America is therefore best described as a range of services that share a core philosophy but differ in the detail of their operation (Pleace and Bretherton, 2013). Nevertheless, part of what was to happen in Finland during 2008–2015 represented what is arguably one of the more radical departures from the detailed operation of the original Pathways model, leading some to argue that some Finnish Housing First services should not be regarded as being a form of Housing First at all (Busch-Geertsema, 2010; Tsemberis, 2011).

The Housing First services that Paavo I introduced were heavily based on existing Finnish practice in delivering services to homeless people with complex needs. In common with some other European Housing First services (Busch Geertsema, 2013), Finnish Housing First services did not provide an Assertive Community Treatment (ACT) service. ACT was not used in Finland and is rarely employed in Housing First in Northern Europe more generally, in part because access to health, drug and mental health services is universal. Housing First in Finland was also broadly targeted at all long-term homeless people, not just those with severe mental illness or problematic drug and alcohol use, in a context where social protection (welfare) systems were relatively generous and universally accessible (Pleace et al., 2015). Again, in common with some other European Housing First services (Bretherton and Pleace, 2015; Busch-Geertsema, 2013), Finnish Housing First service users held their own tenancies, giving them the same housing rights as any other citizen renting an apartment and also managed their own finances (Pleace et al., 2015).

Where Finnish Housing First could sometimes really differ from the Pathways model was in the use of congregate housing. Finnish Housing First services included apartment blocks containing up to 90 or more apartments, all of whom were Housing First service users. Scattered housing models using mobile support services were also in existence in Finland, but large, congregate Finnish Housing First services were at the core of the strategy. The use of a congregate approach was seen by some as going against a core principle of the original Pathways model, which was the use of ordinary housing in ordinary communities (Tsemberis, 2010).

In other parts of Europe, congregate forms of Housing First are relatively unusual, as most European experiments with Housing First and operational services currently use scattered housing (Busch-Geertsema, 2013; Bretherton and Pleace, 2015; Pleace and Bretherton, 2013); however, the congregate Finnish Housing First services look less unusual from a North American perspective, where congregate forms of Housing First are not uncommon (Larimer et al. 2009; Pearson et al., 2007). As noted, the original Pathways model has been highly influential, but the reality of Housing First in North America is not confined to that one model of Housing First; it is far more diverse.

The decision to convert existing buildings into Housing First apartment blocks had a key advantage, which was that Finland was able to deploy a significant number of Housing First places both relatively quickly and relatively cheaply. Finland, while a wealthy country, faces significant issues in terms of finding suitable land and resources to build affordable housing in major cities, particularly within the capital Helsinki. Converting

existing buildings into Housing First apartment blocks meant enough suitable housing to potentially reduce long-term homelessness could be rapidly brought into use. Paavo I, which as noted sought to reduce long-term homelessness by 50%, was designed to bring 1,250 units of housing with support into use between 2008–2011. Paavo II, having been set the goal of ending long-term homelessness during 2012–2015, brought further investment in support services. By 2014, 1,724 housing units offering support, of which 1,069 were new services, were in place across 11 cities (ARA, 2013). These services were a mix of congregate Housing First and scattered housing services with mobile support workers.

Finland witnessed large scale conversion of existing temporary and emergency accommodation for homeless people into self-contained apartments to which support was delivered using a Housing First model. This was the most radical aspect of the strategic approach in Finland, in that there was *replacement* of much existing homeless service infrastructure with a mix of congregate Housing First services and scattered housing services with mobile support. Finland's response to long-term homelessness became a Housing First *strategy,* with markedly less use being made of earlier forms of homelessness service, particularly emergency accommodation.

Finland witnessed large scale conversion of existing temporary and emergency accommodation for homeless people into self-contained apartments to which support was delivered using a Housing First model.

The use of congregate models of Housing First within the Finnish strategy was contentious. Some argued that a Housing First service should always place homeless people with high support needs into ordinary housing in ordinary communities (Busch-Geertsema, 2010; Tsemberis, 2011). The core ideas of Housing First are built around an objective of normalisation, a recovery orientation that seeks to promote health, well-being, positive social supports, civic participation and economic activity (Hansen-Löfstrand and Juhila, 2012).

For some of those who advocate the approach, Housing First *must* involve ordinary housing in an ordinary neighbourhood. Housing is seen as bridging the gap that is thought to have formed between homeless people with high support needs and society. In other words normal housing is seen as central to processes of social integration that are seen as being at the root of sustaining an exit from homelessness (Johnson et al*.,* 2012; Pleace and Quilgars, 2013). Housing First is largely based on earlier supported housing models designed for resettling former psychiatric patients into the community in the U.S. These services were specifically intended to avoid institutionalised responses and insofar as possible normalise life for former psychiatric patients, again with a goal of delivering social integration that would facilitate what was defined as a normal life in a normal community (Ridgway and Zipple, 1990). Implicit within the criticisms of Finnish congregate models of Housing First was the belief that without processes of normalisation centred on social integration, neither health nor well-being would improve and evictions, abandonments and general failure would be the result (Tsemberis, 2011).

Again, from some North American perspectives, the use of the congregate model of Housing First is less contentious. The use of congregate Housing First models is more widespread in the U.S. than Europe and there is some evidence of successful implementation of congregate models (Larimer et al., 2009; Pearson et al., 2009).

In Finland, the anticipated failure of congregate Housing First did not occur. In 2008, 2,931 people were long-term homeless in Finland's 10 biggest cities. The level fell to 2,192 in late 2013, a reduction of 25%. Long-term homelessness fell from 45% of all homelessness to 36% of all homelessness in Finland between 2008 and 2011 (Pleace et al., 2015). During the period of 2010 to 2014, the annual national homelessness counts reported a fall from 3,079 long-term homeless people to 2,443 long-term homeless people (ARA, 2013), a 26% drop.

The long-term homeless people on whom congregate Housing First was targeted were being rehoused and sustaining that rehousing. Congregate Housing First was part of a wider response, particularly as Paavo II was rolled out, which also included mobile support services being delivered to ordinary scattered housing, but the congregate Housing First services filled up, stayed full, and – crucially – appeared stable (Pleace et al., 2015).

There were also concerns about how well environments containing quite large numbers of formerly long-term homeless people could be managed, as there were Finnish Housing First services with 90 or more apartments in a single block (Kettunen and Granfelt, 2011). Significant management problems had been encountered in Australia with the Common Ground model, another American import, which also used large apartment blocks in which formerly long-term and recurrently homeless people were supposed to live alongside ordinary citizens to promote their social integration (Parsell et al., 2014). Denmark also found the congregate services were less stable than Housing First using scattered housing, albeit that the congregate services were still relatively successful (Benjaminsen, 2013).

There were some initial problems in managing the Finnish congregate Housing First services. Drug and alcohol use and challenging behaviour occurred and some evictions occurred for criminal and nuisance behaviour (Kettunen, 2012; Kettunen and Granfelt, 2011)

There were some initial problems in managing the Finnish congregate Housing First services. Drug and alcohol use and challenging behaviour occurred and some evictions occurred for criminal and nuisance behaviour (Kettunen, 2012; Kettunen and Granfelt, 2011); however, the congregate Housing First services appeared to reach a steady, stable state over time, with levels of trouble and rates of eviction being reported as negligible by 2014 (Pleace et al., 2015). The congregate model was not, of course, a universal success. Some long-term homeless people left and some were evicted. Despite these challenges, and though it was not the sole response used to try to reduce long-term homelessness, congregate Housing First does appear to have contributed significantly to bringing down levels of long-term homelessness in Finland.

Thinking about why Housing First appears to have been successfully used in Finland, it is worth revisiting some of the criticisms made of scattered site Housing First. Housing First using scattered housing can deliver a sense of security, predictability and a foundation on which social integration can be built (Padgett, 2007). However, other researchers have argued that the *mechanism* by which social integration is delivered and by which Housing First uses ordinary housing to deliver social integration is unclear. Scattered housing versions of Housing First are presented as being designed to provide support to facilitate social integration, but the processes by which this is achieved are, it has been argued, only quite vaguely described (Johnson et al., 2012). Advancing the idea of ordinary housing as a key mechanism for delivering social integration, without being clear about exactly how the process works is potentially problematic, but what is arguably more detrimental is not allowing for the potentially negative effects of living in scattered housing (Pleace and Quilgars, 2013).

An ordinary apartment in an ordinary neighbourhood will not necessarily be an always positive experience; neighbours can be hostile as well as supportive and local communities do not always possess positive social capital. With careful planning these issues should be avoided, but ordinary housing in an ordinary neighbourhood can be a potentially toxic environment for someone like a Housing First service user with severe mental illness or other support needs (Pleace et al., 2015). Selection of housing may be a fallible process and there is also often going to be a reality of resource constraint restricting which housing can be used, as experienced by British low-intensity support services when they can only source housing in less than desirable environments (Pleace with Wallace, 2011). Some concerns about social isolation have also been reported among scattered Housing First service users in Canada (Kirst et al., 2014).

Congregate homelessness services can present risks ranging from bullying through to exposure to drug and alcohol use if not carefully managed (Parsell et al., 2014); however, there may also be opportunities, particularly around positive peer support from people who are experts by experience or neighbours who know what a Housing First service user has been through because they have been through it themselves. Work in Ireland focused on collecting the views of homeless people about the imminent introduction of Housing First services in the national strategy highlighted the value homeless people can place on support from their peers in well-run congregate services (Pleace and Bretherton, 2013b). Finnish experience in this regard raises some significant objections to the idea of simply dismissing congregate models of Housing First as inherently unworkable.

The Finnish experience adds to the evidence that detailed replication of the original Pathways model of Housing First is not necessary to achieve good results in reducing long-term homelessness (Tsai and Rosenheck, 2012). Finnish congregate Housing First works within a framework of broad principles which are a central part of the original Pathways model of Housing First but which were also already widespread in Northern European, including Finnish, homelessness services before Housing First became so prominent. By delivering harm reduction, a non-judgemental flexible approach, open ended support, separation of housing and treatment and a heavy emphasis on consumer choice, congregate Housing First in Finland appears to have delivered good results. Both European and North American experiences show that Housing First can exist in many forms and perform well if the emphasis is maintained on regarding homeless people as fellow human beings whose rights and choices need to be respected (Pleace and Bretherton, 2013).

The Achievements of the Finnish Strategy

Reducing Long-Term Homelessness

Long-term homelessness has been reduced in Finland. The use of congregate Housing First, the wider use of preventative services and the ongoing development of scattered housing services with mobile support all have made a contribution. Yet the problem of long-term homelessness has not been solved. The original objective of halving long-term homelessness set for Paavo I was not reached, and Paavo II has not achieved the goal of eliminating the experience of long-term homelessness. There were still 2,443 long-term homeless people in Finland in 2014, 29% of the total homeless population of 8,316 including concealed households (ARA, 2014).

The achievements of Paavo I and Paavo II in reducing homelessness have to be seen in context. Short-term homelessness, what in the U.S. is often termed 'transitional homelessness' (Kuhn and Culhane, 1998) caused by financial factors and relationship breakdowns and experienced by populations whose defining characteristic is relative poverty, has always been a relatively small problem in Finland. By 2008, *prior* to Paavo I and II, transitional homelessness had already been reduced to comparatively very low levels, with only around 8,000 Finns experiencing homelessness. Indeed, Paavo I and Paavo II had placed so much emphasis on the more persistent social problem of long-term homelessness precisely because other forms of homelessness had already been brought down. Long-term homelessness was targeted by a strategy, which by the point Paavo II was reached was becoming broader, because it was long-term homelessness that was seen as being at the core of the social problem of homelessness.

In Canada, it has been estimated that least 200,000 people experience homelessness every year, equivalent to 5.6% of total population (Gaetz et al., 2013). Direct comparison with the point in time data collected by Finland is not possible, but the 0.14% of Finns experiencing homelessness at any one point does suggest a significantly lower rate than Canadians. Americans experiencing homelessness on any one night numbered some 610,000 in January 2013. This was equivalent to 0.19% of the U.S. population, which might seem remarkably similar to the Finnish figures until it is remembered that the American statistics *only* cover people living on the street, in emergency shelters and in transitional housing (HUD, 2013). That same homeless population in Finland living on the streets, in emergency shelters and in transitional housing, in 2014, numbered 362 or 0.006% of population (ARA, 2014).

In comparison with European countries outside Scandinavia, Finnish homelessness statistics are low. It was also the only European country reporting falls in overall homelessness during 2014 (Busch-Geertsema et al., 2014). In comparison with much of the economically developed world, Finland has moved from a position in 2008 when it had a comparatively very small homelessness problem, to a position where it has *further* reduced homelessness.

The story in relation to long-term homelessness is more mixed. Looking at people experiencing sustained homelessness who have high support needs ('chronic homelessness' in American terminology), 109,132 people in this group were homeless on one night in the U.S., equivalent to 0.034% of the population. In Finland, the 2,443 long-term homeless people found in the 2014 homelessness survey were equivalent to 0.045% of the population. While Finland has brought down the numbers of people experiencing long-term homelessness by 26% between 2008 and 2014, and reduced the proportion

of homeless people who are long-term homeless from 45% in 2008 to 29% in 2014 (ARA, 2014), long-term homelessness was still occurring at what, from a Finnish perspective, was an unacceptable rate.

The review of the Finnish strategy indicates that all the existing approaches being taken to further reduce long-term homelessness are proving to be effective. Indeed one of the main solutions appears to be the expansion of these existing services, possibly including greater use of congregate Housing First alongside supported housing services using scattered housing and the planned expansion of preventative services. Long-term homelessness fell throughout the period 2008–2014 and fell fairly steadily, a clear indication that the strategic response is proving effective for many long-term homeless people.

The review of the Finnish strategy indicates that all the existing approaches being taken to further reduce long-term homelessness are proving to be effective.

Ongoing Challenges for Finland

Finland now has less low-threshold emergency accommodation than was once the case, and questions have begun to arise about whether all those people who had once used emergency accommodation can successfully transition to Housing First. For some, Housing First is simply not appropriate because their support needs are low, or because their homelessness had occurred for economic or social reasons, not because they needed any treatment or support from mental health, health, social work or drug and alcohol services. This group is served primarily through increasing use of preventative services that can either stop evictions or allow rapid re-housing when homelessness does occur (Pleace et al., 2015).

For other homeless people, who have high support needs and are either experiencing long-term homelessness or at risk of doing so, but for whom Housing First is not an alternative, there is a question of what alternatives should be pursued. Issues around congregate Housing First not being suitable for every long-term homeless person, nor being what every long-term homeless person wants could be handled in part by the provision of scattered housing which has mobile support services. If someone does not want to live with others with high support needs, then ordinary housing in an ordinary community could be used instead. Yet both broad models of Housing First, those using congregate and those using scattered housing, experience at least some attrition, some of which may be the result of high-risk long-term people needing more intensively supportive environments, which might be other forms of supported housing but which might also be mental health services. Finland has not attempted to solve long-term homelessness with a single policy solution. Congregate Housing First

is prominent, but it is by no means the only response in a coordinated effort that also includes preventative services and other models of housing with support. Yet the relative persistence of long-term homelessness, even as absolute and proportionate levels were brought down during 2008–2014, suggests there is scope for further experimentation, which is something the Finns are prepared to contemplate (Pleace et al., 2015).

A key success of Paavo I and II was the coordination and cooperation between all levels of government in Finland. It was through the building and maintenance of political cooperation that the strategy was able to deliver significant reductions in homelessness. Cooperation from the local authorities running the cities and towns, the NGOs providing homelessness services, the Y Foundation and the central government were essential in developing the mix of enhanced access to social housing, preventative services, lower intensity supported housing using scattered apartments and the Housing First services that brought down long-term homelessness. Significant financial resources had, as noted, been allocated to the strategy at both central government and municipal levels.

By contrast, some other countries, such as Sweden, the UK and the U.S., have not been able to deliver this degree of policy coherence and administrative cooperation in their attempts to reduce and prevent homelessness (Pleace et al., 2015). Success, in this regard, was fuelled by evidence of success in the strategy itself. Paavo I did not meet the key objective of halving long-term homelessness, but long-term homelessness was nevertheless visibly reduced and that, in itself, fuelled the ongoing cooperation that was seen under Paavo II.

Apparently everything in Finland is working in the way that it should work: the strategy is highly coordinated, it has clear, logical goals and the mix of prevention combined with innovative congregate and scattered site supported housing services also appears to be working well. It seems logical to ask, given this situation, why homelessness in Finland has not been effectively eradicated.

One answer to this question is to note that, by international standards, Finland is actually close to eradicating homelessness. Levels are so low relative to those found in France, Germany, the U.S., Canada, the UK and indeed almost any country outside Scandinavia that the extent to which Finnish homelessness can really be considered a significant social problem might seem debatable. Finnish achievements in keeping homelessness levels very low are not unique. Denmark for example has achieved similarly impressive results from a coordinated policy (Benjaminsen and Andrade, 2015), but Finland has probably shown more success than any other country in the last five years in reducing homelessness (Busch-Geertsema et al., 2014). From the perspective of the individuals and agencies responsible for Paavo I and II, this is not a satisfactory response; 8,316 homeless Finns, of whom 2,443 were long-term homeless (ARA 2014), may not, in international terms, be a comparatively large number, but it is still too many.

Another answer is to call for further innovation and expansion of the service mix that has already been developed in response to homelessness. More prevention, more housing with support, in both congregate and scattered forms, are needed, as these services are all demonstrably bringing down long-term homelessness and overall levels of homelessness. One limitation of this argument, which has been identified by practitioners and policy makers within Finland itself, is that it cannot be assumed that homelessness is static in nature. There are longstanding trends in economically developed countries. A high-need population of lone homeless men with alcohol problems has shifted in composition; there are more women, there are more young people and, in Northern Europe particularly, migrants are increasingly being seen in higher need homeless populations (Busch-Geertsema et al., 2014). Finland is experiencing these same trends and services, including congregate Housing First, that work well with current long-term homeless populations but that might become less effective as those populations shift in composition and need (Pleace et al., 2015).

Yet Finland may now be approaching the threshold of what can be achieved through innovation and coordination. This threshold exists because of another policy issue, one that is fundamentally important in setting the entirety of the strategic response to homelessness into a wider policy context: Finland lacks a sufficient supply of affordable housing. This shortage of affordable housing is relative. Finland has more social housing and social protection (welfare) systems that enable poorer and unemployed citizens to rent housing privately, but it still has more housing need than can be met by the existing housing supply. Access to the private rented sector and social rented sector may be further enhanced for homeless people in Finland. There are innovations around access to private renting that can be introduced and allocation systems for social housing can also be altered to improve access for homeless people; however, both the social rented and private rented sectors have multiple roles. They exist to serve general housing need alongside any potential role in meeting the housing needs of homeless people and while there is not enough affordable housing for the general population there will never be enough housing for homeless people (Pleace et al., 2015).

There are innovations around access to private renting that can be introduced and allocation systems for social housing can also be altered to improve access for homeless people; however, both the social rented and private rented sectors have multiple roles.

Finnish housing standards and affordable housing supply are good by European and especially by global standards; 4.9% of Finns spend 40% or more of their household income on housing costs, compared to a European Union average across 28 EU member states of 11% of population. Only 1% of Finns are recorded as living in severe housing deprivation, compared to a European Union average of 5% (Eurostat, 2015). Yet pressures on the housing stock are real, particularly in the most expensive housing markets like that found in Helsinki, and while those problems persist a lack of housing will ultimately undermine even the most coordinated and comprehensive homelessness strategy.

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A CRITICAL REVIEW OF CANADIAN FIRST NATIONS AND ABORIGINAL HOUSING POLICY, 1867 – PRESENT

Yale D. BELANGER

INTRODUCTION

In the early 1990s Canada's national media trained its investigative lens on poor reserve-housing conditions, exposing the depth of what was then described as a crisis. This did not provoke Ottawa's effective response even if the heightened attention did prompt First Nations and Aboriginal leaders to greater levels of political advocacy, which improved public awareness leading Canada's Auditor General to study the issue in 2003.[1] Unfortunately no substantial policy changes resulted and national reserve-housing conditions continued their decline. Poor housing is linked to growing national Aboriginal homeless rates both on and off reserves as well as staggered economic development, inferior health standards and diminishing educational outcomes (Belanger, 2007; Belanger et al, 2012b; Canada, 2015; Christensen, 2013; Ruttan et al, 2008; Weasel Head, 2011). All the same, characterizing the federal, provincial and territorial governments – and by association Canadians in general – as unsympathetic would be extreme. Between 2006 and 2013 the Government of Canada provided $2.3 billion in on-reserve housing support to First Nations, which contributed to an annual average of 1,750 new units and 3,100 renovations annually (Canada, 2013). It would seem that Canadians are demanding improved Aboriginal housing conditions even if bureaucratic efforts to date have failed to translate into practical community outcomes. In May 2015, for instance, the CBC reported that the federally sponsored $300-million First Nations Market Housing Fund established in 2008 had produced 99 new reserve homes to date – out of a proposed target seeking 25,000 privately owned dwellings by 2018 (Beeby, 2015). With this in mind one must critically reflect upon: one, why the aforesaid housing conditions continue to deteriorate and, two, why Canada's response demonstrates little sense of urgency.

1. The term 'Aboriginal peoples' indicates any one of the three constitutionally defined groups that form what is known as Aboriginal peoples in Canada (Métis, Inuit and Indian) and who self-identify as such. The term First Nation is used here to denote a reserve community or Indian band. The term 'Indian,' as used in legislation or policy, will also appear in discussions concerning such legislation or policy. The term 'Indigenous' here does not represent a legal category; rather, it is used to describe the descendants of groups present in a territory at the time when other groups of different cultures or ethnic origin arrived there and who identify as such. Statistics Canada measures Aboriginality in four different ways. Most importantly, they distinguish between Aboriginal ancestry and Aboriginal identity. Aboriginal ancestry measures Aboriginality through a self-declaration of Aboriginal ancestry, whereas Aboriginal identity asks individuals if they self-identify as Aboriginal (whether First Nations, Métis or Inuit). Moreover, individuals are given the option of identifying with more than one category (for example, one might declare oneself both First Nations and Métis). For the purposes of this study, 'Aboriginal' refers to those who self-identify as Aboriginal (whether First Nations, Métis or Inuit) and only those who choose a single category.

Therefore the starting point for this discussion is to explore Canada's Aboriginal housing policy, which may appear somewhat unorthodox in a book discussing the growing importance of establishing systems approaches to ending homelessness. However, by exploring federal Aboriginal housing policy we can produce insights that help to clarify why reserve homelessness and urban Aboriginal homeless rates continue their rise, and this is essential to developing informed homelessness policies and intervention strategies. Canadian Aboriginal housing policies remain influenced by the *Indian Act of 1876,* which identifies Aboriginal people as legally unique persons who for most of the twentieth century were ineligible for mainstream programs – including the *National Housing Act* of 1938. Restricting policy development further is how provincial officials interpret S. 91(24) of the *British North America* Act (BNA) of 1867: that is, that the provinces are inoculated from having to politically respond to "Indians, and lands reserved for the Indians," due to the fact that they are federal responsibilities. The resulting jurisdictional debate has spawned a popular tactic whereby assorted provincial ministries and departments assigned responsibility for homelessness and housing programming regularly and consciously abandon 'Indians' to the federal trust. Such political posturing leads to Aboriginal people being trapped in a jurisdictional void and unable to access analogous non-Aboriginal housing programs or homeless relief. As such, Indians and their lands remain the responsibility of Aboriginal Affairs and Northern Development Canada (AANDC), a federal ministry that has frequently declared its intention of delegating its 'Indian' housing duties to the Canada Mortgage and Housing Corporation (CMHC).

As this chapter shows, ad hoc housing policies resulted that were unable to accommodate the demands of reserve communities, whose growing populations outstripped local housing assets. The federal government's leisurely response produced staggered renovation schedules leading to extreme overcrowding, after which time reserve homelessness and urban relocation became normative. By the 1990s, the foundation of a major housing crisis was in place, all of which I argue is attributable to the legal and policy separation of 'Indians' from mainstream Canadian society and thus existing programming. A brief discussion of contemporary Aboriginal homeless trends precedes an overview of reserve housing conditions tracked through various government and academic reports dating to the 1930s. Canada's reluctance to recognize or accept responsibility for improved reserve housing conditions is clearly identifiable. A brief overview of the *Indian Act's* evolution is then offered to illustrate how Aboriginal separateness is fashioned. Notably, in this setting First Nations leaders played a minor role in formulating the housing policies impacting their communities – they were expected to simply await word of and then administer federal decrees. Reserve leadership is encouraged to adopt greater responsibility for housing, albeit fashioned from policies created outside of the community in Ottawa. The conclusions follow revealing the key themes while offering insights on how to move forward.

Tracking the Historic and Ongoing Failure of Canada's Aboriginal Housing

Urban Aboriginal and First Nations (reserve) homelessness is a mounting concern in Canada. In 2012, it was reported that 6.97% of urban Aboriginal people were considered to be homeless on any one night, compared with 0.78% of the non-Aboriginal population. More than one in 15 urban Aboriginal people were deemed homeless, compared to one out of 128 non-Aboriginal Canadians. Put another way, urban Aboriginal people are eight times more likely to be or to become homeless than non-Aboriginal urban individuals (Belanger et al, 2012). While we have a general understanding of urban Aboriginal homeless trends we lack an analogous understanding of reserve homelessness. Available anecdotal information does speak to an experience that is typified by deteriorating housing accommodating multiple families, reserve homeless shelters (where they exist) becoming overwhelmed by growing homeless populations and escalating churn levels (i.e. homeless individuals and families frequently abandoning the reserve for the city only to return homeless) (Belanger & Weaselhead, 2013; Norris & Clatworthy, 2003). In each case, we are comfortable in concluding that Aboriginal pathways to homelessness are diverse and range from economic marginalization to attending residential schools, negative experiences with child welfare agencies, social marginalization and isolation and systemic discrimination, personal trauma, jurisdictional and coordination issues and the Indian Act (Thurston & Mason, 2010). Acknowledging the impossibility of capturing the intricacies of each one of these categories in one chapter, this essay evaluates the evolution of reserve and urban Aboriginal housing policy and how this influenced and in turn perpetuates rising Aboriginal homelessness levels.

To start, the post-Confederation transition to Euro-Canadian housing occurred after most First Nations had been relocated onto reserves following the conclusion of the first Numbered Treaty period (1871–1877). Individuals and families resistant to European architectural formats remained housed in traditional dwellings such as tee-pees, longhouses, and birchbark covered shelters. Igloos tended to be the popular housing style in the north prior to the 1950s' influx of non-Aboriginal resources workers, military and bureaucrats. For communities attempting to preserve traditional ways, including time-honoured housing models, plummeting animal numbers incited failing subsistence economies, undermining community development efforts while making it virtually impossible to construct traditional dwellings. For those in new homes minimal effort was directed toward educating reserve residents in the art of house maintenance and general upkeep for Canada's Indian civilization program promoted either abandoning the reserves or adopting private property regimes in newly formulated municipal townships. Indian agents assigned to the reserves recorded the pace of community advancement by tracking the construction of barns, homes and outbuildings. But because the reserves themselves were fated to decommission little consideration was given to the reality that the new homes would age thus demanding renovations and future replacement. All of this occurred during this period in which housing also came to be accepted as an individual responsibility, which compelled limited government assistance for reserve home construction.

By 1941, for the first time since its inception, the Canadian census noted an increasing Indian population. For Aboriginal leaders dealing with a nascent reserve housing crisis this was a harbinger of things to come, especially when factoring in the need to work with a parsimonious Indian Affairs branch whose administrators were preoccupied with ending the financially debilitating 'Indian problem' (Dyck, 1991; Titley, 1986). Aboriginal leaders were shocked

at how dismissive federal and provincial officials were about reserve housing problems considering the Ewing Commission (1934–1936) verified deplorable Métis and Indian housing conditions. As one of the first government commissions examining Indian issues to include a discussion about housing, the Alberta Royal Commission led by Supreme Court of Alberta Judge Albert Ewing was struck to evaluate Métis health, education and general welfare, and described Métis and Indian individuals and families "living in shacks on road allowances and eking out a miserable existence, shunned and suspected by the white population. Those living in more remote places are better off, but their living is precarious" (Alberta, 1936). While this report did not scrutinize in detail specific housing concerns, it did forewarn provincial officials of a budding crisis.

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First Nations and Aboriginal leaders noted that the Alberta reserve housing crisis extended to all provinces, something that was confirmed by a series of published reports starting in 1948. For instance, two Special Joint Parliamentary-Senate Commissions studying the Indian Act's impact on Aboriginal peoples cited the need to improve reserve housing and sanitation (Canada, 1946–1948, 1959–1961). Celebrated anthropologist Harry Hawthorn and his colleagues Cyril Belshaw and Stuart Jamieson identified ongoing housing difficulties in their 1955 socio-economic study of B.C. Indians (Hawthorn et al, 1955; Hawthorn et al, 1958). In 1963 Hawthorn and Marc Adelard Tremblay initiated an extensive national study of Aboriginal social, economic and political conditions that would portray reserve housing as "over-crowded; child sleeps with siblings in same bed; little or no privacy; scarcity of furniture; sometimes dirty house; often un-attractive, unpainted and uncared for" (Tremblay et al, 1967: 111). A federally sponsored survey of reserve housing conditions sandwiched between these two reports confirmed in 1958 that 24% of reserve families required 6,999 new houses costing roughly $16,796,000.[2] Two Royal Commissions during the 1960s spoke to Aboriginal housing conditions: the Royal Commission on Health Services noted extremely poor reserve housing (Canada, 1964; 1965) whereas the Royal Commission on the Status of Women in Canada highlighted Métis difficulties in procuring housing (Canada, 1970).

Responding in part to the research during the late 1960s and throughout the 1970s, a number of different federal programs and demonstration projects were established to combat reserve and urban Aboriginal housing difficulties, as discussed below. By the 1980s however it was clear to most observers that reserve housing conditions were quickly deteriorating (Table 1), and that urban Aboriginal residents were likewise struggling to obtain adequate and affordable accommodations. In 1983 the Special Committee on Indian Self-Government recommended providing substantial funding for community infrastructure (e.g. improved water, sewage and housing facilities) in anticipation of land claims resolution (Penner, 1983). The Nielsen Task Force's 1985 report noted the poor state of on-reserve housing: one quarter of reserve units were in need of major renovation, one third were overcrowded and more than $500 million was required to address the housing shortage[3] (Nielsen, 1986). The Standing Committee on Aboriginal Affairs Report *Unfinished Business: An Agenda for all Canadians in the 1990s* also cataloged a reserve housing crisis (Canada, 1990).

Building on these conclusions, the Office of the Auditor General would deduce in 1991 that: one, the annual supply of reserve houses did not meet the normal replacement demand, two, the older reserve housing

2. This would be $140,485,748 in current dollars (April 2015), adjusted for inflation. Figures generated by using the online Bank of Canada Inflation Calculator (www.bankofcanada.ca/rates/related/inflation-calculator/).

3. This would be $1,015,273,312 in current dollars (April 2015), adjusted for inflation.

was among the poorest in Canada and, most disturbingly, three, the Department of Indian Affairs and Northern Development had no specific plan to address the existing shortage. In 1992 the House of Commons' Standing Committee on Aboriginal Affairs commissioned the first comprehensive study devoted to Aboriginal housing in Canada: *A Time for Action: Aboriginal and Northern Housing*. Released in December 1992, it reported that roughly half of 70,000 reserve houses were considered unfit to live in and that the immediate construction of 21,700 new homes was required. Additionally, 6,700 homes needed replacing and as many as 44,500 required substantial repairs. In total, $2.1 billion was needed to provide safe and adequate housing[4] (Canada, 1992). During this period the Royal Commission on Aboriginal Peoples (RCAP) was in the midst of what would become the most extensive and expensive commission in Canadian history, and the most comprehensive and credible account of First Nations and Aboriginal issues. Its 1996 report concluded that reserve and Métis and Inuit housing was sub-standard to a degree that it represented an acute risk to Aboriginal health and safety. Eleven recommendations related to housing were presented, all of which the federal government ignored (Canada, 1996). These included federal and provincial acknowledgment of their governments' obligation to ensure that Aboriginal people have adequate shelter, providing supplementary resources helping Aboriginal people meet their housing needs and supplying resources for construction and upgrading and operating water and sewage systems thereby ensuring all First Nations communities had adequate facilities and operating systems in place within five years, among others (Canada, 1996).

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In each instance subsequent federal budgets contained inconsequential funding hikes for First Nations, Métis and Inuit housing that scarcely made a dint. For the most part the majority of this series of reports' findings and recommendations were duly shelved. Then, in 2003, Canada's Auditor General Sheila Fraser generated the most impressive coverage of the national reserve and budding urban Aboriginal housing crisis. While she began by noting signs "of improvement in some First Nations communities," she bluntly concluded that "there is still a critical shortage of adequate housing to accommodate a young and growing population" (Canada, 2003: 1). Fraser determined that there was a national lack of 8,500 reserve houses, and that 44% of the 89,000 reserve houses were in need of major repairs (Table 1). She further calculated that $3.8 billion was needed to resolve the outstanding housing issues, which represented the second time in just over a decade that an auditor general proposed a billion-dollar response to failing reserve housing[5] (Canada, 2003). The Canadian government chose once again to ignore an auditor general's warnings as evidenced by the *On-Reserve Housing Support* report released in 2011, which detailed minimal progress toward resolving the issues while noting that between 20,000 and 35,000 new units were still needed to meet current demand (i.e. people on waiting lists), 16,900 housing units required repairs and 5,200 units needed to be replaced[6] (Canada, 2011).

4. This would be $3,172,607,656 in current dollars (April 2015), adjusted for inflation.

5. This would be $4,655,092,144 in current dollars (April 2015), adjusted for inflation.

6. The AFN suggested these numbers were low and that the number of new units needed was roughly 85,000, and that based on current funding formulas and existing birth and fertility rates an estimated backlog of 130,000 units would develop between 2010 and 2031 (AFN, 2012).

TABLE 1

	New Homes Required	Replacement Homes Needed	Homes in Need of Repairs/Renovations	Estimated Total Cost (2015$)
1958	6,999	n/a	n/a	$140M
1966	12,000	n/a	n/a	$607M
1985	10,000	2,400 annually	11,000	$1.02B
1992	21,700	6,700	44,500	$3.17B
2003	8,500	n/a	39,160	$4.66B
2011	20,000–35,000	5,200	16,900	n/a

Although the succession of academic studies and government reports identified troubling trends and many offered innovative recommendations, reserve housing as well as Métis and Inuit housing continues to deteriorate. Urban Aboriginal peoples also find it increasingly difficult to secure adequate housing (A. B. Anderson, 2013; Belanger et al., 2012b). Federal officials remind the media regularly that Canada provided a total of $2.3 billion in on-reserve housing support between 2006 and 2013, leading to an annual average of 1,750 new units and 3,100 renovations (Canada, 2013). This total alone represents less than half of what Fraser recommended needed to be spent back in 2003, which reveals what has become a normative federal public relations approach to dealing with Aboriginal housing that is reliant on quoting dollar figures absent a list of realized or potential outcomes. As an example, recognizing that $3.17 billion (2015 dollars) was required to mitigate reserve housing difficulties, the government in 1992 chose to allocate less than 1/10th of that amount (just under $205 million) to construct 3,300 houses and renovate 3,200 existing units (Martin, 1993: 16,802). Similarly, three years following Fraser's report proposing more than $4.6 billion be spent on reserve housing issues, $393 million (2015 dollars) was doled out over a five-year period to construct 6,400 new units and renovate 1,500 existing units (Canada, 2005: 96).

The contemporary federal approach to First Nations, Métis and Inuit housing embraces managing as opposed to resolving an ongoing crisis. Perhaps most disturbingly this section highlights a troubling reality: substandard Aboriginal housing is not a contemporary issue but rather is an ongoing crisis that dates at least to the 1960s.[7] We have chosen to disregard this well documented public phenomenon even though prior to the 1990s the specter of poor on-reserve housing surfaced every decade or so (Canada, 2003) due to the media's ongoing efforts. The recent proliferation of new and seemingly ubiquitous communications technologies permits an increasing number of media consumers and citizens the opportunity to observe and interrogate the Canadian government's unabashed efforts to reassure the public that everything is being done to improve the situation. But as discussed in the following sections, I believe that the matter is not one of intent: the government and its agents have attempted to respond to the aforementioned housing issues. The problem in part lay with the Indian Act system that crafts Aboriginal separateness – a government edifice, it must be noted – and its murky character that relies on keeping Indian issues housed with a proven-to-be-inept federal ministry. It encourages provincial and territorial officials to abandon responsibility for Indian issues based on Constitutional paramountcy, which has proven injurious to any and all attempts made to improve reserve and off-reserve housing.

7. I am currently researching a book on Aboriginal housing policy to Confederation in 1867, and to date the data suggests that the housing crisis being discussed dates to the late 1800s and the start of a bureaucratically imposed transition from traditional to European-style homes.

Establishing Aboriginal Separateness: The Legislative & Policy Setting

The lack of clarity concerning where First Nations (reserve) people fall in the housing policy matrix has made it extremely difficult (or so politicians claim) to develop a coordinated policy response. This is, however, needed to assist in policy development and the implementation of the related intervention strategies. As a result, the existing policies and legislation designed to encourage public housing and improve affordability, promote individual home ownership and augment housing starts have indeed had a narrow impact on reserve and urban Aboriginal housing outcomes (Miron, 1988; Rose, 1980). The reason is not due to a lack of Aboriginal understanding of the various concepts related to home ownership or renting (e.g. down payments, mortgages), but rather results from the federal fixation on administering Aboriginal people as wards of the State (Belanger, 2013). The belief in Indian wards to the government's guardianship can be traced in formal policy to the Royal Proclamation of 1763. That year King George III granted Indians protected status, an inferior legal standing one held until attaining colonial citizenship[8]. Losing one's status as an Indian was considered an honour in the eyes of the Crown. Subsequent colonial legislation sustained this category to 1860, when authority for Indians and their lands was formally transferred to the Canadian colonial legislature, which endorsed Indigenous peoples accepting European/colonial norms.

Following Canadian Confederation in 1867, the pith and substance of these several "acts of civilization" reaffirming the idea of protected Indian status and the related need to be lifted from this inferior standing to full British citizenship, were formally codified in the *Indian Act* of 1876. By the 1870s it was expected that Canada's recently implemented policy of assimilation would lead to Indian civilization by the 1900s and that the category 'Status Indian' would vanish. This did not occur due in part to the policy architects' failure to foresee Aboriginal resistance to social integration. Consequently an infrastructure of attendant institutions was needed if Canada was to achieve its stated goals. Child welfare and in particular residential schooling would emerge as the key assimilation tools illuminating a bureaucratic ideology that was powerfully influenced by beliefs of Indian inferiority (Leslie, 1999; Titley, 1986). Indian agents were primarily responsible for implementing federal Indian policy on reserves, which as a rule involved usurping traditional political authorities, suppressing religious practices and transforming social roles (Harring, 1998; Pettipas, 1994).

In this setting Indian agents were responsible for reserve housing and they encouraged Aboriginal people to transition into modern European-modeled homes – even in the north where Indian Affairs officials attempted to adapt southern-style homes in ways that accounted for neither culture or climate. Indian agent reports demonstrate bureaucratic enthusiasm for Aboriginal people adopting western-style housing, thus ensuring sanitary conditions and ultimately civility. Perry (2003) has explored this link between colonial desires to improve Aboriginal housing and the corresponding societal diffusion of housing, gender and family-related ideals, while noting that minimal federal resources were assigned to facilitate this transition. For Aboriginal leaders believing that their reserves were legally protected spaces and as such deserving of improved housing policies, it was noted in 1936 that the reserve system "was designed in order to protect the Indians from encroachment, and to provide a sort of sanctuary where they could develop unmolested until advancing civilization had made possible their absorption into the general body of the citizens."[9] By the early twentieth century, bureaucratic attention had shifted away from

8. The Royal Proclamation is incorporated as S. 25 of the Constitution Act, 1982.

9. A 2006 Globe and Mail article by Julius Strauss ("Is the Canadian model for relations with aboriginals beyond repair") attributes this quote to an unnamed 1921 government document. To date I have been unable to unearth the quote's "government" origins. The best resource to date is the Chilliwack Progress at http://theprogress.newspapers.com/newspage/43177760/. It does however effectively convey the general attitudes of the period concerning the utility of Indian reserves.

housing to securing land surrenders and ensuring residential school attendance (Martin-McGuire, 1998; Miller, 1996; Milloy, 1999). Federal officials simply settled into a waiting pattern anticipating the reserves' changeover into municipalities. Predicting that private homeownership would naturally materialize signaling the federal civilization program's end, status Indians would in effect transition into non-status Indians now eligible for any and all federal and/or provincial programs related to housing (and one would anticipate homelessness programs in the late twentieth century). As a result, reserve housing policy fell by the wayside until the mid-1950s, when hints of a housing crisis began to circulate. Still convinced of the need to develop separate policies to aid with Indian development, Ottawa responded to Aboriginal housing (and later homelessness) in the only way it could: by developing policies structured to encourage Indians to abandon their reserves for the cities in an effort to improve their lives through the resulting heightened access to education and employment.

THE IMPACT OF ONGOING ABORIGINAL SEPARATENESS ON HOUSING POLICY

Aboriginal people daily confront the effects of the aforementioned legislative and policy separation. While the government has abandoned the language of assimilation and tutelage, it remains dedicated to the *Indian Act* model. Now however, rather than promoting assimilation through civilization as evidenced by Indians moving off reserves, newer approaches embrace First Nations attaining Aboriginal self-government as a means of devolving responsibility for Indian affairs – including housing – to First Nations communities. Further muddying the waters is the division of Constitutional powers, which has pit provincial and federal officials in ongoing and increasingly heated debates about the precise responsibility for Indian affairs. The following sections will explore the ongoing impacts of the *Indian Act* and this Constitutional divide on how we conceive of, and how it influences our ability to respond to Aboriginal housing needs.

While the government has abandoned the language of assimilation and tutelage, it remains dedicated to the Indian Act model.

Legislation and Policy Separation

The looming reserve-housing crisis of the 1940s had by the 1960s developed into a full-blown disaster and a regular media storyline. As federal officials struggled to come to grips with the issues the media expanded its gaze to explore Inuit (Eskimo) and Métis housing. The Globe and Mail in particular produced several stories detailing worsening Inuit health due to poor housing (Green, 1962; "TB ravages Eskimo shack town; 24 per cent hit, NWT council told," 1963). Métis housing issues had by 1967 been singled out as problematic ("Just outside," 1967) as had urban Aboriginal living conditions ("Lack of adequate housing citied in YWCA survey," 1965; "Study finds city Indians overcrowded, suspicious," 1965). This naturally led to a dialogue of treaty Indian housing concerns compared to those of non-treaty Indians, who were frequently and erroneously portrayed simply as urban

Aboriginal peoples (Platiel, 1970; "Time is running out, Treaty Indian warns," 1968). The media of the 1970s acknowledged the legal separation of status- and non-status Indians and similarly explored their housing issues both independently and in comparative perspectives (J. Anderson, 1971). Tellingly the media had also implicitly picked up upon – and was in the process also perpetuating – Aboriginal separateness that was evident in the popular legal definition of Indian and the resulting categories (bureaucratic and legal) that continued to expand in response to federal attempts to combat Aboriginal housing concerns.

Additional federal funding ($84.5M) was allocated to Indian, Inuit and Métis housing in the mid-1960s with the goal of ending the reserve housing crisis by 1971 ("Establish 1971 goal to end housing shortage on Indian reserves," 1966). But many different Indian groups received differing amounts highlighting the government's liking for defining Indians in ways that could rationalize spending or funding cuts. For instance, those defined as Indians received greater funding amounts than what was allocated to Inuit and Métis due to the fact that the latter two groups lacked formal legislative definition during this period. The same could be said for the nascent and growing urban Aboriginal community, which would have to wait an additional two years before a $1-million off-reserve housing program was announced for its 35,000 individuals (15.2% of the national Indian population).[10] Reserve housing would remain a federal focus until the Ministry of Housing and Urban Affairs was founded in 1971, although by the 1970s Indian urbanization was becoming better understood. That year a $200-million funding infusion was aimed at establishing a number of urban demonstration housing projects (Walker, 2004, 2008).[11] By 1972 urban Aboriginal non-profit housing societies had begun to surface leading to the creation of more than 100 national corporations.

Federal funding did lead to noticeable improvements in reserve and urban Aboriginal housing, but the provincial premiers remained reticent to commit additional resources. Citing financial concerns as the key impediment, the majority of premiers also feared that accepting responsibility for anything remotely related to Indian affairs would signal their willing acceptance of responsibilities for Indians and their lands. The provincial premiers were also on watch for similar types of devolution policies after rejecting a federal scheme at the 1964 Dominion-Provincial Conference on Indian Affairs. Seeking to devolve Aboriginal health care and its costs to the provinces, provincial premiers lashed out by describing the plan as a blatant federal attempt to offload the federal responsibility for Indians to the provinces (Belanger, 2014). The quarrel spilled over into broad jurisdictional dialogues typified by the provinces declaring their certainty in the federal government's responsibility for "Indians, and lands reserved for the Indians," which included reserve housing (and in later years urban housing programs). Notable exceptions to these trends occurred in Saskatchewan and Ontario, where the leaders of both provinces acted on grave concerns about reserve housing dating back to the 1960s. In certain instances funding had been provided and federal/provincial programming established to improve reserve housing. For the most part however provincial officials remained unwilling to engage the issue.

Two issues emerge at this point that demand consideration. The first is the separation of Indians into the categories of status and non-status Indian, which is an *Indian Act* construction. Since status Indians are formally recognized as legal Indians they are deemed in need of funded programs to help facilitate their transition to civilized status. Non-status Indians are however considered formerly legal Indians who have attained a suitable level of civilization. In the latter case, which brings up the second issue of

10. This would be $6,790,323 in current dollars (April 2015), adjusted for inflation.

11. This would be $1,358,064,516 in current dollars (April 2015), adjusted for inflation. A demonstration project is conducted under government supervision, to better understand the issues and solutions associated with (in this case) rental housing. The goal is to review the project's operations for the purposes of devising best practices and to then develop processes that result in improved levels of housing capacity and access to adequate and affordable housing.

concern, non-status Indians are no longer considered a government obligation and are consequently no longer eligible for equivalent federal programs, including those for housing and homelessness (although they can potentially access provincial off-reserve housing and homelessness programs) (Lawrence, 2004). Those Indians who recognized the benefits of retaining their status may make claim to federal resources and secure policy attention. By opting to restrict its policy focus however the federal government in turn "provided Indian status with a set of characteristics that made it a desirable category for those who were marginalized as a consequence of the same laws" (Newhouse et al, 2014: 9). The authors of the report, *Delivery of the Aboriginal Human Resources Development Strategy in Urban Canada*, highlighted this inequality:

> *To illustrate the need for urban Aboriginal policy, one needs only to examine the expenditures of the Department of Indian Affairs and Northern Development. As noted in the section on demographics, 30% of Canada's Aboriginal population are registered Indians and of those approximately half live off reserve, or 15%. DIAND spends nearly $7 billion a year servicing almost entirely First Nations on reserves, while HRSDC, through the AHRDS agreement, spends approximately $320 million a year for people who live both on and off reserves. Based on these figures, approximately 81% of this funding for Aboriginal people is going to 15% of the total Aboriginal population, which demonstrates a significant misallocation of funds and further demonstrates a need for the development of policy frameworks for urban Aboriginal people (Holders, 2002).*

In each case two key themes to emerge are: one, the provincial desire to contribute limited financial capital to urban Aboriginal housing issues and, two, to facilitate new, less costly partnerships with and between stakeholders, the latter of which should occur while avoiding any formal commitment to reserve housing, what has historically been portrayed as an exclusively federal domain.

The provincial response to Aboriginal housing remains influenced by this means of legally privileging status Indians and reserve communities through policy. Only two provinces – British Columbia (B.C.) and Nova Scotia – have implemented polices directly referencing First Nations housing. The most comprehensive is the Tripartite First Nations Housing Memorandum of Understanding that B.C. signed with the First Nations Leadership Council and the Government of Canada in 2008 committing each party to develop an inclusive approach to improve housing for First Nations communities, individuals and families living both on and off reserve (B.C., 2014). Provincial participation in Nova Scotia's Tawaak Housing Association (est. 1981), a private, non-profit housing corporation, is restricted to providing for partial organizational funding (Association, 2014). In the absence of a formal national housing strategy, most provincial governments have developed social housing plans and housing and homelessness frameworks that progressively identify their need to engage non-reserve Aboriginal peoples, but none focus specifically on reserve housing.

The language used in most cases does not commit a province to resource provision but, as the New Brunswick government example demonstrates, speaks of the importance of helping to improve partnerships "with private sector, municipalities, non-profit associations, Aboriginal organizations and other stakeholders to develop innovative solutions to housing challenges and expand the stock of affordable housing" (Corporation, 2014). More recently Alberta responded to the devastating June 2013 southern flooding by signing two memoranda of understanding with and directing more than $180 million to the Siksika ($83 million) and Stoney Nakoda ($98 million) First Nations for rebuilding reserve homes and infrastructure (Gandia, 2013; Seewalt, 2013). What this may hold for ongoing Aboriginal-provincial relations concerning housing is yet to be seen. Unfortunately, as of July 2015 only 130 Stoney homes had been fully repaired with the end of 2016 given as the final restoration date (Hudes, 2015).

Policy Separation on the Ground

So how does this legal and policy separation impact Aboriginal people seeking improved housing? Or mitigate housing risk or work toward ending homelessness? Responsibility for federal First Nations (reserve) housing was assigned to the CMHC in 1996. This transfer of authority was first mentioned in the 1950s and had gained ample momentum by the 1970s. DIAND took formal actions in 1976 to affect this changeover that National Indian Brotherhood (NIB) leader Noel Starblanket successfully rebuffed. He responded by also demanding that the DIAND retain its provision of Indian housing (Ponting & Gibbins, 1980). The NIB's successor, the Assembly of First Nations (AFN), echoes Starblanket's arguments by insisting that Canada is bound by treaty rights to ensure First Nations have shelter. By involving the CMHC, the AFN adds, federal officials are attempting to circumvent their responsibilities by delegating a federally enshrined housing responsibility to a Crown agency (AFN 2013). Treaty rights in this instance remain undefined, nor is it certain whether the proclaimed federal responsibility for reserve housing is considered specifically to be a treaty right or part of Canada's fiduciary obligation (trust responsibility) for Indians.

The NIB's successor, the Assembly of First Nations (AFN), echoes Starblanket's arguments by insisting that Canada is bound by treaty rights to ensure First Nations have shelter.

The federal government counters that all housing – be it Aboriginal or non-Aboriginal housing issues – is strictly a matter of policy. It is not a right or an entitlement derived from treaties or constitutional status. Housing is a social policy and Aboriginal housing policy, generally speaking, is based on this premise. Support is therefore based on "need" (Canada, 1996). When, the CMHC accepted responsibility for reserve housing in 1996 it acknowledged this provision and the attendant policies established to guide its supervision by placing greater "emphasis on future planning and community control of reserve housing decisions and to gradually relieve the reserve housing crisis" (Olthius et al, 2008: 274). More First Nations consequently undertook community planning processes. Now responsible for the governance of reserve housing through by-laws, many First Nations now own, administer and manage the reserve housing stock while fashioning community plans, establishing zoning and ascertaining regulations. The CMHC provides housing assistance to support new housing construction, the purchase and/or renovation of existing housing and AANDC-supported development of housing capacity. These monies can be used at each First Nations' discretion for construction, renovation, maintenance, insurance, capacity building, debt servicing and the planning and management of their housing portfolio (CMHC, 2014). Although it may appear that additional funding is being made available, absolute responsibility for local housing development is assigned to each First Nations; however, even though First Nations may technically exercise discretion the general rules guiding funding use were devised in Ottawa by bureaucrats hoping reserve residents will abdicate treaty-protected lands in lieu of purchasing individual plots for home construction. Without engaging in an extended dialogue about reserve socio-economic outcomes, which significantly constrain establishing private property regimes, those who have accepted responsibility for creating reserve housing programs do so (almost exclusively) without seeking input from reserve community planners.

It becomes evident when reflecting on the 1961–1993 programming period that reserve-housing issues took precedence (and they still do from a policy perspective), over those of Inuit, urban Aboriginal and Métis. Returning once again to law and policy, the federal disregard for non-reserve housing is in part attributable to the *Constitution Act* (1982), which conflates Indian, Métis and Inuit into a catchall category Aboriginal. This undermined how the governments of the 1980s were able to respond to these distinctive communities' assorted housing concerns. As an

example, despite the proclaimed need to improve reserve housing local program administrators were nevertheless forced to compete for funding with all Aboriginal programming portfolios (through grant writing and modest lobbying efforts). Add to this the fact that reserve housing programs were allocated the majority of funding which meant that Inuit, urban Aboriginal and Métis programs financially suffered. Among the more notable initiatives was the Urban Native Additional Assistance program established in 1984. The Urban Native Additional Assistance bridged the operating costs/operating income gap to "put urban Aboriginal housing institutions on a viable financial footing for the first time while also facilitating operating enhancement in… administration, counseling and maintenance regimes that have contributed significantly to the success of the urban Aboriginal housing institutions" (Congress of Aboriginal Peoples, 2004).

Initially identified as separate from mainstream programs, from the outset this CMHC program offered its administrators the freedom to formulate and provide Aboriginal-specific services (Belanger et al, 2012a). It did however push Aboriginal interests further away from mainstream programming initiatives while also making Aboriginal-specific programs vulnerable to cutbacks. Proof of this was the Rural and Native Housing Program's termination in 1991. In its wake Ottawa did manage to cobble together assorted strategies in the interim to temporarily enhance urban Aboriginal housing while it attempted to subtly extricate itself from providing urban Aboriginal housing programming, which was later assigned to a coterie of private, public and third-sector parties. In recent years low-income, off-reserve Aboriginal people have become eligible for CMHC housing programs available to all Canadians. There is also the $1-billion Affordable Housing Initiative, which sought to boost the affordable housing supply through federal cost sharing accords with provincial and territorial governments. Ottawa spends $2 billion annually on federal programs accessible to Aboriginal people, which include Public Housing, Non-Profit Housing, Rent Supplement, Rural and Native Housing, Urban Native Housing and Cooperative Housing.

One could argue in this instance that the government is seeking to finally end the ward-guardian relationship by formally integrating Aboriginals into national and provincial housing programming. This may be the desired outcome. However, ongoing inter-jurisdictional bickering hinders its realization while simultaneously consuming substantial human and financial capital. First Nations and Aboriginal people also find themselves caught in a jurisdictional void and thus restricted from accessing analogous non-Aboriginal housing programs and homeless relief due to the fact that they may be a specific legal category of Indian. Checking a box in this way, one could argue, could provide an effective means of establishing improved responses to Aboriginal needs. Viewing such processes from a larger systems perspective, however – as this chapter has endeavored to do – simply exposes the historic bureaucratic obsession with Aboriginal separateness, which in turn leads to our contemporary political inability to fully appreciate or reconcile in policy unique Aboriginal housing needs.

CONCLUSION

Should we be surprised that Aboriginal separateness is a socially, politically and legally ingrained certainty in Canada, and that this hurts our ability to respond to an Aboriginal housing crisis dating to at least the 1950s? As this chapter has demonstrated, no. As a result Aboriginal housing priorities remain conspicuously low at both the federal and provincial level due in large part to their complexity and an enduring political desire to see Indian assimilation into Canada's social fabric. Reflecting on how federal desires regularly trump Aboriginal needs and without giving provincial premiers a pass, academics and advocates alike continue to remind Ottawa of its responsibility to adopt a leading role in Aboriginal programming and policy by virtue of its historic relationship with Aboriginal peoples (Graham & Peters, 2002; National Aboriginal Housing Association, 2004; Walker, 2006, 2003). Adaptable models have yet to materialize for federal and provincial responses rely upon historic and antiquated systemic approaches to "Indians, and lands reserved for the Indians," which are characterized by an ongoing federal/provincial feud over precise responsibility for Indians and federal management of the crisis as opposed to seeking its resolution. Superior attempts to harmonize federal and provincial approaches to reserve and urban Aboriginal housing concerns are needed if any progress in mitigating First Nations and Aboriginal homelessness can be made.

Until Aboriginal housing and homelessness become part of Canada's everyday business, and in ways that acknowledge the systemic disadvantages Aboriginal peoples confront...
...any interventions will remain Band-Aid approaches and ultimately of limited practical value.

As Thurston and Mason (2010) note, the federal policies we rely upon to inform our Aboriginal housing and homelessness interventions are the foundation of our many problems. Aboriginal homelessness is from their perspective attributable to the Indian Act, jurisdictional and coordination issues, residential schools, social marginalization and isolation, and systemic discrimination and stigmatization within home reserve communities. Colonization's impacts are strikingly evident and have led to a forced Aboriginal dislocation from traditional lands and ways of living even as the non-Aboriginal majority clings to the belief in the need to eliminate reserves – even if the desired urban residential sites are deemed alien environments to an inherently rural Aboriginal culture (Belanger & Walker, 2009; Malloy, 2001; Nelles & Alcantara, 2011). As perpetual outsiders, therefore, popular beliefs equating urban Indians as displaced cultural curiosities are validated (Francis, 1992). Until Aboriginal housing and homelessness become part of Canada's everyday business, and in ways that acknowledge the systemic disadvantages Aboriginal peoples confront (e.g. geographic disparity, socio-economic condition, urban-reserve divides, federal and provincial silo approaches to Aboriginal policy creation, soon-to-be-lapsing urban housing subsidy programs hinting at future crises and perhaps the most important issue – the endemic lack of Aboriginal partnerships guiding the decision making processes), any interventions will remain Band-Aid approaches and ultimately of limited practical value.

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High-level Governance
Challenges and Opportunities

4.4

INTERAGENCY COUNCILS ON HOMELESSNESS: CASE STUDIES FROM THE UNITED STATES & ALBERTA

Carey DOBERSTEIN & Jasmine REIMER

INTRODUCTION

Interagency councils have been formed for a number of policy issues in recognition of the fact that many social problems are too complex to be solved by a single sector, agency or organization alone. Issues relating to child and youth welfare, homelessness and mental health are complex, interconnected and simultaneously involve multiple systems of care. Without coordination, the various systems can be disorderly, containing unnecessary duplication or even agencies and policies working at cross-purposes, all of which can prevent an effective policy response or even exacerbate the problem. Having a 'cluttered' and fragmented system not only makes service delivery inefficient and difficult to navigate for those who need help, but it also ends up having a substantial price tag as the cost of managing a social problem often exceeds the cost of preventing it (Hamrick & Rog, 2000: 355). As a result, there is a need for a coordinated, integrated effort to effectively and efficiently respond such that the various systems, often under the control of different ministries or even levels of government, are in some degree of alignment. In this regard, the objective of interagency councils is to bring together a group of various stakeholders and representatives from agencies, organizations and sectors – inside and outside of government – to create a streamlined and collaborative response (Keast et al., 2007: 10–11). Put simply, interagency councils act as an organizational framework to ensure that the relevant sectors and policies are collectively working towards the same goal.

This chapter presents the origins and purposes of interagency councils in North America and contemplates the extent to which they have led to progress in identifying and implementing solutions to homelessness, both in the U.S. and in Canada. We begin by exploring the roots and organization of the United States Interagency Council on Homelessness (USICH). We track the key developments of the USICH, first in the context of an increased awareness of homelessness as a complex social problem, but also its role in a nation-wide push for interagency coordination in order to end, rather than simply manage, homelessness. We then proceed to briefly present Interagency Councils on Homelessness (ICHs) at the state level, particularly those found in Ohio and Texas to understand the diversity with which they can be organized, the criteria for success and the resulting

progress and outcomes. The third section of the chapter introduces the Alberta Interagency Council on Homelessness (IAC) as the first in Canada, identifying its origins, structures and functions, as well as its early successes and challenges going forward. We conclude the chapter by reflecting on what the Alberta IAC might mean for other Canadian provinces and the future of homelessness policy and governance across Canada.

INTERAGENCY COUNCILS FOR COMPLEX POLICY PROBLEMS

As a governance framework to encourage collaboration and resolve policy disjunctures, interagency councils have a long history of use. Apart from homelessness, perhaps the most significant issue area that has experimented with institutions of interagency collaboration is related to child and youth services. In order to effectively respond to social problems pertaining to children and youth, the systems of child welfare, juvenile justice, education, substance abuse and mental health have been targeted for integration, particularly in the U.S. Howell et al. (2004) explain the nature of this issue in their proposal for an integrated infrastructure for youth services: "[y] outh's problems tend to come bundled together, often stacked on one another over time. The need for an integrated response is buttressed by the fact that children and adolescents are often sent haphazardly through the fragmented systems charged with addressing their problems" (145). Here it is evident that the need for interagency councils is twofold: youth problems are complex and the system responsible for helping them is uncoordinated and inefficient, potentially making the problem even worse (Nichols, 2014).

Just as with child and youth issues, where problems manifest across different sectors and policy domains, addressing homelessness is likewise characterized by a complex array of interrelated policies and programs. Homelessness is an issue that includes multiple service systems that are often working at disparate purposes. Hambrick and Rog (2000) argue that the homeless serving system "has developed segmentally. Housing is separate from health services, which are separate from mental health services, which are separate from employment services and so forth. Each has a separate funding stream, a different set of rules and usually a separate location" (354).

In this way, effective and sustainable efforts to end homelessness cannot be achieved if the very system designed to provide them is disjointed. As a result, interagency councils to end homelessness have been proposed to create linkages between various agencies and organizations, and even whole levels of government, and to coordinate their efforts so that the homeless-serving system is easy to access and effective in its

response. These systems include healthcare, corrections, education, child welfare and emergency shelters, and are managed at different levels of government and non-profit community organizations. Often discharge out of sectors such as corrections and healthcare can result in individuals entering into homelessness if they are not properly supported (see chapters X,Y,Z in this issue). Hambrick and Rog (2000) suggest that every agency "makes a partial contribution, serving some part of the problem for some part of the homeless population" (354–355). Thus if someone experiencing homelessness seeks assistance, the system they engage with is often so complicated they face multiple barriers to receiving the help they need (Provan & Milward, 1995: 2). In other words, there is an array of agencies with disparate purposes that lack the coordination to actually create meaningful long-term change. Thus ICHs aim to reform the homeless serving system itself, but also to adopt a holistic, comprehensive approach that involves all key sectors that touch homelessness to come up with a more centralized plan with focused goals to create smoother and more sustainable solutions to ending homelessness.

METHODS

To understand the history and evolution of interagency councils in North America, we researched publicly available policy documents in the respective jurisdiction, as well as consulted previous academic research in the area. For the Alberta IAC, in addition to document analysis we conducted five interviews with current IAC members and bureaucratic support staff to complement the publicly available documents and reports since the IAC was created. Potential interview subjects were prioritized based on highest levels of involvement (e.g. chairs of subcommittees) and those with the longest history on the IAC and were conducted with the assistance and cooperation of the Alberta IAC bureaucratic secretariat. The primary focus of the semi-structured interviews was to ask participants to reflect on the design of the IAC, as well as governance successes and challenges. All interviews took place in spring 2015.

ICHs IN THE U.S.

ICHs find their origins in the U.S. nearly 30 years ago, beginning first at the national level. As an independent agency of the federal executive branch, the USICH is the primary means through which the U.S. government formulates its policies and responds to homelessness at the national level, with the fundamental purpose to foster collaboration, cooperation and coordination between public and private stakeholders, federal organizations, agencies and programs. The USICH was institutionalized in the Stewart B. McKinney Act (now the McKinney-Vento Act) in 1987 amid the early signs of the impact of welfare state restructuring and retrenchment that preceded the rapid growth of homelessness across many jurisdictions (Hambrick & Rog, 2000: 360–361). By the late 1980s homelessness was considered less a latent social problem and increasingly identified by advocacy groups as a systemic issue (Baumohl, 1996). As a result of various protest movements and campaigns across the U.S. homelessness emerged from the shadows as not only a major social problem, but also as a national crisis in which the federal government bore a responsibility to act (Bauhmol, 1996: xiv-xvi).

The McKinney Act was significant insofar as it was the first major response by the federal government towards homelessness in 50 years and it substantially increased the funding for homelessness programs. It was a critical turning point as it not only acknowledged that the government has a clear responsibility to respond to homelessness, but it also understands it to be a complex, interconnected social problem that cannot be fixed by one "simple solution" (Foscarinis, 1996: 163). The McKinney Act included more than 20 grant programs in areas such as health care, housing and food assistance, but most notably created the Interagency Council on the Homeless – renamed the USICH in 2002. It first comprised 15 federal agencies or departments[1] and later added five more. The McKinney Act also encourages planning and coordination in a similar fashion be implemented at the state and local levels.

The primary mandate of the USICH is to "review federal aid to homeless people, monitor, evaluate, and recommend improvements to federal, state, local, and private programs to aid homeless people, and provide technical assistance to such programs" (Foscarinis, 1996: 163). In order for the USICH to coordinate the federal response to homelessness and for funds to be released to McKinney Act programs, the Act required that there be a comprehensive plan to end homelessness containing guiding principles on which the USICH can base their policies and actions. They also set out specific timelines, areas of focus and goals for councils to follow. So, beginning with the Comprehensive Homeless Assistance Plan (CHAP), various plans have been introduced since 1987, including *Priority: Home!* in 1994 and, following amendments to the McKinney Act in 2009, *Opening Doors* in 2010. Each of the plans is briefly presented below to demonstrate the evolution of the USICH since its creation.

Priority: Home!

Priority: Home! The Federal Plan to Break the Cycle of Homelessness is the plan that came out of an executive order from President Clinton that required that a federal plan be developed in order to break "the cycle of homelessness and prevent future homelessness." The executive order declared that the plan should propose a continuum of care, which is designed to create an effective, navigable process for those experiencing homelessness in which all pathways lead to housing and help (Hambrick & Rog, 2000: 360–361). Rather than short-term emergency relief, *Priority: Home!* aimed at longer-term goals to improve the service delivery system in order to prevent homelessness. This included a three-pronged approach: emergency shelter, transitional housing and permanent and/or supportive housing (Couzens, 1997: 276–80).

The funding for the plan came from the Department of Housing and Urban Development (HUD) and had long-term goals to "expand the number of housing subsidies and to provide comprehensive services" (Couzens, 1997: 277). These included wraparound supports such as treatment for drugs and alcohol, parenting, childcare and also funds to "improve coordination efforts for such programs between state and local governments" (Couzens, 1997: 278). Furthermore, it supported more coordination and linkages between programs such as health care and housing (Foscarinis, 1996: 171). The plan also suggested larger measures such as reforming the welfare system in order to prevent people from falling into homelessness in the first place, although these policy levers are outside of HUD's mandate and control.[2]

Ultimately, although *Priority: Home!* respects the initial efforts derived from the McKinney Act, it emphasizes that "the time has come to go beyond these initial efforts" (Secretary of Housing and Urban

1. Among others, the partners of USICH include the Departments of Defense, Education, Health and Human Services, Housing and Urban Development, and Justice.

2. Despite the positive changes described in the plan, whether or not the funding would be provided to carry them out varied depending on the party in control of Congress. At the time Priority: Home! was released social spending on homelessness was, despite what is suggested by the title of the document, of lower priority as demonstrated by the dramatic cuts in spending in the mid-1990s. The plan also noted that although cooperation amongst service providers may be advantageous and desirable in theory, in practice competition between them in some cases proved to be a barrier to interagency collaboration (Couzens, 1997: 279).

Development, 1994: 46). *Priority: Home!* responded to criticisms of McKinney Act programs for being too fragmented in nature and therefore still difficult to navigate, but also for doing little to open up access to programs often restricted as mandated by Congress. To remedy this, the plan proposed longer-term, institutional coordination and restructuring in order to prevent homelessness instead of simply responding to it as an emergency problem with short-term solutions.

HEARTH ACT

Signed by President Obama in 2009, the Homeless Emergency Assistance and Rapid Rehousing Act (HEARTH) was the first major amendment to the McKinney-Vento Act and the work of the USICH. It marked a further step towards coordination and cooperation in preventing and reducing homelessness. A key aspect of the HEARTH Act was its consolidation of the three programs under the McKinney Act that are involved in the Continuum of Care (CoC) program: the Supportive Housing program, the Shelter Plus Care program and the Moderate Rehabilitation/Single Room Occupancy program. The objective of the CoC program is to "address the critical problem of homelessness through a coordinated community-based process of identifying needs and building a system of housing and services to address those needs" (Department of Housing Urban Development, 2012: 45,422). Essentially, the CoC program reinforces the theoretical underpinning of the USICH: solving homelessness is not simply about providing shelter, but involves a variety of other social, economic and physical factors that need to be addressed. From this perspective, the HEARTH Act signalled a move towards increased streamlining of various programs and providers, with the goal of "increas[ing] the efficiency and effectiveness of coordinated, community-based systems that provide housing and services to the homeless" (Department of Housing Urban Development, 2012: 45,422–45,224).

Opening Doors

The *Opening Doors* plan was developed following the enactment of the HEARTH Act in 2010. It marks the first nation-wide comprehensive plan to end homelessness in the U.S. Centred on the belief that "no one should be without a safe, stable place to call home" (USICHd, 2010: 7), the USICH developed this plan based on the principles that it should be collaborative, solutions-driven, cost-effective, implementable, lasting, scalable and measurable (USICHd, 2010: 8). Within these guidelines, *Opening Doors* sets out to achieve four goals: ending chronic homelessness in five years, prevent and end homelessness among veterans in five years, prevent and end homelessness for families, youth and children in 10 years and, lastly, to set a path to ending all types of

homelessness. Its purpose is to strengthen existing ties between agencies and to adopt a stronger collaborative approach to ending homelessness. Ultimately, the plan is a roadmap for action for the USICH and its 19 partner agencies.

The methods that the USICH aims to undertake in order to create collaboration across levels of government and sectors includes education of the public, states and localities and the involvement of citizens, including those experiencing homelessness themselves. Specific actions of *Opening Doors* include collaborative and cooperative measures across a variety of sectors and levels of government. For example, the Department of Education intends to enable homeless students to apply for financial assistance for college and the Departments of Health and Human Services and Veterans Affairs intend to work with the American Bar Association to remove barriers that prevent veterans from obtaining housing and employment (USICHd, 2010: 60). These changes hinge on the observation that "barriers that get in the way of people getting the supports and services they need must be addressed. This includes… the complexity of navigating multiple programs that operate in isolation" (USICHd, 2010: 23).

Opening Doors not only aims to create partnerships and programs that aid those who are at risk of or are experiencing homelessness, but also offers a plan to create a simplified continuum of care; however, the central feature of *Opening Doors* is that stable housing is the first step to ending homelessness. All other elements of this plan stem from the essential belief that providing someone who is experiencing homelessness with stable housing enables them to better receive services instead of housing being rewarded after treatments and rehabilitation have been conducted. In this sense, housing serves as a "launching pad" from which clients can receive the help they need and be set on the path towards stability and independence, consistent with Housing First principles (USICHd, 2010: 4–5).

USICH PROGRESS

Equally important to discussing the USICH's foundational principles and goals, as well as criteria for success, is how effective it has been at reaching them. On the theoretical level, interagency collaboration, coordination and cooperation should reduce homelessness as gaps in service and cases of policy incoherence are minimized. However, whether or not this approach has had the desired outcomes in practice is a complex question to answer, given the multiple drivers of homelessness.

There are three ways by which the USICH measures the progress towards its goals: annual changes in the number of individuals experiencing homelessness, the number of veterans experiencing homelessness and the number of families with children experiencing homelessness. Yet simply measuring the annual amount of homelessness may be misleading, even if the ultimate goal is to minimize those numbers. Other factors that could shape these performance measures are whether the political parties in control of Congress allocate enough funds for the suite of homeless programs, as well as the state of the economy. A dip in the economy or even a natural disaster undoubtedly results in significant increases in homelessness. In this regard, annual measures of the amount of homelessness would not always reflect the success of the USICHs' or state ICHs' efforts, but rather larger structural and contextual factors.

A report released in 2014, four years after the release of *Opening Doors*, reveals that homelessness is declining in part due to the USICH's efforts towards cross-sectoral collaboration and coordination and adherence to the initiatives, principles and guidelines set in place by *Opening Doors*. Data collected via point-in-time counts show that homelessness nationwide was reduced by 10%, veteran homelessness by 33%, chronic homelessness by 21% and family homelessness by 15% (USICHg, 2014). The report proclaims the success of *Opening Doors* as more people entering into homelessness in each of these categories are connected to housing and supports. Yet, homelessness has been on the rise in some areas of the country and more systematically addressing youth homelessness remains an area that needs further development and research (USICHg, 2014).

Despite the efforts made by the USICH in the years since the implementation of *Opening Doors* the end of the report raises an important issue concerning the stability and guarantee that these collaborative, cooperative efforts can increase in the future. As mentioned, due to changing political winds that affect the administration and Congress, funding allocated to certain federal departments of the USICH has not always remained a priority on the national agenda. If this effort is not more or less consistently sustained or accelerated, homelessness will continue to be a pervasive social problem, even with the collaborative institutional architecture. In addition, despite the progress made to reduce homelessness, one of the main barriers that still exists is the shortage of affordable housing (USICHf, 2013: 30). Simply, without enough housing any amount of interagency collaboration and cooperation will not reduce the number of people experiencing homelessness.

STATE LEVEL ICHS IN THE U.S.

Although the USICH has made progress toward creating a coordinated system to respond to homelessness at the federal level, *Opening Doors* makes it clear that it is the task of the states and communities to create their own plans to increase collaboration in order to meet the goals described in the federal plan, particularly since many important policy levers relevant to homelessness are exercised at the state level, just as is the case with Canadian provinces. Naturally, the states are more cognizant of the specific needs and condition of homelessness within their area, and 41 states have created their own ICHs and local continuums of care (Couzens, 1997: 280).

The impetus for state involvement in homelessness began before the introduction of the McKinney Act in 1987 as states in the early and mid-1980s were already acting beyond the "disaster relief approach" that the national government had been using (Watson, 1996: 172). Since the introduction of the McKinney Act, states have been centres for interagency collaboration and coordination. They bring together service providers, local non-profit organizations, state governments and agencies in order to create a smoother, streamlined continuum of care for those experiencing homelessness in the state (Watson, 1996: 175). State homeless initiatives have been primarily funded by the Federal Department of Housing and Urban Development through the consolidated grant program previously discussed under the HEARTH Act. Activities at the state level mirror those at the federal level in the sense that state ICHs aim to provide more housing and create their own state-tailored plans that align with the goals and principles in *Opening Doors*.

The purpose of state ICHs is essentially twofold: to build on the activities and objectives of the USICH and to report to the governor when implementing strategies (USICHb, 2003: 4). State ICHs have a chair and a vice chair which are appointed by the governor

or elected from within the council. The USICH's guide *Developing a State Interagency Council on Homelessness* emphasizes that state councils should also include mayors, city councillors, county commissioners and city managers to ensure its success (USICHb, 2003: 4–15). States have also developed 10-year plans with an emphasis on the elimination of chronic homelessness, consistent with the focus of the federal government. Similar to the USICH, state ICHs also work to establish partnerships at all levels, including non-traditional stakeholders such as faith-based organizations, business owners and the philanthropic community (USICHb, 2003: 14).

According to the USICH, the characteristics of a successful state interagency council include, among others, dedicated staff, membership inclusion of the core state agencies such as Housing, Welfare and Human Services and "active participation in the governor's office." Other criteria for success include the documentation and results-driven approach of the council's activities (USICHb, 2003: 16). With the broad framework of state ICHs articulated, it is helpful to see how they work in practice, and thus in the sections below we briefly outline the state ICHs in Ohio and Texas as brief illustrative examples before turning our attention to the newly created Alberta ICH.

Ohio

The Ohio Interagency Council on Homelessness and Affordable Housing was established in April 2007 by Governor Ted Strickland. Its stated mission is "to unite key state agencies to formulate policies and programs that address affordable housing issues and the needs of Ohioans who are homeless or at risk of becoming homeless," with a particular focus on supporting the chronically homeless (Technical Assistance Collaborative, 2009: 1). It is organized around the Permanent Supportive Housing (PSH) approach, which aims to provide housing with extensive supportive networks for those who are disabled or experiencing chronic homelessness. Ohio has been described as being on the "cutting edge" of housing and disability policy (Technical Assistance Collaborative, 2009: 6) and this is largely due to its PSH approach. Ohio's plan states that this initiative can be implemented anywhere as long as an affordable housing unit is available with proper wraparound supports to ensure the client remains housed (13). The main area Ohio focuses on through interagency collaboration therefore is creating an institutionalized link between affordable housing and health care in order to end chronic homelessness.

Ohio also demonstrates its understanding of systems planning in ending homelessness through its Returning Home Ohio (RHO) initiative. Based on the understanding that discharges out of correctional facilities often result in homelessness, RHO works with those being released out of Ohio prisons who are at risk of becoming homeless due to their history or their disabilities, providing access to the services they need to be successful. A report released in 2012 revealed that those who were RHO participants were less likely to be repeat offenders and be re-incarcerated (Rehabilitation and Corrections Ohio, 2014). Thus in response to the relationship between homelessness and discharge from correctional institutions, Ohio created a collaborative initiative in order to address this gap by coordinating these two previously separate systems.

The Ohio ICH has therefore exhibited success in terms of systems integration through collaboration by prioritizing explicit linkages to associated health and correctional systems that contribute to homelessness. Yet apart from addressing collaborative approaches to ending chronic homelessness at the state level, Ohio's plan has been somewhat controversial as it does not explicitly address the other types of homelessness as outlined in the federal *Opening Doors* plan. A comprehensive vision for system integration that captures the entire spectrum of housing and support needs is essential, and the case from Texas offers a window into such an effort.

Texas

Given its size, the efforts in Texas demonstrate how interagency collaboration is feasible in geographically large and populous states as well as smaller jurisdictions. The Texas Interagency Council for the Homeless (TICH) was established in 1995. Its activities include "surveying current resources for services for the homeless in the state," assisting in the coordination of state services for the homeless and "increasing the flow of information among separate providers and appropriate authorities" (Texas Department of Housing & Community Affairs, 2015). The TICH comprises 11 different agencies including the Texas Department of Housing and Community Affairs, the Department of State Health Services, the Department of Criminal Justice, the Texas Education Agency, the Texas Veterans Commission and the Texas Workforce Commission.

Texas' comprehensive plan to end homelessness is called *Pathways Home* and offers guidance on how the state can create a more coordinated and collaborative system to end homelessness. The strategies fall under four categories: affordable housing and supports, homelessness prevention, data, research and analysis, and state infrastructure (TICHb, 2013: 6). The preventative measures entailed in this plan include increasing "the coordination of state agency services to enhance the state's preventative capacity" and to "increase the capacity of state institutions to prevent instances of homelessness and shelter use upon discharge from facilities" (TICHa, 2012: 61).

The agencies that comprise the TICH collaborate and coordinate their activities to achieve nine goals, including surveying current resources, assisting in coordinating and providing statewide services, increasing the flow of information and coordinating with the Texas Workforce Commission to assist those experiencing homelessness with employment and training (TICHb, 2013: 5–8). In its 2013 progress report, the TICH details the successes that it has made in these areas. Notably, it proposed the development of a "data house" which would compile and integrate data on homelessness from the state's 15 different Homelessness Management Information Systems.

Increasingly, it made efforts to make linkages between the TICH and the hundreds of localized CoC programs that exist across the state. The TICH receives most of its funding from the CoC grant programs created by the McKinney-Vento Act. They have aided Texas in progressing towards efficiently and effectively assisting those who are experiencing homelessness. In fact, between 2005 and 2010 the number of individuals experiencing chronic homelessness decreased by nearly 20% (TICHa, 2012: 15). Significant successes were also reported as state agencies have demonstrated collaboration and coordination with local efforts, especially in the area of preventative measures. For instance, in 2009 the Texas Department of Housing and Community Affairs introduced the Homelessness

Prevention and Rapid Re-Housing Program which successfully prevented many people from falling into homelessness during the recession (TICHa, 2012: 15–16).

However, despite these successes the report acknowledges that they lack comprehensive and available supportive services that enable people to be successful and remain housed once they are rehoused. Further coordination and cooperation of state agencies may result in more effective resource allocation (TICHa, 2012: 50). Yet the failure of the TICH in this area is primarily attributed to a lack of funding. Thus while the Texas ICH has the more comprehensive systems integration vision and wider collaborative effort than the Ohio ICH, it remains hamstrung by resource scarcity. Elected officials appear drawn to create and empower ICHs given arguments of efficiency when systems are better integrated, but often do not appreciate that the ambitions of ICHs – to end homelessness – are much greater than the goals set in the past and thus require substantial new long-term investments. Yet for the Texas ICH, and other state ICHs, the main barrier to success comes in the form of limited funds from the federal government, which we will see is also a challenge in the Alberta context, which is the first jurisdiction in Canada to adopt the ICH model.

A PLAN FOR ALBERTA **AND THE ALBERTA ICH**

Alberta is a province that has had a large and rapid increase in population in recent history, putting pressure on the affordability of housing markets and public services. Homelessness in Alberta spiked dramatically in the mid-2000s alongside the energy-driven economic boom and thus policy makers began to confront the growing problem. Some of the main reasons why homelessness has proliferated in Alberta are the high cost of living, shortage of affordable housing and high rates of in-migration. Like all Canadian provinces, there was a patchwork of services to support the homeless population, but it was gradually recognized that homelessness has many faces and thus cannot be tackled using siloed agencies that work at disparate purposes. Enough research has demonstrated that homelessness results from a wide array of issues including family violence, disabilities, addictions and the inability to afford housing. Homelessness is also not a homogenous issue in the sense that it consists of the chronically homeless, the transient homeless (infrequently experiencing homelessness), the employed homeless, homeless youth and homeless families. With this understanding, policy makers in Alberta realized that there needed to be a fundamental shift in direction in how they viewed homelessness and responded to it – namely integrated cross-sectoral solutions in order to actually reduce homelessness over time instead of simply managing it.

To shift from the emergency-relief approach, Alberta began to examine ways in which homelessness could be effectively ended with longer-term solutions focused on housing, supports and the prevention of homelessness. In 2009 the Alberta Secretariat for Action on Homelessness developed *A Plan for Alberta: Ending Homelessness in 10 Years*. The purpose of the plan is to create a roadmap with guidelines, objectives and principles on how to achieve interagency collaboration and how to implement the plan to end

homelessness. The premise of the plan is rather simple: ending homelessness is the right thing to do. 'Ending homelessness' means that no one will be homeless for more than 21 days before they are rehoused in permanent housing and provided with the supports they need to remain housed. The plan is centred on five priority areas including better information, aggressive assistance, coordinated systems, more housing options and effective policies. Within these five overarching areas are strategies to better develop data collection and methods, develop ways to prevent discharge from other sectors into homelessness, developing more housing opportunities, shifting shelters away from long-term housing of homeless and examining ways to reduce poverty. In order to meet the objectives entailed in the plan, there is a need for continued financial support from the Alberta government.

The *Plan for Alberta's* development and implementation began prior to the establishment of the IAC, chiefly through the Alberta Secretariat for Action on Homelessness. During this time, studies and consultations were conducted on what worked well for the community and what did not, in order to advise a future IAC on what practices they should employ. From this perspective its predecessor, the Secretariat, recommended to government that a formalized IAC would be of value to facilitate systems coordination, streamlining and collaboration amongst different sectors and agencies to end homelessness.

Inspired by the interagency efforts emerging out of the U.S., in February 2013 the Government of Alberta created the Alberta IAC to provide the provincial government with policy-focused advice on the implementation of the 10-Year Plan. This is the first of its kind in Canada and thus is important to investigate as other provinces and jurisdictions in Canada contemplate similar interagency institutions. Supported by the efforts of the pre-existing Alberta Secretariat for Action on Homelessness, the Alberta IAC is premised on the understanding that homelessness is a complex issue that needs to be solved through comprehensive solutions resulting from an interagency collaborative effort. In this respect, the IAC is a "unique partnership" that is "tasked with identifying systemic barriers, developing solutions, and providing strategic recommendations to the Government of Alberta" (Felix-Mah, et al., 2014: 1). Thus the objective of the IAC is to bring together these stakeholders in order to collaborate on provincial policy changes to advance the goals of the provincial plan, much like we have seen with similar institutions in the U.S. Specifically, its mission statement is to give policy direction, regulatory and program changes for the success of the 10-year Plan and is therefore an advisory board to the Government of Alberta, through the Minister of Human Services. The IAC aims to "lead the systemic and transformational changes" necessary to achieve the vision of ending homelessness by 2019 (Savoia & Stone, 2014: 5). This involves leveraging the "interdependence between partners, who may have different mandates, to create a seamless system where all partners share accountability in achieving agreed upon outcomes" (IAC, 2014 quoted in Joslin, 2014: 7).[3]

1. Notably, seven Alberta communities have developed 10-year plans that go alongside the provincial plan including Edmonton, Calgary, Wood Buffalo, Grande Prairie, Lethbridge, Red Deer and Medicine Hat.

Organization and Activities

The Alberta IAC is comprised of 33 representatives from numerous sectors and organizations that are involved in housing and homelessness, including First Nations, Metis and Inuit organizations, family and community support services, housing management bodies, local government and provincial government ministries that are responsible for the delivery of social and income supports for vulnerable Albertans, affordable housing, health and corrections and representatives from the federal government. It is worth noting that the inclusion of senior government representatives on its own government advisory body like the IAC is not a typical practice. This forum thus provides an opportunity to generate new policy ideas with input from government and non-government experts before they are submitted to government for further consideration and analysis.

The Minister of Human Services appoints members to the IAC, monitors the actions and performance of the council and receives formal recommendations from the group. The IAC is expected to report annually to the Minister of Human Services on its activities and on the progress of *A Plan for Alberta* (Stone, 2013: 12).

Council members collectively assessed the challenges to the achievement of the plan and developed five key priorities to pursue:

1. Aboriginal people, youth, seniors, women fleeing violence, newcomers and people with disabilities have access to specialized housing and supports that are tailored to their needs and strengths;
2. Prevention of homelessness is adequately resourced and successful;
3. Sustainable investment strategies are in place to achieve the successful implementation of the 10-Year Plan;
4. Integrated case management and service delivery are characteristics of local homeless-serving systems; and
5. The root causes of homelessness are addressed through integrated service delivery and public policy.

Currently there are four subcommittees of the IAC, which are the primary vehicles through which it aims to achieve its priorities. These are: Integrated Housing and Supports Framework, Governance, Prevention and the Funding and Investment Committees. The committees have their own specific roles and functions that together work toward achievement of the goals stated in a *Plan for Alberta*. For example, the Integrated Housing and Supports Framework Committee has investigated methods by which greater integration of housing and services can be achieved and has reported its findings to the Government of Alberta. The Prevention Committee has contributed to Alberta's Poverty Reduction Strategy and has created a partnership with the Canadian Observatory on Homelessness to aid in their identification of homelessness prevention measures. Other committees have also made partnerships and worked towards increasing their collaboration. The IAC partnered with the Alberta Centre for Child, Family and Community Research to produce the *Housing and Homelessness Research Strategy for Alberta* in 2014 and continues to guide its implementation. In this report, priorities identified are homelessness prevention and early intervention, effectiveness of intervention, and the continuum of housing and homelessness supports and services (Felix-Mah et al., 2014: 1–2).

Goals and Progress

There have been three reports on the progress of *A Plan for Alberta* since implementation began in 2009 (ASAH 2010; 2011; 2012). They were publicly released before the IAC assumed the role as advisory body to the minister in charge of the implementation of the plan. Yet looking at success in the form of mere numbers, since the implementation of the 10-year plan, as of March 31, 2015 over 11,000 Albertans experiencing homelessness have been enrolled in Housing First, over 3,800 have graduated from a Housing First program and 73% of those have remained housed since the beginning of the plan (Alberta Human Services, 2015). There have been fewer incarcerations and less time spent in jail as well as less interaction with the health care system for those who have participated in Housing First. There have also been more coordinated government policy response initiatives through the Safe Communities Initiative, Service Delivery Transformation and Information Sharing Framework (Alberta Secretariat, 2013). Other progress detailed in the three-year progress report include efforts in the area of developing better information. For example, the Alberta Homelessness Research Consortium was developed which funded 11 research projects between 2011 and 2012.

The Alberta ICH has only been operational since 2013, so it would be premature to make any definitive declarations about areas of success or failure. Yet it is also helpful to reflect on its contributions thus far, as well as the challenges the IAC has faced, particularly as other jurisdictions contemplate creating similar collaborative governance institutions to address homelessness at the provincial level. The research team interviewed a handful of key actors currently involved with the Alberta ICH to better understand its major activities and achievements, as well as the barriers or challenges to achieving the goals set forth by the IAC and the provincial *10-Year Plan to End Homelessness*. The interview data and excerpts are presented anonymously to protect respondents and to incentivize frank assessments of success and challenges of the IAC.

In terms of the major activities of the IAC, interview respondents nearly uniformly suggested that the key deliverables thus far have been the dozen formal recommendations the IAC has made to the Minister of Human Services – after considerable internal discussion, analysis and debate – as key steps for the government to take to end homelessness in Alberta. The nature of the advisory relationship between the IAC and the minister means that respondents were not able to divulge the precise recommendations, as this is protected by confidentiality rules in the parliamentary system. Yet we do know that there have been recent changes in government policy associated with what one respondent called a "full-spectrum" provincial housing strategy as well as internal work underway regarding institutional discharge policies that bear the stamp of the IAC, as another IAC member hinted. Yet a common regret expressed among interview respondents is that they have yet to receive any responses to their recommendations from the minister, and thus even the membership is unclear about the effect they have had on government policy. "The [IAC] is an advisory body, not in charge of policy implementation or even policy development," one respondent closely involved with the IAC reminds us.

Thus a major piece of the work of the IAC is to contribute their collective expertise based on their roles as leaders in their sectors and to make formal recommendations to the minister after conducting research, analysis and internal debate. One example of research undertaken to support this role is the *Rural Homelessness* report, funded by the Government of

Alberta in partnership with the IAC and the Alberta Centre for Child, Family and Community Research, which was impactful as an educational piece – raising awareness that homelessness is not merely a big city problem – but also a policy and program piece. Even if the IAC had no direct role in implementation, it does have the capacity to reveal issues related to the implementation of the provincial plan that require a provincial policy response. Several interview respondents linked this report with the decision to expand provincial homelessness funding to rural areas never before reached.

Likewise the Government of Alberta launched *A Plan to Prevent and Reduce Youth Homelessness* in February 2015, which was endorsed and supported by the IAC during the approval process. One interview respondent closely associated with the IAC remarked that the youth plan is a notable achievement because it is "one of the only pieces of policy I have seen that actually articulates the roles of the 10 or 11 ministries as it relates to youth" rather than simply identifying vague connections across ministries. The IAC supported the creation of the youth plan, and its position that specialized populations require a specific response contributed to the creation of the *Plan to Prevent and Reduce Youth Homelessness in Alberta,* which places its priorities on prevention and awareness, early intervention, client-centred supports and research and evaluation (Alberta Human Services, 2015). This plan articulates that youth homelessness has different causes and characterizations than other types of homelessness and needs a comprehensive approach to reduce it. It aims to undertake a collaborative and coordinated approach to bolster prevention and housing and supports while creating smooth, healthy transitions from emergency shelters to rehousing and other supports (Alberta Human Services, 2015).

In terms of concrete outcomes stemming from the work of the IAC, this is an area in which the interview respondents were more divided. Some suggested that there have been few, if any, tangible policy or programmatic changes since the IAC began advising the minister on system-level policy as it relates to homelessness, whereas others claim that there are achievements, but they are often not manifested publicly. With respect to the latter, one example offered by an IAC associate is that they made a strong case to government that "housing and homelessness were inseparable – that they needed to be considerable together," which was not how it was conceptualized prior to the creation of the IAC. And this is impactful, according to the respondent, because this type of paradigm change gets infused into subsequent government actions such as the provincial housing strategy. To another respondent, this type of conceptual change "has potential to have a long-term impact on the situation, but certainly won't have an impact overnight." IAC members interviewed suggested that they learned from senior bureaucrats in relevant ministries that their work on housing and supports integration is also being picked up within the bureaucracy. And further on the less visible manifestations of changes of thinking and even policy within government, one interview respondent remarked that there are numerous cross-ministry efforts stemming from IAC activities and recommendations.

Those more critical of the lack of tangible outcomes stemming from the IAC suggest that on the fundamental task of an ICH – to break up silos and achieve coherent alignment of services across sectors – the Alberta IAC cannot yet claim much success. Multiple interview respondents indicated that there has been limited sectoral realignment from corrections, child welfare or the health care system, the discharge policies and practices of which have major implications for homelessness. One of the critical voices suggested that the Alberta Plan to End Homelessness says that these sectors must not discharge individuals into homelessness, but "unfortunately we have not seen a favourable response from corrections in that regard, [and while] health understands it a bit more, [they have] not been active [enough] in the local communities [to have an effect]." Another respondent was more forgiving, suggesting that the IAC has largely

completed its mandate – to provide credible and actionable recommendations to the minister – and that the onus for implementation is on government, not the IAC. On the measure of outcomes, one respondent closely involved with the IAC suggested that it is sometimes difficult to make a case to the community about the work of the IAC because much of it remains confidential (as they are formally advising a minister), but also because IAC annual reports to be distributed to the community have not been approved by the minister. As such, "we can talk in general terms…about what we are doing [at the IAC], but nothing specific, which weakens our legitimacy [out in the community]."

ICH Governance Reflections and Lessons

The central lessons from the U.S. state-level ICHs examined earlier is that conditions for success must first involve a mandate and scope of activity that is expansive – the Texas ICH meets that condition, whereas the Ohio ICH faces criticism for too narrowly focusing on the chronically homeless, with much less attention given to prevention measures like those around income support, education and employment, which would be more characteristic of a systems planning philosophy. Indeed, the U.S. ICH guide for state ICHs suggests that successful state ICHs will include representation from and policy relevance to "mainstream income support, health care, behavioural health, human services, veterans, housing, corrections, transportation, education and labor departments and agencies" (USICHb, 2003: 11). The second key lesson from the Ohio and Texas ICHs is that funding scarcity, in particular federal funding, is a key barrier to sustained success. In both examples it is evident that choices are critically constrained by funding pressures, resulting in half-measures or inconsistent efforts that stall progress towards ending homelessness.

In addition to these larger lessons around mandate and funding from the cases, devising and operationalizing an ICH is not an easy task – a lot of decisions need to be made with respect to its authority, membership and governance structures – and thus there are also practical considerations associated with getting an ICH off the ground. As such, we asked our interview respondents involved with the IAC to reflect on the features of governance that work well, as well as those which represent barriers to the achievements of the goals of the IAC.

IAC associates interviewed uniformly identified that the governance model of the IAC as a "collaborative policy forum" that operates on the basis of consensus is perhaps the best feature. One respondent confirmed that the Alberta Secretariat for Action on Homelessness looked at the U.S. interagency councils as examples, learning that effectively addressing homelessness required a lot of different partners to be involved, particularly those from the community. Another respondent indicated that while not every issue is resolved on a consensus basis, "there has been a tremendous amount of consensus around the table, which points to the members' willingness to part with their own agendas" after considerable discussion and exchange of ideas. Others confirm that the "consensus model is a good thing, [although] a majority vote would be easier, it is a better model to try to achieve consensus." It is remarkable that consensus is achieved regularly among 30-plus IAC members. One respondent claims that she was "initially aghast at the thought of a 30-plus council, but it has worked well." This is partly achieved because the most important work is done at the subcommittee level, which is

then approved or refined by the larger IAC. Although not formalized, the co-chairs and the subcommittee chairs meet before each full IAC meeting to discuss achievements, direction and challenges, which from a governance perspective is more manageable than 30-plus person strategy sessions.

In terms of leadership, there are both positive features of governance as well as features that may need to be reformed. Most interviewed suggested that having an MLA as a co-chair of the IAC is a very good thing, as "they can speak to the minister and government caucus as a colleague," which is important to keep the issue salient for elected decision makers. This is consistent with the findings in the U.S. ICHs that suggest that leadership from elected officials, in particular the respective governors' offices, is an essential component of success (USICHb, 2003:). One area identified by a number of the interview respondents touches on the varying levels of sustained commitment among the representatives of the associated provincial ministries on the Alberta IAC. Interview respondents were pleased to see the high level of engagement of one of the provincial government representatives and are hopeful that this level of engagement will be reflected among all provincial government representatives going forward. Multiple interviewees felt that lack of engagement could pose a risk to successful systems planning and integration at the provincial level. One respondent suggested that "if all [provincial government representatives] were like the [engaged one], the IAC could be way farther ahead on achieving its goals and priorities." Another claimed that "overall the intent is good – [it] is great to have senior level people involved directly in homelessness in the community, but there needs to be money and government to act on the recommendations… or else it doesn't work."

One barrier to the success of the IAC, identified by a number of interview respondents, was that while the IAC has a key formalized avenue to advise the Minister of Human Services, this does not extend to other ministers in charge of relevant files. To one respondent, "when recommendations relate to other sectors [like corrections, for example], it can be difficult [to generate change] because the jurisdiction is outside of the department [of the Minister of Human Services] – it puts the onus on that one minister to work with his/her colleagues." Part of the challenge, according to one respondent, is that "some of the areas of work by the IAC tread on some [other] sectors, and they are uncomfortable with that. Everybody is on board [theoretically] until it impacts them," which is when the IAC encounters resistance, as their mandate is to come forward with recommendations that challenge the status quo. Another respondent reiterates that "we send a recommendation to the one minister, but we don't know how or if those recommendations are getting through to more than one minister [or Cabinet as a whole]."

In this vein, a number of interview respondents suggested that the reporting line could be enhanced as a means to improve the systems integration and change efforts. For example, some suggested that the IAC reporting to one minister may not be sufficient, and that they should either be able to advise or report to multiple ministers or even the premier in order to achieve a truly government-wide lens. Perhaps an even larger problem, according to multiple respondents, is the frequent turnover of ministers (and premiers) in recent years in Alberta, which "creates uncertainty and grinds everything to a halt." This is also a challenge identified in research and lessons from U.S. ICHs, which acknowledges the difficulties of elected official turnover, which can be mitigated by a governance structure that empowers the long-term committed ICH members from the community to maintain continuity and an "emphasis on partnership, not partisanship" (USICHb, 2003: 16).

CONCLUSION

In recent years, Canadian communities have realized that despite efforts to address homelessness, their responses have had mixed results. A 2013 Canadian Alliance to End Homelessness (CAEH) report proclaimed that "all levels of government – federal, provincial, regional, municipal and aboriginal – must show leadership, strategic engagement and investment…[and] that challenge now is to work together, across all levels of society, to coordinate and implement successful prevention and intervention programs and policies that will put an end to homelessness" (2013: 33). The report emphasizes that although Canada has been recognizing the need to have a more collaborative, systems-based approach to ending homelessness, there still continues to be a lack of affordable housing. The lack of sufficient affordable housing remains a critical risk to the objective of ending homelessness in Canada.

However, the CAEH report does not propose the creation of a federal interagency council as in the U.S., presumably due to the fact that provinces control the main areas of jurisdiction relevant to ending homelessness. Similar to the American model of state interagency councils described in this chapter, Canadian provinces can adopt plans and governance institutions tailored to the specific needs of the homeless in their respective provinces. Although there have been laudable efforts in other parts of Canada to reduce homelessness, Alberta has demonstrated the most collaborative and strategic effort at the provincial level. A number of lessons emerge from the analysis of the first two years of the Alberta IAC that are not only important as Alberta refines its approach, but also as other provinces contemplate similar interagency governance institutions to promote systems planning and integration to end homelessness.

Features of the Alberta IAC that other provinces would be encouraged to mimic would be (i) genuinely inclusive, cross-provincial membership from community and government, (ii) a consensus model of deliberation and decision making, and (iii) elected official leadership on the council as a means to remain on the agenda of government. There are also features of the Alberta IAC that represent barriers to the goals of ending homelessness, including (i) frequent leadership turnover in the bureaucracy, IAC leadership and even the premier's office, that has stalled systemic change efforts, (ii) the single-minister advisory role of the IAC is a limitation and ought be expanded to other relevant ministers and (iii) the lack of public information disclosed about IAC advice and activity harms its public awareness and legitimacy within the community. While it may be attractive to some to contemplate a situation in which IAC possesses the institutional authority and legitimacy to make decisions on its own, rather than as an advisor to government, this represents a challenge to norms of public sector accountability, especially when major systems and public expenditures are at stake. We should resist temptations to exclude elected officials

from homelessness issues for the sake of more strategic policy and planning, and instead find ways to draw them into the debate such that it is an issue that remains a high priority on their agenda, regardless of the ideological orientation of the governing party.

As a pioneer of interagency councils to end homelessness in Canada, Alberta has shown promising leadership, but has also experienced the growing pains of trying something new and innovative. A forthcoming internal review of the Alberta IAC demonstrates a desire to reflect on the first few years and to identify refinements and opportunities to sustain the effort to end homelessness in Alberta. Systems planning and integration as it relates to homelessness demands that all Canadian provinces take stock of their suite of policies and programs and understand how they fit with each other. The Alberta IAC demonstrates that it is an appropriate venue for such discussions and reform recommendations. Likewise an interagency council at the federal level, as we have seen in the U.S., or some other national collaborative body, could lead to greater national collaboration and greater support for future provincial interagency councils.

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High-level Governance
Challenges and Opportunities

4.5

SYSTEM PLANNING:
A CASE STUDY OF THE CALGARY HOMELESS FOUNDATION'S SYSTEM PLANNING FRAMEWORK

Katrina MILANEY

INTRODUCTION

System planning in Canada has been understood and contextualized within a number of disciplines and frameworks. For example, within the province of Ontario's Health Planner's Toolkit, system planning is a "functioning system of health services… like the connectivity of the human body… and requires command centers, a supportive contextual infrastructure and a series of linked and inter-supporting activities" (Ardel, Butler, Edwards & Lawrie, L. 2006, p.5). Some human service organizations in Canada have taken up system planning to look for and fill gaps in their current model, as well as "identify opportunities for better integration, streamlining and coordination between service providers, agencies and resources" (Ontario Municipal Social Services Association, 2014, p. 4).

Programs and services for people experiencing or at risk of homelessness have been in existence in Canada for several years; however, conceptualizing and implementing a "systems response" or coordinated system planning within the homeless-serving sector is a contemporary approach. In other countries, system planning to address homelessness emerged much earlier. For example, in Australia there was a shift in the 1970s towards the coordination of services to support people to end their experience of homelessness (Neale, Buultjens & Evans, 2012). In the U.S., system planning has evolved over the last three decades following legislative changes in the 1980s that led to several 10-year plans to end homelessness (plans) in jurisdictions across the U.S. These plans prioritized community-based support programs like low-barrier harm reduction housing for chronically homeless adult singles (e.g. Housing First) and included data collection on client, program and homeless system-level outcomes. This helped generate research and evaluative studies that showed the economic and social value of coordinated and intentional systems of care (Leginski, 2007). In Canada, system level coordination of homelessness practice and policy has really only emerged within the last decade. Much of this shift can be attributed to research and data from other jurisdictions like Australia and the U.S. that showed improved stability, health and well-being for people and reduced costs and strain on public systems. This work influenced community leaders in several Alberta cities and helped initiate government support

and funding for plans to end homelessness. Seven cities in Alberta created and implemented 10-year plans, including Calgary, which was among the first in Canada. The Calgary Homeless Foundation (CHF) emerged as the leading community-based organization to implement, monitor and adapt Calgary's 10 Year Plan to End Homelessness. Many of the goals and strategies in this plan are modelled on plans from the U.S. that prioritize Housing First, standardized practices, consistent data collection and measurable outcomes for continued improvement.

Regardless of the jurisdiction, discipline or discourse, system planning is arguably necessary to better understand and improve the coordination, integration and intersection between and amongst specific service components. Turner in 2014 described system planning within a Housing First context as "a method of organizing and delivering service, housing and programs that coordinates diverse resources to ensure that efforts align with homelessness-reduction goals" (p. 7). In this chapter I take up this understanding of system planning and apply it to a case study of CHF's System Planning Framework (CHF, 2014), a tool created as one component of the overall system's approach to ending homelessness in Calgary. The intention is to share learnings which may be helpful to community leaders and service providers as more and more cities across the country make commitments to end or reduce homelessness.

A case study approach was used to examine Calgary's approach and framework in particular, as a case study allows an analysis of an individual case, person, organization or community that focuses on the developmental aspects of the unit or the process of its development (Yin, 2009). Advantages of case studies include a deep understanding of context and process and a high conceptual validity (Flyvbjerg, 2011). A case study is particularly appropriate here because it allows for a detailed examination of the process towards system planning and the development of the framework itself. The intent is not to say that the approach taken by the CHF was the "best," but rather to present the process and share learnings, strengths, issues and opportunities. The chapter concludes with suggestions to ensure the system can be further strengthened towards expansion and sustainability and to meet the complex and diverse needs of those experiencing homelessness in Calgary.

BACKGROUND AND PURPOSE

According to Cresswell (2009), the purpose of a case study is to engage in an in-depth examination of a "bounded" activity, event, person or organization within its contextual environment and it should therefore occur over a sustained period of time. In a case study, context is important as, according to Merriam (1998), to understand the development and process of a particular case it is impossible to separate the phenomenon from that context. Information for this case study comes from several years of professional experience in reviewing and generating research and data and incorporating them into recommendations for strategic decision making and planning. I spent four years as a strategy lead for a community coalition to understand and reduce poverty and then five years in research and strategic planning at the CHF. My discussion of system planning and the System Planning Framework is from an insider's perspective in that I supported and then led strategic and evidence-based decision making and system planning from 2009–2014. Because of my close involvement with the subject matter, it is important to highlight my

Information for this case study comes from several years of professional experience in reviewing and generating research and data and incorporating them into recommendations for strategic decision making and planning.

own process for researcher reflection throughout this case study (Cresswell & Miller, 2000). While my experience created certain advantages in terms of understanding and articulating process and context, it also required continuously reflecting on my own biases (Finlay, 2002). To mitigate those biases, this case study is presented for information sharing only, and not necessarily as an example of a best practice. In addition to my learnings and observations over five years, this case study included a review of several documents: the three iterations of Calgary's 10 Year Plan, two iterations of the System Planning Framework and five years of the CHF's annual Strategy Review report.

When Calgary's 10 Year Plan was launched in 2008 and updated in 2011, three phases were described as necessary to achieve the Plan's goals. Phase one was to "create rapid, meaningful and visible change." Phase two was "building a homeless-serving system to end homelessness" and the final phase was "fine tuning the Plan for sustainability" (Calgary Homeless Foundation, 2012, p. 6-7). The foundation of Calgary's system was created in phase one with the addition of several new housing and case management programs and was enhanced in phase two with the addition of several initiatives and strategies to assess the effectiveness of the Plan's goals and to better coordinate service delivery. As Calgary is moving into phase three, the CHF and its partners have an opportunity to ensure system planning is sustainable towards and beyond 2018.

As Calgary is moving into phase three, the CHF and its partners have an opportunity to ensure system planning is sustainable towards and beyond 2018.

I was hired as a Research and Policy Analyst at the CHF in 2009 and worked in that role until 2012 when I was promoted to Vice President of Strategy. When I was hired, Calgary's 10 Year Plan was in phase one, and so our focus was generating new funding and creating a number of housing and support programs for people experiencing homelessness, e.g. harm reduction for chronically homeless men, programs for women and families fleeing exploitation and violence and youth being discharged from correctional facilities. During this time we also built a research and public policy agenda to begin to generate local data and evaluation protocols to measure the impact of our efforts. The strategy portfolio included research and policy, the Homeless Management Information System (HMIS), data collection, program performance and evaluation and system planning. In addition to evaluative qualitative and quantitative information, community consultation was a key strategy towards developing organizational and community priorities, identifying environmental stressors/factors and developing solutions. This was formalized through the creation of the System Planning committee which included more than 30 people from service agencies, the public sector, academia and government. This committee met quarterly to determine the critical components necessary for effective system planning. This committee was a driving force behind phase two of the Plan: "building a homeless serving system to end homelessness" (Calgary Homeless Foundation, 2012, p. 7). This committee identified the need for cross-sector collaboration with provincial Health and Justice Ministries to reduce discharging from public systems into homelessness and the need to better coordinate intakes and assessments to reduce barriers for people entering housing and support programs. An outcome in 2011–2012 was the first iteration of a System Planning Framework that included definitions and processes to assess the effectiveness of the system of care.

SYSTEM PLANNING AT THE CHF

The CHF has been committed to ongoing learning and development since it began funding housing programs in 1998. This commitment led to its shift to lead implementer of Calgary's 10 Year Plan in 2008. In its first iteration, Calgary's Plan articulated a commitment to being a "living document"—one that would be revisited and updated on a regular basis to reflect new and emergent learnings. System planning was identified as the priority approach because it was known that more than 130 agencies in Calgary were providing supports to people experiencing or at risk of homelessness. This system was difficult to navigate for service providers, let alone someone trying to access supports on their own. The intention behind strategic and evidence-based system planning was to build capacity and improve services for people by ensuring that programs follow certain standardized practices, that budgets match the level and intensity of the program model and that people are accepted into support programs that match their level of need.

This approach is important because ending homelessness long term is complex and does not exist in isolation of other social issues, or of broader structural forces like culture, economics and politics. There is research to show that the pathways into the child welfare, justice and emergency shelter systems are similar (Covington & Bloom, 2003; Kohl, Edleson, English & Barth, 2005; Tutty el al, 2013) and that many people experiencing homelessness are also experiencing or have also experienced family violence, mental health issues, substance use, poverty, under or unemployment and/or a lack of social supports. While homelessness occurs across the lifespan and within several cultural groups, in Canada Aboriginal people are over-represented amongst homeless groups and women (Patrick, 2014), children and youth have particular vulnerabilities related to age and risk for violence and exploitation (Worthington, et al, 2010; Homes for Women, 2013). Broad socio-political factors that create and often exacerbate the issues include a lack of affordable and appropriate housing options, stigma, racism and exclusionary public policy that creates barriers for those on the margins of society (Bassuk & Rosenburg, 1988; Shlay, 1994; Bassuk et al., 1997; Paradis, Novac, Sarty, & Hulchanski, 2008; Barrow & Laborde, 2008; Broussard et al., 2012). While each individual or family's experience is different, the level of vulnerability and complexity of support needs is usually the result of the combination and cumulative effects of these factors (Frankish, Hwang, & Quantz, 2005). Therefore, by shining a light on the experience of homelessness and creating a coordinated system of care to respond, we have the potential to positively impact other social, political and economic phenomenon.

Incorporating several components or processes into system planning was intended to create an adaptable, nimble and responsive system of care that could be adjusted based on changes to broad social, economic and political shifts, but also to the individual and diverse needs of people experiencing homelessness. This was done in a number of ways: the creation of an annual research and public policy agenda, an annual strategy review (of key indicators, emergent research and program outcomes), initiation of consistent methods of data collection (annual point-in-time count and HMIS), and through active participation in a number of committees and community initiatives.

Research and Public Policy Agenda

The annual research and policy agenda was created so that we could propose evidence-based alternatives to service delivery and public policy. For example, in the U.S., a low income housing tax credit provides incentives to private sector developers to build and sustain affordable housing units, particularly relevant in a city like Calgary where approximately 6,000–14,000 new units of housing are built annually (Canada Mortgage and Housing, 2014). The CHF did a feasibility study including the implications of implementing this tax credit and duly recommended its creation to the federal government.

Annual Strategy Review

The annual Strategy Review report included analysis of environmental factors like vacancy rates, average rents and employment and migration rates, as well as local, provincial, national and international emergent research, and a review of each CHF-funded program. The intention was to assess strengths, identify areas to build capacity and then implement needed changes to program models and budgets based on established best practices. The information in the Strategy Review was used to develop recommendations which were presented to community partners. This information supported 10 Year Plan strategies but also further informed investment decisions, policy and advocacy strategies and government relations.

Data

We coordinated annual point-in-time counts to assess changes in the overall numbers and basic demographics of people experiencing homelessness and included HMIS analysis at the agency and program level to assess more detailed patterns in demographics, presenting issues and movement through programs.

Committees and Community Initiatives

Involving community partners and soliciting feedback is integral to system planning. CHF staff have participated in a number of committees and initiatives including the Calgary Action Committee on Housing and Homelessness, Aboriginal Standing Committee on Housing and Homelessness, Calgary Youth Sector, System Planning and Discharge Planning committee, and the Client Action Committee. These groups have contributed substantially to ending homelessness initiatives in Calgary, including the development and implementation of plans to end Aboriginal and youth homelessness and the creation of the System Planning Framework.

The intention behind the CHF's approach to system planning is to use the information collected from a variety of sources and their feedback loops to create purposeful and strategic processes for decision making in order to strengthen our capacity to build and coordinate a system of care that was responsive to the complexities of Calgary's services and client needs. The original intention was to observe and assess the full continuum of options with the ultimate goal of improving the client experience. It was understood that although the basic principle underlying our 10 Year Plan was simple, i.e. everyone deserves and can be successfully housed and supported, the implementation of a system of care that is responsive to the diverse and complex experiences of people is difficult and requires a fully integrated system that is well resourced, collaborative and assessed and improved along the way.

It is important to note that the system and the components within it are not finished. There is still much to learn; hence the intention of creating a system with measurable outputs and outcomes and embedding them within a culture of learning—continuous learning for continual improvement. Gaps and barriers that are identified through system planning, e.g. a lack of appropriate and affordable housing options for people with very complex safety

and mental health needs, can be seen as an opportunity for improvement through evidence-based advocacy and strategies to fill those gaps.

It should also be noted that taking up one of the strategies described above to make decisions may not be sufficient. Instead, each component tells a part of the story and, viewed together, these evidence points give a more fulsome and comprehensive picture of the system as a whole. For example, in 2012–2013, Calgary's economy was returning to a "boom" cycle. Having recently recovered from the global recession, unemployment rates were dropping, migration rates to Calgary were increasing and, subsequently, rental stock was both decreasing in availability and increasing in cost. Calgary's flood in 2013 exacerbated an already tight rental market and service agencies within the homeless-serving sector were reporting increased numbers in emergency shelters and increased demand for basic needs services. In addition to learnings from the HMIS, several community-based committees that included service providers and people with lived experience suggested that the lack of affordable housing stock and limited diversity of housing options was an issue that the CHF should take up in order to find solutions. Consequently the CHF led a collaborative project to formalize relationships between private sector landlords and community service agencies to bridge communication gaps and ultimately increase agency access to rental units specifically for people experiencing homelessness.

CASE STUDY: CALGARY'S SYSTEM PLANNING FRAMEWORK

The first CHF System Planning Framework was created in 2011 to align the 10 Year Plan's vision to end homelessness with achievable and measurable goals. The Framework emphasized the use of evidence for decision making, including data, research, program learnings and community feedback and advice. Although the CHF was the lead organization, it was noted that expertise from the community, whether agency staff or people with lived experience, was key to successful implementation. The primary components of the Framework were descriptions of program models, tools and indicators to measure and evaluate the system of care and methods to assess success, including quality assurance. These are important to help ensure that people are referred to the program that can best meet their needs. In other words, the right people can be matched with the right program. For example, women or families fleeing violence can be referred to a program that offers place-based housing with intensive case management created specifically for the safety and trauma support needs of women and children. It also facilitates efficiencies as program staff have shared understandings and can use common language. The framework was reviewed and updated in 2013 to ensure that the definitions and key concepts were reflective of new learnings emerging in local, provincial and national best practice research. The description below is from the 2013 version of the Framework.

The primary components of the Framework were descriptions of program models, tools and indicators to measure and evaluate the system of care and methods to assess success, including quality assurance.

THE KEY COMPONENTS OF THE SYSTEM PLANNING FRAMEWORK

Program definitions:

Calgary's system of care includes eight distinct but complementary program types that are consistent with those used by Alberta Human Services (the primary funder in Alberta of housing and support programs) to allow a comparative analysis across the province. They include: Prevention, Outreach, Triage, Assessment and Diversion (which has been operationalized through Coordinated Access and Assessment [CAA]), Emergency Shelters, Rapid Rehousing, Supportive Housing (which includes short-, mid- and long-term supportive housing), Permanent Supportive Housing, Graduate Rental Assistance and Affordable Housing. While each is tailored for a particular group and/or level of support needs, together they are intended to provide diverse and varied options to support diverse and varied needs.

Prevention: A homelessness-prevention program is designed to target and provide short-term financial and case managed supports to individuals and families at imminent risk of homelessness before an experience of homelessness. This is typically understood as having extremely low income and a housing crisis such as an eviction notice. Because the intervention is meant to be short-term (three to six months) there is an expectation that the person or family in need can demonstrate long-term financial stability post-intervention. Typical interventions in a prevention program include counselling and advocacy including referrals to community resources and short-term assistance for rental or utility arrears, often to offset a temporary gap in employment. Understanding the effectiveness of prevention programs is critical in order to determine if the program has an impact on reducing the incidence and prevalence of homelessness. The CHF's HMIS system is one way to do this as it can show if after receiving an intervention in a prevention program, that individual or family enters an emergency shelter in the future.

Coordinated Access and Assessment (CAA): The intent of CAA is to streamline access into housing and support programs regardless of where the person or family enters the system. Each participating program uses the same assessment tool at intake and case managers meet weekly to determine who is in the greatest need and which program is the appropriate fit to match the person's or family's level of complexity. It has two primary components: place-based or a specific location where people can come in and do an intake assessment, and through several agencies who use the same tools and processes when people access through that particular agency, and a mobile component whereby CAA staff can go onsite to emergency shelters and conduct assessments with people staying there. In this way, a person or family only has to do one intake and then the referrals are done on their behalf by agency staff and those with the greatest needs are prioritized.

Emergency Shelter: An emergency shelter provides temporary accommodation and crisis supports. Shelters play a key role in the system of care often because they are the first point of entry into the homeless-serving system for individuals and families. Emergency shelters can participate in CAA in order to facilitate referrals to housing and support programs.

Rapid Rehousing (RR): RR programs are designed for people who are unable to end their experience of homelessness without support. Rapid rehousing is meant to be time limited and provide low- to moderate-intensity support. Typically people referred to RR programs have financial barriers but less complex issues than someone who would be referred to a permanent supportive housing program. Often people who are appropriate for RR have demonstrated success in housing stability in their past but are facing a particular issue like sudden job loss or family breakdown. The program elements include short-term rental assistance and light touch case management like referrals to community resources.

Supportive Housing (SH): SH programs are designed for people with moderate- to high-complexity needs. In addition to financial barriers there may be issues with substance use and/or mental or physical health. While there is no mandated length of stay for the program, case managed supports are designed to reduce dependency, improve health and increase stability. People in supportive housing programs will likely be able to sustain their housing without case managed supports after a period of time. In Calgary, supportive housing programs can be place-based, in a dedicated multi-unit building used exclusively by the program, scattered site, or private rental units across the city They can also be harm reduction or abstinence-based (depending on the wants and wishes of the individual or family) and the case management model typically follows either Intensive Case Management or Assertive Community Treatment guidelines.

Permanent Supportive Housing (PSH): PSH is a long-term supportive housing program with no maximum length of stay. People referred to a PSH program are considered to be amongst those with the most complex support needs. In addition to financial barriers people may have severe and/or chronic mental and physical health issues or disabilities. Although it is possible for some people to improve their health and well-being enough to move on to more independent living, it is assumed that the majority of people in PSH programs will always require some type of support to sustain their housing and prevent a return to homelessness.

Graduate Rental Assistance Initiative (GRAI): GRAI is a rent supplement program designed for people who have been through and finished a housing and support program but who may still need extra financial supports. People in scattered-site units are able to stay in their housing and continue to receive a rent supplement until they have enough income to sustain it on their own. The intent of the program is to reduce the risk that a person or family will lose their housing and return to homelessness once case management supports are over.

Affordable Housing (AH): AH are housing units with rents considered to be below the average market rent for that unit size. Affordable housing is primarily income based and often provides no or minimal support interventions. While there is often no time limit, people are likely assessed annually to ensure they still require AH.

Measuring and Evaluating the System of Care

HMIS: The HMIS is a web-based information technology system that is managed by the CHF and was modelled after similar systems in the U.S. It is designed to collect client-level data in order to assess indicators like who is being housed and who is successful or unsuccessful in sustaining that housing. At the individual level, HMIS can help us understand the support needs of people entering the system. These needs can also be reassessed several times while the person is in the program and can therefore help the CHF and service providers to understand whether or not the program is a good fit. At the program level, HMIS shows how many people are being housed each month and how many are leaving the program. It can also indicate if the program exit or discharge was because a person has successfully moved on or if they were evicted and why. This is an important tool as it can identify red flags or opportunities to discuss with the program staff what the issues may be, e.g. perhaps the program is understaffed and needs additional resources. At the system level, all programs of the same type (e.g. PSH) can be compared to see if their clients have similar characteristics and outcomes, as well, if there is a sub-group (e.g. youth) that is more or less successful in the program. The data can be compared because each program asks the same 10-12 questions or universal data elements (UDE's), e.g. name, age, gender, cultural background, last known address and housing needs. Further questions are tailored to the specific program type, e.g. all prevention programs ask about housing history whereas supportive housing programs ask about homelessness history. Because a number of emergency shelters in addition to housing programs are utilizing the HMIS system a person or family's flow into and out of homelessness can be followed. For example, we can understand how many people accessing homelessness prevention programs were unsuccessful, or ended up in an emergency shelter post-intervention.

These are important sources of information for system planning, not because HMIS data tells us what the problem is, but because it can facilitate further discussion to understand the context of the issue and, more importantly, potential solutions. Finally, service providers (and the CHF) can submit the data from the HMIS system to their funders to satisfy requirements for client and program level outcomes.

Quality Assurance

Data collection and analysis is one aspect of evaluating the effectiveness of the system of care; however, applying multiple methods broadens and deepens the evidence and decision making process. The CHF has created a system-wide annual program review whereby they interview frontline staff, case managers and management staff in each funded program. In addition, a survey is sent out to all clients currently in housing programs. The intent is to capture perspectives and experiences as well as provide an opportunity to give feedback directly to the CHF.

The CHF also undergoes its own annual review with its funders through quarterly and annual reports to the federal government and an in-person on-site review. This review typically occurs over the course of two days whereby representatives from Alberta Human Services review policies and financial documents, meet with staff and visit a few funded agencies to collect further feedback. A report with recommendations for improvement is submitted and follow-up is expected.

DISCUSSION

The analysis of documents, experience and observations leads to a discussion of opportunities and issues, as well as suggestions to ensure the hard work of the first six years of Calgary's system planning approach can be enhanced. The system of care just described creates a foundation of language, tools and indicators to measure and evaluate success, collect learnings and propose improvements within the system as a whole; however, there are broader learnings that must inform the future development of system planning and the Framework itself:

1. ***There is no such thing as perfection in system planning.***

Current program models and definitions were largely developed based on literature and evaluative studies from other jurisdictions. Their effectiveness in terms of being able to adequately, appropriately and safely support people is consistently monitored and improvements are made. Having clearly defined program types is meant to provide clarity to program staff, to facilitate referrals as appropriately as possible and to satisfy the needs of funders in terms of providing an assessment of outcomes. The intent is to ensure that if an individual or family is referred to a program and is not successful in that program agency staff and/or case managers can then facilitate a referral to a more or less intensive program model. Unfortunately, assessments, triage and referral processes and quality assurance processes are not perfect, but we can do better by having structured processes in place that are meant to reduce gaps and barriers, particularly if they are consistently evaluated and improved.

2. ***Client choice must be prioritized.***

Individual and family needs and wishes must be at the forefront of decision making. HMIS, CAA, and the System Planning Framework are tools to improve efficiency and effectiveness but the people accessing the programs must be supported to decide their own futures. Calgary's intent was to build a system of care that included a variety of program models and system navigation tools so that regardless of individual needs and wants there was a program to match; however, there are still gaps that need to be filled. The System Planning Framework and associated tools give us details at the person, program, agency and system level that help us to learn about these gaps and to try and fill them, but ultimately there is no true success if we can't be cognizant, responsive and respectful of peoples' wishes and wants in addition to their assessed needs. Ensuring that there are consistent and meaningful opportunities to listen to and learn from people accessing programs should be prioritized.

3. Challenges are opportunities for learning.

Many tools and processes have been created in the last six or seven years in Calgary, and all of them came with challenges. For example, CAA is a practice used pervasively in ending homelessness plans in the US. Its intentions are good: reduce barriers, streamline access and fill gaps; however, there aren't currently enough financial resources or stock of affordable housing to support everyone who needs it. The result is a number of people being assessed with no program space to refer them to. This should not be seen as a failure of CAA. The CHF and service providers in Calgary's homelessness sector now have a deep and broad understanding of the support and housing needs of some of Calgary's most vulnerable people. CAA has also helped articulate the capacity that needs to be added. This issue, although difficult to deal with, is an opportunity for the CHF and its community partners to advocate based on sound evidence and to build government and private sector relations to fill these gaps.

4. The success of system planning is dependent on community support and continued leadership.

The first two phases of Calgary's plan were fast moving. System planning, while intended to create efficiencies and improve the client experience, created many demands on agencies delivering housing and support programs. Implementing new definitions and discourse, HMIS reporting, CAA and annual program reviews has created a continuous learning and feedback loop, but also created an administrative burden for homeless-serving sector partners. The overall growth of homelessness has stabilized in Calgary since 2008; however, there are still more than 3500 men, women and children experiencing homelessness in Calgary on any given day (Calgary Homeless Foundation, 2014), thousands more who will access an emergency shelter each year and more still who are at imminent risk of becoming homeless. Meaningful engagement and community support are necessary to sustain and build upon the work to date. While Calgary's 2015 updated plan articulates the need for "community ownership and collective leadership" (Calgary Homeless Foundation, 2015, p. 4), it is critically important to clearly define roles. The CHF has been mandated to lead the implementation of the Plan since its inception in 2008 and should balance this role with authentic and respectful community collaboration or risk losing momentum.

CONCLUDING THOUGHTS

Examining the approach to system planning and the particular framework developed in Calgary is an opportunity to add to the dialogue and shared knowledge as ending homelessness initiatives expand across the country; however, this is just one example.

System planning to end homelessness is a fairly new phenomenon in Canada and there is still much to learn; however, implementing strategies to improve service coordination and measure and evaluate impact is important as it creates opportunities to improve outcomes at the person, program and sector level. Examining the approach to system planning and the particular framework developed in Calgary is an opportunity to add to the dialogue and shared knowledge as ending homelessness initiatives expand across the country; however, this is just one example. This examination is an opportunity for other jurisdictions and community leaders to foresee challenges and potentially develop strategies to mitigate. Key learnings from this case study include knowing that perfection is not possible in system planning, client choice must be prioritized in order to ensure responses are relevant and meaningful, challenges should be viewed as opportunities for learning and community support and strong leadership are essential to sustaining an effective system response.

To enhance and sustain the system of care into and beyond Calgary's 10-year timeline, the CHF must continue to lead but build and strengthen partnerships in an authentic way. Phase three of Calgary's plan, "fine tuning the Plan for sustainability" (Calgary Homeless Foundation, 2012, p. 7), is underway. The lessons learned in phases one and two of the plan have revealed the need to adapt interventions and program types to reflect diverse personal experiences. Issues related to health, disability and poverty, vulnerability due to marginalization and social exclusion are not isolated to those experiencing homelessness. The impact of creating a system of care that can respond to diverse personal and structural marginalization has the potential for far reaching impact, including reducing costs and strain on public systems and, more importantly, better addressing and supporting people with complex needs.

Arguably the biggest barrier to effective system planning to end homelessness is the lack of affordable and safe housing options. It is imperative that the CHF lead a community-based movement to engage all levels of government and the private sector into policy change that incentivizes the development of non-market housing. Without an influx of new units, the program dollars to resource them and authentic community involvement, the impact of Calgary's 10-Year Plan and its system planning approach will be weakened.

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High-level Governance
Challenges and Opportunities

4.6

THE "FIRST CITY TO END HOMELESSNESS": A CASE STUDY OF MEDICINE HAT'S APPROACH TO SYSTEM PLANNING IN A HOUSING FIRST CONTEXT

Alina TURNER & Jaime ROGERS

INTRODUCTION

Medicine Hat is a city of 61,180 people and Southeastern Alberta's urban centre (City of Medicine Hat, 2014a). Its economy relies primarily on natural gas, agriculture and ranching (City of Medicine Hat, 2014b). Despite being known as Gas City, due to its role in the resource industry, Medicine Hat has most recently become known for becoming the "first city to end homelessness" (Chan, 2015). In May 2014, community stakeholders launched a refocused plan to end homelessness with an end date in 2015. Though the work had been happening for a number of years locally, considerable attention has emerged since then across Canada and even internationally, evidenced by numerous media articles and news reports (CBC News, 2014; The Economist, 2014; Maki, 2014).

The Medicine Hat Community Housing Society (MHCHS) leads the implementation of the local plan to end homelessness locally. To ensure the implementation of the plan builds on the expertise of diverse partners and shifts to address changing conditions, MHCHS works closely with the Community Council on Homelessness (CCH), which is made up of approximately 20 stakeholders that represent a broad cross section of interests and expertise locally including service providers in the housing and homeless sectors, private sector, police, human services and corrections representatives. This interest in the Medicine Hat approach has led to ongoing requests for information on the 'key ingredients' essential to the community's success and learnings to advance dialogue across communities working to address homelessness. This chapter addresses these requests by focusing on the learnings reported by community members engaged on the ground implementing the initiative.

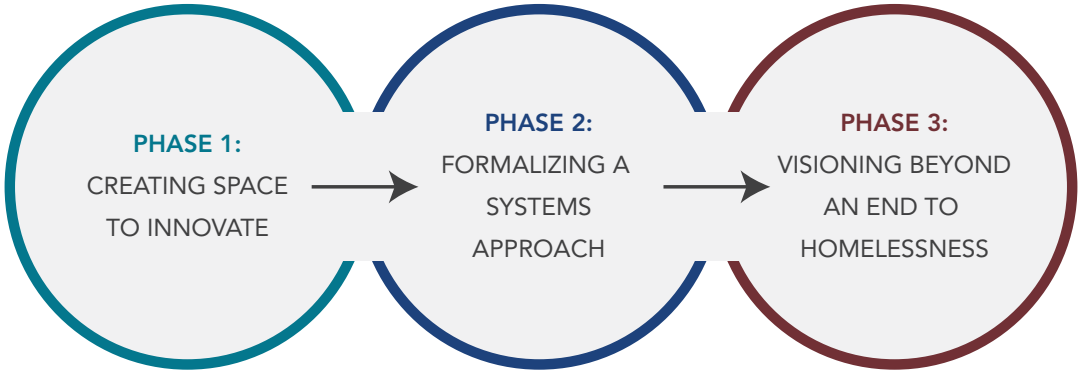
The Medicine Hat approach to ending homelessness relies on Housing First and system planning. The basic idea behind Housing First is simple: provide a person experiencing homelessness with housing and then offer them supports to address other issues they may be facing. Rather than requiring someone to prove their worthiness for housing (such as being sober or getting job, etc.), Housing First considers access to housing as a basic human right. The application of Housing First as a philosophy across the homeless-serving system is essential to making a sustained impact on homelessness.

In fact, one of the first steps in system planning is identifying shared values or philosophical orientations to ensure stakeholders are driving towards common objectives with a shared understanding. "Rather than relying on an organization-by-organization, or program-by-program approach, system planning aims to develop a framework for the delivery of initiatives in a purposeful and strategic manner for a collective group of stakeholders" (Turner, 2014: 2).

"Rather than relying on an organization-by-organization, or program-by-program approach, system planning aims to develop a framework for the delivery of initiatives in a purposeful and strategic manner for a collective group of stakeholders" (Turner, 2014: 2)

While theoretical frameworks are helpful in outlining the broad strokes of system planning in a Housing First context, it is important that the actual on-the-ground process of implementation be considered as well. In fact, the Medicine Hat case study highlights how interdependent and contingent the processes, players, events and resources are within a dynamic and constantly shifting context. The case study traces the evolution of the approach since the early 2000s to present day through three phases. While no recipe of the 'perfect ingredients' is supplied, the chapter highlights key learnings to date that may be of interest to other communities working to end homelessness using a systems approach grounded in Housing First. This is by no means a chapter about how to definitively end homelessness; it is about sharing learnings from key stakeholders engaged in this work in a particular local context as a means of advancing national dialogue on this issue.

FIGURE 1 *Phases of Evolution of the Medicine Hat Effort to End Homelessness*



METHODS

The lead researcher worked with MHCHS lead staff to identify potential participants based on their involvement in the plan to end homelessness and its implementation. Participants were regarded as knowledgeable on Medicine Hat's work in this area and selected to provide a wide array of perspectives as people who work in frontline agencies, community leaders, public system partners and government representatives. Key stakeholder interviews of approximately one hour were conducted with 18 participants from October 2014 to December 2014. A further 10 potential participants were approached, who were unable or unwilling to participate in the project. Detailed notes were taken during the interviews, which consisted of semi-structured questions that had been provided to respondents ahead of time. The table below summarizes the roles of the interviewees to further contextualize findings.

The data collected was analyzed thematically to deduce recurring patterns. Relying on a qualitative research approach based on a grounded theory, analysis of the interviews was undertaken throughout the data collection process rather than as a one-time effort. This enabled an iterative process whereby the interviews could be guided to probe newly emerging themes as the case study work unfolded. Quantitative data available from existing data sources including previous analyses of system performance in the 2014 update of the Medicine Hat plan to end homelessness, the 2015 point-in-time homeless count and available community-level data from the National Household Survey and Canada Mortgage and Housing Corporation (CMHC) were also synthesized to shed additional light on the local context.

This case study has a few methodological limitations that are worth noting, including a relatively short time frame for data collection which hindered the participation of potential stakeholders during a busy period in the late fall of 2014. Some stakeholders may inadvertently not have been included in this process. The researcher and lead MHCHS staff relied on their knowledge in the homelessness field to inform the interview questions included, though this may have missed other relevant areas. As the case study relied on MHCHS staff's recommendations of participants, this will influence reporting bias and thus potentially skew the findings. Despite these limitations, this is an initial attempt to capture learnings at a single point in time. Future research can build on this analysis complementing it with broader stakeholder selection locally and potentially examining the case study in relation to other communities from a comparative lens.

TABLE 1 *Stakeholder Interviewees*

INTERVIEWEE ROLE	NUMBER OF INTERVIEWEES
Academic Researcher	1
Community Volunteer	1
Consultant	1
Management -level Staff in Funding Organization	5
Management-level Staff in Homeless-serving Organization	4
Municipal Official	2
Private Sector Representative	1
Public System Representative	2
Frontline Service Provider in Homeless-serving Organization	1
Total	**18**

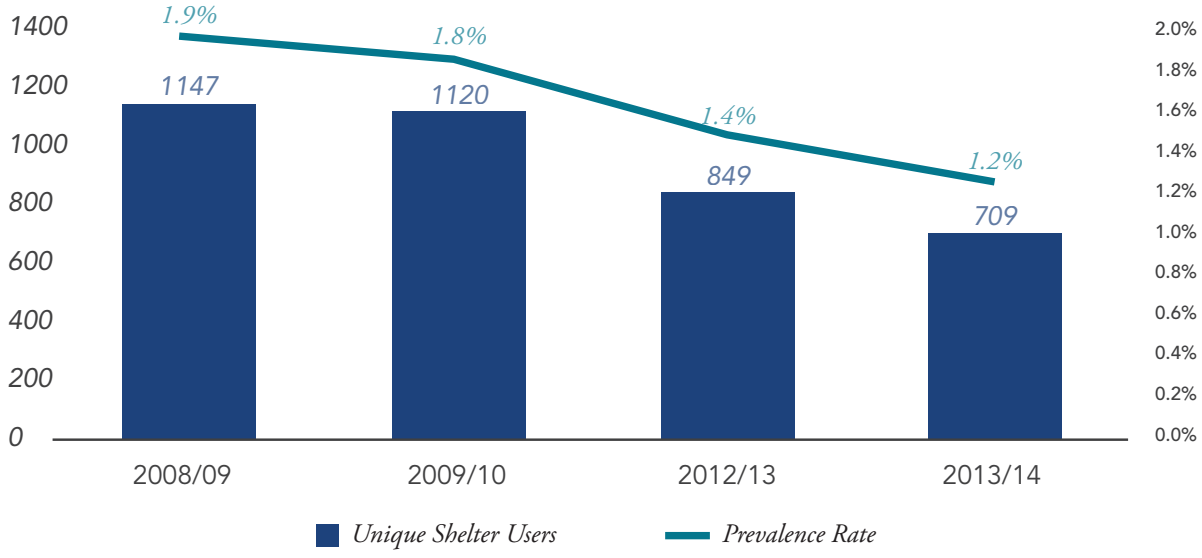
SETTING THE CONTEXT

While the focus of this analysis is primarily on qualitative data from key stakeholder interviews, it is important to also complement findings with figures that add context to the discussion particularly relating to the dynamics impacting homelessness locally. Aside from these concerns about having objective proof to declare an end to homelessness, Medicine Hat's initiative faces some critique with respect to the magnitude of progress. In particular, community stakeholders report concerns they have heard that the "reason we are successful is cause we are small and we don't 'really' have a homeless problem" (Management-level Staff in Funding Organization 1). This section provides contextual information to inform the qualitative findings in the chapter.

Community stakeholders report concerns they have heard that the "reason we are successful is cause we are small and we don't 'really' have a homeless problem" (Management-level Staff in Funding Organization 1)

In terms of housing efforts, from April 2009 to December 2014, 848 individuals had been housed across four Housing First programs funded by MHCHS, including 275 children, with a 72% retention rate.[1] Of those who exited programs, 75% had successful exits to stable housing. Additional data pointing to progress concerns emergency shelter use: the number of individuals using emergency shelter as a percentage of the general population decreased significantly from 2008/09 to 2013/14[2] (City of Medicine Hat, 2012).

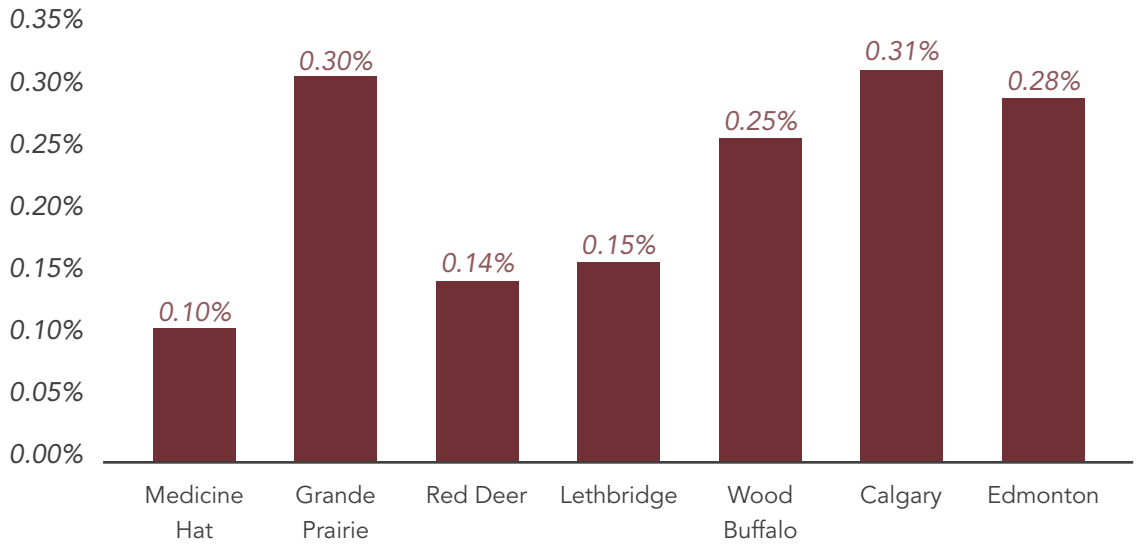
FIGURE 2 *Medicine Hat Emergency Shelter Use Prevalence Rate*



1. Refers to percentage of participants served in period who have successfully exited the program or remain housed as program participants. Calculation excludes exits due to death.
2. The source for the table data on emergency shelter use was found in MHCHS' 2014 Progress Report (MHCHS, 2014).

The provincial homeless point-in-time count conducted in October 2014 found 6,663 individuals to be experiencing homelessness in the province's seven cities. Most of the homeless enumerated were in the two major urban centres, whereas Medicine Hat sat at one percent (7 Cities on Housing & Homelessness, 2015). However, when we consider the proportion of those enumerated as a percentage of the total population in the community, Medicine Hat emerges as having the lowest rate at 0.10%.[3]

FIGURE 3 *Per Capita Homelessness (Point-in-time Counts as Percent of Total City Population)*



Attributing these figures to be a direct and sole result of the Housing First initiatives and the ending homelessness efforts would be inaccurate. Though important factors, it is critical that we contextualize these figures in relation to broader socioeconomic trends, such as population growth. Whilst all seven cities experienced population growth related to the oil and gas industry, Medicine Hat saw a modest growth of 1.2% from 2008 to 2013 compared to an overall average across the seven cities closer to 10% (7 Cities on Housing & Homelessness, 2015: 27).

Moving to housing market trends, the most recent CMHC rental market reports in the fall of 2014 suggest vacancy rates and average rental costs are increasing, with some exceptions. Medicine Hat's average rent was the lowest among the seven cities at $761 in the primary rental market. Despite the comparatively low rental rates, the percentage of Medicine Hatters with a low income is higher than other Alberta communities. As the table below outlines, the percentage spending more than 30% of income on shelter and thus considered to be in core housing need by CMHC is comparable with the other cities in Alberta (7 Cities on Housing & Homelessness, 2015).

3. The per capita rate is calculated with data published by 7 Cities on Housing & Homelessness (2015: 26).

TABLE 2 *Key Indicators Across Alberta Cities*

	Pop. in Low Income (LIM-AT)	Housing Affordability (Households Spending >30% Income on Shelter)	Vacancy Rate	Average Rental Cost	Primary Rental Market Units
Medicine Hat	13.1%	21.9%	4.1%	$761	3,340
Grande Prairie	n/a	22.6%	1.2%	$1,094	3,757
Red Deer	11.6%	26.5%	2.2%	$906	6,093
Lethbridge	11.5%	24.5%	4.8%	$847	3,790
Wood Buffalo	4.5%	18.5%	11.8%	$2,013	2,991
Calgary	10.6%	25.0%	1.4%	$1,213	38,294
Edmonton	10.8%	24.6%	1.7%	$1,103	67,900
Data Source	NHS 2011	NHS 2011	CMHC Oct. 2014	CMHC Oct. 2014	CMHC Oct. 2014

Source of table information: 7 Cities on Housing & Homelessness (2015: 27).

Looking at the results of the 2014 Alberta homeless point-in-time count, a considerable level of migration among the homeless population surveyed is evident. About 18.4% of respondents were new to the community (under one year); however, looking across various communities shows great variance on this issue. Medicine Hat reports a considerably higher percentage at 44.8% compared to other communities. One suggested explanation for the higher proportion of newcomers to some communities is the reduced backlog of long-term homeless people. When the long-term homeless group is removed from the population surveyed, the proportion of those new to the community increases. Thus, it does not necessarily represent a higher mobility in these communities; rather, it may reflect overall rehousing trends in relation to the snapshot methodology used in the count.

The data presented reinforce the need to understand ending homelessness initiatives in a broader socioeconomic context and adjust approaches in real time for those engaged in implementation, funders, policy makers and researchers. Despite these encouraging numbers, the data raise important points about how the broader sector measures the relative success of ending homelessness initiatives, which must be understood in the context of broader socioeconomic trends. As communities begin to publically declare they have in fact achieved the goal of 'functional zero' with respect to ending homelessness (Chan, 2015; Klingbeil, 2015), it will be essential that agreed upon definitions and measures of an end to homelessness are developed and shared at a national level. Despite these promising signs of progress, there is no internationally recognized definition of what an end of homelessness looks like, what indicators and targets communities should use to measure their progress or process of verifying whether a community has indeed met its goal. Though beyond the scope of this chapter, agreement on the specific measures for assessing an end to homelessness will have to be sought at a national and international level.

As communities begin to publically declare they have in fact achieved the goal of 'functional zero' with respect to ending homelessness (Chan, 2015; Klingbeil, 2015), it will be essential that agreed upon definitions and measures of an end to homelessness are developed and shared at a national level.

KEY FINDINGS

Phase 1: Creating Space to Innovate

Building on a Solid Foundation

The context in which the initial community mobilization to end homelessness occurred is closely entwined with the MHCHS. MHCHS has a long history of delivering housing and supports locally, as well as functioning as a coordinating body for homelessness and affordable housing initiatives in Medicine Hat beginning in the 1970s. This foundation enabled the nascent ending homelessness initiative to emerge leveraging existing organizational infrastructure, relationships and coordination mechanisms. One of these coordinating mechanisms included the existing Community Advisory Board (CAB), which oversaw federal homelessness funds. Because of the role of the CAB in community planning and developing funding priorities, Medicine Hat had processes in place to engage diverse stakeholders in conversations about service gaps and emerging trends prior to the introduction of Housing First.

Another pre-existing coordination body was the collective table of seven Alberta cities working on homelessness issues since 2001; Medicine Hat has been an active participant of the 7 Cities on Housing and Homelessness. While the 7 Cities initially began working together as community entities overseeing federal funds, they now coordinate local plans at a systems level and align funding resources for greater impact and progress towards ending homelessness with accountabilities to several provincial or federal funders (7 Cities on Housing & Homelessness, 2014a). The 7 Cities table, like MHCHS, served as a consistent part of the initiative's foundation as a platform for knowledge sharing and innovation that reinforced and helped evolve system planning and Housing First in Medicine Hat. It also provided a strong coordinating backbone for the various communities to advance a common agenda provincially and stimulate investment in Housing First in the first place.

A Provincial Boost

Consultations in the early 2000s consistently re-affirmed the need for more affordable housing and homeless supports. While the federal Supporting Community Partnerships Initiative (SCPI) and the Alberta Homelessness Initiative were valuable resources, a notable shift emerged with the Government of Alberta's investment in innovative program pilots aimed at alleviating homelessness. The resulting Outreach Initiative Pilot Projects (OIPP) initiative committed approximately $16 million to the seven Alberta cities, including Medicine Hat at $2 million over two years (2007–2009) to support innovative projects that assisted in moving people experiencing homelessness towards independent living and stable housing.

Though homeless supports already existed in the community, the influx of the new provincial OIPP funds earmarked for innovative projects provided an impetus in the community to try something new. The emergence of Housing First as an innovative approach to resolving homelessness, particularly for those with complex mental health and addictions issues, coincided with the availability of these new funds as well. Initial OIPP funding was not exclusively mandated to Housing First programs, though the ensuing programs had elements of the approach embedded within them. The projects were also part of a provincial evaluation across the seven cities that introduced a common data set, acuity assessment focused on support needs for program participants and a shared program classification process.

In 2009, the 7 Cities received the contractual responsibility for overseeing provincial investment on a go-forward basis. The success of the OIPP initiative along with collective advocacy across the province resulted in a near doubling of investment to $32 million for the funding stream – now referred to as Outreach Support Services Initiative (OSSI).

Early Transitions to Housing First

As the provincial evaluation of the OIPP pilots concluded in 2009, the Government of Alberta mandated the transition of programs to the Housing First model, where appropriate. This period was described as a 'storming' time full of tension by several stakeholders (Municipal Official 2; Consultant 1; Management -level Staff in Funding Organization 5; Community Volunteer 1) where funding decisions across the province resulted in the closure of some programs and considerable changes in others that evolved into Housing First programs. In Medicine Hat, tough conversations ensued with respect to what Housing First meant for agency operating models and guiding philosophies. As a result, some programs chose not to transition and became defunded during the 2008/09 period. For some, Housing First was not a good fit with the organization's area of expertise or philosophical approach to service delivery. Such decisions signaled the need to make evidence-based decisions on funding for the "good of the whole – we had to leave our agency hats at the door" (Management-level Staff in Funding Organization 5).

During this period, the MHCHS formed a Housing First steering committee to help guide the community's transition from a systems perspective. Here, the community leveraged an external consultant's expertise to help guide and provide critical impetus in the change process. "It was such an eye-opener hearing about Housing First – but we were ready for it" – as one stakeholder noted. The consultant provided the community with a way forward at a practical level, introducing common triage and assessment processes, coordinated intake procedures and highlighting the value of performance management early on. Tensions nevertheless surfaced as Housing First challenged practices and beliefs across the sector and broader community. The use of tax dollars to assist those with complex addictions and mental health issues, considered people who "choose to be homeless" (Municipal Official 2) by the broader Medicine Hat community, was met with resistance and challenged during the early adoption of the approach.

Aligning Efforts

Medicine Hat's adoption of Housing First benefited from the policy shifts underway at the provincial level during this period, which prompted the considerable funding commitments to support ending homelessness initiatives at the community level and a public commitment politically to end homelessness. Being part of the 7 Cities collective further affirmed the local drive for change. This was the period where colleagues in Calgary, Lethbridge and Edmonton were already launching plans to end homelessness, as well as program pilots testing Housing First in practice. A key argument used across communities and provincially was the benefit of Housing First from a cost-savings perspective as well. Though local evidence did not exist at the time, other studies, particularly from the United States, confirmed it was less costly to provide housing and supports to end long-term homelessness as opposed to relying on emergency responses which led to expensive use of shelters, emergency health services, police and jails.

At the provincial level, the Government of Alberta mobilized to adopt a plan to end homelessness in 2008 grounded in Housing First as well (Alberta Secretariat for Action on Homelessness, 2008). The plan called for new investment in program supports and affordable housing to operationalize Housing First and resulted in considerable and ongoing increases in funding dedicated to ending homelessness. Again, the business case argument for Housing First was used consistently to secure increased investment, complemented by emerging evidence from within Alberta on cost savings realized and declining shelter use.

In 2009/10, Medicine Hat received a total of $780,000 in OSSI funds, which rose to $2.8 million by 2014/15: a 260% increase over five years. While it is unclear how the inner workings of the provincial budgeting process were determined to result in the increase, at the community level the 7 Cities continued to report success from Housing First initiatives but also ongoing demand for additional funding to meet program

gaps. Advocacy efforts with the province helped in securing additional funds as well. It is important to highlight that while Medicine Hat continued to receive federal homelessness funds throughout the early 2000s, the amount invested through the Homelessness Partnering Strategy (about $350,000 annually) was notably lower than the resources available from the province.

TABLE 3 *Government of Alberta Investment in Housing First (OSSI) (Alberta Human Services, 2015)*

	2009/2010	2014/15
Medicine Hat	$780,000	$2.8 million
Alberta Total	$32 million	$82.6 million

Coordinating the Implementation of a Plan

While the programmatic transitions to Housing First progressed, the Housing First steering committee began community consultation and planning to develop a local plan to end homelessness. Consultations throughout 2009 culminated in the launch of *Starting at Home in Medicine Hat: Our 5 Year Plan to End Homelessness (2010–2015),* which laid out a vision, key principles and core strategies to realize the goal of ending homelessness in 2015 based on the principles of Housing First. The Housing First steering committee evolved into the Community Council on Homelessness (the Council) charged with governance of the implementation of the plan with the MHCHS as the lead implementing body. As a subcommittee of the MHCHS Board of Directors, the Council is recognized as the community stakeholder group that provides stewardship for the community plan on ending homelessness, serves as an active advisor and makes funding recommendations to the MHCHS board in its capacity overseeing federal and provincial homelessness funds. The Council is made up of diverse leaders in decision-making roles from across government and non-profit sectors including public systems such as health, people with developmental disabilities, community funders, income supports, police, correction, child intervention and poverty reduction. Other members represent the business community, particularly landlords.

It is important to understand the role of the MHCHS as lead implementing agency and funder in this process. During the initial ramp up phase, MHCHS was considered to be "more of a community developer and cheerleader" (Consultant 1) bringing diverse stakeholders to the table and facilitating their leadership in the change process. Over time, the coordinating body took an increasingly central role leading practice change with accompanying funding allocation and monitoring. The current role of the MHCHS in community, which is shared with its counterparts across Alberta cities, includes that of planning lead, funder and performance manager, as well as knowledge leader and innovator (7 Cities on Housing & Homelessness, 2014b). Some of the roles of the coordinating body are in fact mandated through contracts with federal and provincial government – others are assumed as a result of practical gaps at the community level or functions it had already had in community before taking on ending homelessness work.

Building the Foundation of the Homeless-serving System

The early phases of mobilization were remembered as a period of risk taking and innovation. As the community was trying a new approach through its first slate of Housing First programs, the old rules no longer applied – yet formalized processes were also lacking, leaving frontline staff, as well leadership, with a certain amount of freedom to learn through implementation. Despite the notable positive results indicated by emergency shelter use reductions as Housing First programs ramped up, challenges continued. The initiative was met with skepticism and implementing stakeholders worked extremely hard to ramp up and demonstrate success. They continued to leverage existing knowledge, looking to Housing First models elsewhere, research and external experts. The Toronto Streets to Homes model was particularly influential during the initial phase, as one of its key developers played a key role assisting in the roll out of Housing First locally.

Housing First programs also worked to develop an intentional coordinated approach at the frontline level to ensure appropriate placement and services for housed service participants. The agency collaborative also engaged key system partners, including health and income supports, to coordinate access to mainstream resources as well. This not only helped challenge existing working models and case management practices, but introduced the community to the practical application of coordinated intake and assessment. Coordinated assessment and triage was introduced in 2010 through the use of a common acuity assessment tool. The use of this tool was reinforced by the provincial push for the adoption of a Homeless Management Information System (HMIS) across Alberta.

A Focus on Service Participants

At the frontline level, the new approach challenged the status quo model of providing housing for those who complied with requirements such as sobriety, taking medication or getting a job, etc. The strong focus on meeting service participants "where they were at" (Management-level Staff in Homeless-serving Organization 2) was consistently mentioned as a key ingredient motivating early adoption across frontline providers (Service Provider in Homeless-serving Organization 1; Management-level Staff in Funding Organization 1; 2; 3; 4; Management-level Staff in Funding Organization 1; 5). In fact, the documented success of the early cohort that participated in the initial Housing First implementation was considered a key factor in the ultimate success of the initiative: there was now "actual proof" (Community Volunteer 1) that Housing First worked from a service participant and system cost-savings perspective. The focus on data collection and analysis that emerged during the early phases took several years to fully ramp up and become integrated into practice. MHCHS saw an early need for "hard evidence to make the business case" (Public System Representative 1) to secure ongoing funding to government and the broader community.

Stakeholders noted that buy-in into the plan and Housing First was not a given during this early phase. In fact, a high level politician, who is now a strong advocate, freely admits his early opposition to the initiative (Maki, 2014). Providing housing and supports to long-term homeless individuals with complex issues challenged the notion of individuals 'pulling themselves up by the bootstraps' and finding their own way through hard work. It also challenged the traditional supports model whereby clients proved their readiness for housing through sobriety and program participation.

Phase 2: Formalizing a Systems Approach

An Intentional Shift to System Planning

A key shift in the evolution of the initiative was prompted by a change in leadership at MHCHS, which brought in a new manager leading the homelessness portfolio in 2011. The manager focused on introducing a system planning approach along with greater performance management and data-driven decision making. This shift was supported by similar processes underway across Alberta's seven cities towards greater formalization of funding allocation processes, performance management and data collection with the introduction of an articulated and deliberate system planning approach to service delivery.

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One of the impacts of the changes in funder expectations around reporting led to the decision of a major Housing First provider to decline renewing its contract to deliver services for MHCHS in 2013. A key concern for the program was the administrative burden placed on staff required for reporting. Other Housing First programs stepped in to collectively take on case management for the program's service participants. This occurrence was mentioned consistently by stakeholders as a key event in the trajectory of the initiative as it marked what stakeholders considered the culmination of a number of changes towards an enhanced formalization of the initiative. It was also a point at which diverse programs came together to work in an enhanced, coordinated manner to ensure service participants' needs were met despite changes in providers.

Enhanced Accountability

The shift towards system planning included an enhanced focus on creating standardized processes with respect to funding allocation, monitoring of outcomes and service quality as well as overall system alignment though coordinated triage and assessment, information management and performance measurement. The shift coincided with the introduction of more robust auditing mechanisms from the Government of Alberta as well, who began formal assessment of the 7 Cities in 2011 in their role as funders. The shift towards system planning and enhanced formalization of performance management and funding allocation processes was consistently described as "a game changer" (Municipal Official 2) for the overall initiative. Being increasingly evidence- and data-driven provided the stakeholders with new resources to prove the concept through "numbers not just anecdotes" (Management-level Staff in Homeless-serving Organization 2). The ongoing development of formalized program procedures and standards, along with staff training, created a continuous cycle of program improvement.

This direction was supported by data highlighting the community's progress. These data were shared in public forums, with media and in communications materials to keep up momentum within the Housing First movement and celebrate success with the broader community. The move to strategically and widely share evidence-based results was considered to have brought additional legitimacy to the initiative. The deliberate use of data in progress reports to showcase cost savings of Housing First to public systems made the argument for increased investment and overall support for the plan transparent and rational. As one interviewee remarked: "the numbers are what they are" – it was no longer necessary to "tug at the heartstrings – we had the data to prove it" (Community Volunteer 1).

The Changing Role of the Coordinating Body

Data and real time monitoring by the MHCHS reinforced the importance of flexibility and adaptation to meet shifting needs in the community across programs. The focus on using data in decision making at the funder and program levels in turn required additional skill-building across organizational levels to ensure data was collected, interpreted and used in a systematic manner. The monitoring of program results and service quality through formal and ongoing site visits, data tracking and ongoing dialogue between the MHCHS and participating agencies was considered to be a catalyst that moved services towards a more coordinated approach. Added expectations around data collection, reporting and the level of oversight by the coordinating body were a change from previous approaches. In some ways, the MHCHS become concerned with the "micro" of system planning (Management-level Staff in Funding Organization 1), rather than the broader community development work it was leading in the ramp-up phase of the initiative.

This administrative burden on agencies played, and continues to play, a key role in ongoing tensions with respect to the role of the MHCHS. In many ways, the MHCHS was following through on its mandated responsibilities from federal and provincial funders – yet, the intentional use of the administrative changes reinforced the systems approach in daily practice. This required that the coordinating body increase its presence as the backbone of the initiative driving change towards enhanced formalization. For instance, the MHCHS mandated data entry from its funded agencies on a monthly basis and introduced a performance management process that included comprehensive site visits and ongoing monitoring. Agencies that may not have had standards of practice in place had to develop new policies and procedures, introduce these as part of staff practice and be responsive to the funder's requirements in a much more rigorous manner than prior to Housing First. MHCHS also developed a core set of standards that agencies were required to adopt – which in some instances conflicted with previous agency practice or philosophy. The focus on data collection and reporting was also new for some agencies that did not have the experience on staff; as a result, the administrative burden often fell on managers to bring programs up to speed with contractual obligations.

Refocusing Strategy

In 2013, the CCH resolved to revisit the original plan to end homelessness in 2013. To update the plan, MHCHS worked with an external researcher to undertake a comprehensive assessment of the community's progress to date and review this against best practices in the research literature. The review process was undertaken using a system planning framework (for a full description of their systems planning framework, please see Turner, 2015), which was applied to a system performance analysis of programs using existing HMIS data and review of MHCHS practices with respect to coordinating the homeless-serving system. The consultation process with key stakeholders occurred throughout the year and culminated in a community summit in November 2013 attended by more than 50 participants, including service providers, public system partners, government, landlords and community members at large. Thirty service participants were also engaged in a consultation to develop a better understanding of their experience with the homeless-serving system and recommendations for improving outcomes in the refocused plan.

While considerable progress was being made, stakeholders also acknowledged that particular gaps in services could be better addressed to assist service participants experiencing long-term homelessness in the community, particularly through permanent supportive housing. There were also service gaps with respect to prevention and particular populations (e.g. youth, Aboriginal people). Further, there was an emerging recognition that enhanced coordination

was needed to enhance housing outcomes further. Enhanced coordination would involve leveraging data at an individual program and system level to make collective decisions about resources and priorities.

The process through which the community reflected on progress, as well as the presence of an external reviewer, led stakeholders to recognize collective accomplishments. As one interviewee remarked: "We thought, hey – we're doing pretty good in Medicine Hat! We are actually leaders in [ending homelessness]" (Municipal Official 2). On the other hand, stakeholders also realized that considerable efforts had to be made to meet the target end date of 2015, particularly with respect to enhancing visibility and support for the work with government and the general public in order to secure necessary resources.

An Achievable End

As the plan review and re-development was underway, the research revealed that the community was on track for meeting targets to end homelessness in 2015 if funding levels continued, particularly if these were enhanced with additional supports for permanent supportive housing. A draft of the refocused plan was developed and brought back to the community on January 2014 to gather feedback on the proposed direction. The participating stakeholders were both invigorated by the projected outcomes for 2015, but also saw it was a risk. The plan gave them just shy of 14 months to end homelessness. The need for an additional infusion of $12 million in new funds to realize the goals was seen as a particularly acute risk.

It was also important that the community be clear in the plan about what they meant by 'ending homelessness.' As one stakeholder remarked: "we're not saying no one's ever going to become homeless in Medicine Hat; what we're saying is that homelessness as a way of life will no longer be a reality though because of the systems we are putting in place to prevent that" (Management-level Staff in Funding Organization 1). The plan set out specific targets through which they would assess whether an end to homelessness had been achieved. For Medicine Hat, an end to homelessness would be apparent when service participants did not experience homelessness for longer than 10 days before they had access to appropriate housing and supports.[4]

The refocused plan became an "empowering and centering force" (Academic Researcher 1) that not only legitimized efforts underway, but would soon propel Medicine Hat to the forefront of the ending homelessness movement as the first community to end homelessness. The refocused plan has a conscious and deliberate embedded system planning approach built into priorities and actions. It reinforces the need for coordinated system planning and service delivery, the use of data and research in decision making, a range of services and housing supports to meet diverse service participant needs and a call to community leadership. While the homeless-serving system is seen as critical to the work of ending homelessness, other public systems are also called to the table through enhanced integration – including health, corrections, domestic violence and poverty reduction. The plan proposed the enhancement of housing and supports options, while looking beyond 2015 to moving increasingly upstream into prevention and maintaining an end to homelessness long term.

4. Note that 'appropriate housing' refers to housing that is affordable according to the CMHC's definitions. According to the CMHC, affordable dwellings cost less than 30% of before-tax household income. Households which occupy housing that falls below any of the dwelling adequacy, suitability or affordability standards, and which would have to spend 30% or more of their before-tax income to pay for the median rent of alternative local market housing that meets all three standards, are said to be in core housing need.

   In addition, housing must meet Modesty Assurance Guidelines available at http://www.housing.alberta.ca/documents/ModestyAssuranceGuidelines.pdf; and Minimum Housing and Health Standards available at http://www.health.alberta.ca/documents/Standards-Housing-Minimum.pdf.

Phase 3: Visioning Beyond an End to Homelessness

The First City to End Homelessness

The launch of the refocused plan in May of 2014 became a critical turning point as Medicine Hat's success was no longer a local phenomenon and the initiative gained the support of a key political figure (Maki, 2014; *The Economist*, 2014). It is important to note that political support for the initiative was not limited to this high-level political figure: interviewees noted that city council was supportive of the work historically, along with local MLAs. Within the provincial government, Medicine Hat and other cities benefited from steadfast support from the various ministers accountable for the homelessness portfolios. However, the media attention garnered by a particular politician was unquestionably a turning point for the community. His support opened doors that were never there before in government and in the business community. It further brought attention to Medicine Hat from other communities: "suddenly we were being asked how we did it, what was the secret 'recipe'?" (Public System Representative 1).

Numerous conversations and relationship building efforts with the right people at the right time led to a gradual increase in their understanding of the initiative and homelessness in general.

It is also important to consider how political support was realized. Numerous conversations and relationship building efforts with the right people at the right time led to a gradual increase in their understanding of the initiative and homelessness in general. For some, this resulted in buy-in for the initiative, which in turn led to a constant need for access to reliable and timely information to be able to speak to and support the issue in public or informal forums. This required accurate data and communications materials, as well as trust between initiative leaders and political and business allies. "It's the little, subtle conversations happening all over the place, over time, that are integral to shifting mindsets and getting buy-in" (Municipal Official 2). "You need people that believe this is possible who could speak to this intelligently who push through despite negativity" (Management-level Staff in Funding Organization 5).

Interestingly, while the recent attention to Medicine Hat's progress brought in new champions, it nevertheless presented a challenge to the effort's veterans who had been doing the heavy lifting through the early years. Ongoing negotiations regarding stakeholders' roles in the effort are occurring, thereby changing its dynamics in real time. What this shift is signaling, however, is broader buy-in and support for the work: "Ending homelessness is something Medicine Hatters are proud of – not just the non-profit sector" (Municipal Official 1). In fact, the city is becoming known for this feat – attracting attention and even economic investment potentially locally for being a socially conscious community according to one municipal official interviewed

The Risk of Success

Becoming known as the first city to end homelessness does not come without risk, particularly in light of the recent drop in oil prices impacting Albertans across the income spectrum. The loss of jobs resulting from the economic slump is enhancing risk for some groups, requiring proactive investment in targeted prevention efforts. Again, a strong systems approach recognizes these shifts and adjusts nimbly to meet new challenges head-on as a collective. The critical dependence on government funds to operationalize the plan's strategic priorities makes the initiative vulnerable to shifts at the political and administrative levels within government. While during early 2015 the threat of cutbacks from the Government of Alberta loomed, the more recent shift in governing parties to the New Democratic Party (NDP) leaves the future nevertheless undetermined at this time. There is awareness that homelessness may not always be "the flavour of the month" (Management-level Staff in Funding Organization 3) and other competing social issues may shift resources and attention away from it.

The province has also been undergoing systematic integration work with respect to homelessness and housing through the Interagency Council on Homelessness, which provides an important platform to address the broader public policy challenges involved in integrating homelessness work with that of other systems, including health, corrections, child intervention, etc. Such major shifts at the provincial policy level, likely to ramp up under the NDP, will have an impact on the initiative locally. Government direction on system integration may result in changes in service delivery and resource allocation locally and will likely impact how system planning is executed at the community level. Navigating such shifts in policy will be critical to maintain momentum while ensuring the ending homelessness agenda is aligned with broader social policy goals. With respect to the Government of Canada, the renewal of the Homelessness Partnering Strategy reinforces Medicine Hat's direction, while the re-focusing of federal funds to Housing First means that the funding allocation in the community may need to shift to ensure a comprehensive system continues to exist and to avoid an over-abundance of particular program types.

Keeping our 'Go-to' People

Additional risks identified related to key roles played by 'go-to' people. Certain individuals were consistently identified as critical to "keeping us on track" (Public System Representative 2) throughout the evolution of the initiative. Some had pivotal roles in kick-starting momentum and opening doors that led to resources and an enhanced profile for the work. Others had developed personal relationships across stakeholders and were able to move the community forward to meet collective objectives. The go-to people referenced most often by stakeholders were those leading homeless system planning work as assigned staff. The position oversaw community planning processes, performance management in Housing First, funding allocation and monitoring, data collection and analysis as well as system integration efforts with public systems like health and corrections. The wide scope of the position ensured one person was deeply immersed in the diverse aspects of implementing the plan to end homelessness and kept abreast of frontline issues, as well as advocacy and funding issues. The position was in a decision-making role as well; rather than gathering information, the staff also oversaw funding allocation and program development and evaluation. In other words, they had the capacity to adjust aspects of system coordination and program delivery in real time, with broader community input.

The content-specific knowledge developed at a system level is centralized in the MHCHS to a certain extent, making the diffusion of the practical "how-tos" (Management-level Staff in Homeless-serving Organization 2) involved in operationalizing system planning and Housing First a priority for the long-term sustainability of the initiative. Recognizing this risk, the MHCHS has consciously begun to enhance the role of agency leadership and the council in system planning work. The current phase sees the MHCHS moving system planning functions increasingly into community – in some ways, resuming its initial role as a community developer and facilitator. This is a result of the increasing recognition that there is a need to make additional efforts to support buy-in into aspects of system coordination, like performance management and data collection, outside of the funding body. The vision for this effort is to embed system planning into the various stakeholder groups that make up the homeless-serving sector and its allies (health, poverty reduction, corrections, etc.) so that ending homelessness is no longer solely an MHCHS or agency job – it becomes a community owned and implemented effort. In this manner, stakeholders would have an enhanced understanding of their roles as part of a system and strive to act in the interest of the group they serve as a collective. Already funding decisions are becoming increasingly determined by strategic conversations among stakeholders based on common priorities, emerging trends, data and evidence rather than being solely driven by the funder.

It is important to highlight that while key leaders were certainly seen as pivotal to the work, the frontline staff and the service participants who do the heavy lifting of operationalizing Housing First are essential to ongoing success. "It was the participants who believed in this that ultimately got this started – if there was no trust [with staff], none of this would be here" (Municipal Official 2). The attraction, retention and training of frontline staff able and willing to work with a complex population was consistently noted as both a critical strength and risk for the initiative. As one stakeholder noted, "you find good people and you let them run with it." It is not surprising to see consistent investment in frontline staff training within agencies and at the system level coordinated by the MCHCS throughout the history of the initiative, though it admittedly remains a challenge given work conditions and wages compared to other available options in a tight labour market.

LOOKING BEYOND ENDING HOMELESSNESS

Interviewees agreed that the "work doesn't end in 2015" (Management-level Staff in Funding Organization 5) – in fact, to truly end homelessness the community could have the opportunity to leverage learning from their success on the homelessness front to expand into other areas, such as poverty, food insecurity and domestic violence. The approach and key ingredients of the homelessness initiative could be examined and applied to this "next phase" since "if anyone can do it, it's going to be Medicine Hat" (Municipal Official 2).

MHCHS's role post-ending homelessness will have to be rethought as well. System coordination and planning will continue to be required by all accounts through enhanced integration of key system planning activities within the council, service providers and allied public systems. Enhanced system integration and the potential of regionalization or expansion to tackle other social issues will similarly challenge stakeholders to adapt while maintaining and building on current success. While homelessness as a long-term experience may be ending at this point in time, the community is "just beginning the hard work of maintaining the gains made."

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CONCLUSION: KEY LEARNINGS IN SUM

Medicine Hat provides an important case study through which to examine the evolution of system planning approaches following Housing First. The key learnings summarized below highlight the dynamics involved in on-the-ground processes of implementation involved in social change and are of particular interest to a broad range of stakeholders working on addressing homelessness, particularly policy makers and funders, service providers and researchers. While this case study presented the processes and phases a community working to end homelessness went through according to key stakeholders, the chapter is not intending to provide a clear-cut model at this point. As other communities review the Medicine Hat experience and reflect on their own, future research can help articulate such a model with general applicability.

Medicine Hat provides an important case study through which to examine the evolution of system planning approaches following Housing First.

1. Shared community ownership:

- Initiative considered a community-owned effort, not that of a single stakeholder.
- A broad vision created space for diverse stakeholders to contribute towards the greater goal.
- Tension was acknowledged and encouraged as part of the initiative's evolution and continuous improvement.
- Success was celebrated consistently to reinforce overall direction of the community and collective ownership.

2. The right people, at the right time:

- Cultivating a diversity of champions behind the scenes and publically to support the initiative at pivotal moments.
- Having access to consistent support throughout the evolution of the initiative from key stakeholders in government, frontline agencies, business sector, funders and the broader community at large.
- Leveraging expertise and bringing in external knowledge leaders to inform local work.
- A strong core group of leaders was in place to act as the foundation of the initiative and create space for early innovation.

3. A focus on data, performance and continuous improvement:

- Use of data in real time decision making to operationalize system planning and enhance performance.
- Leveraging evidence of success in strategic communications to key stakeholders.
- Ensuring data is accurate, relevant and available.
- Balancing hard data with service participant testimony.
- Building a solid business case for investment in the initiative.
- Evidence, performance results and best practices driving investment decisions.
- Broad service provider buy-in and commitment to service excellence were in place across organizational levels.

4. An intentional community-wide system planning approach:

- Nimble and flexible approach to adjust strategies in real time.
- Broad-based system planning was infused across stakeholders beyond coordinating body.
- Intentional phased approach led by coordinating body to enhance community capacity to participate in system planning.
- Diversity of service providers were engaged in the work to develop a coordinated approach: no one program type was excluded from the process. This included emergency shelters, transitional housing, Housing First, prevention services and social housing providers.
- Intentional integration efforts with other systems (health, income assistance, corrections, etc.) were put in place with an eye to 'moving upstream.'
- Emerging planning recognized regional pressures and the need to coordinate beyond the immediate locality.

5. A nimble coordinating body:

- Coordinating capacity to shift approach according to emerging needs from community developer to system planner and increasingly merging the two approaches.
- Ability to be strategic in creating space for dialogue on tensions, while keeping the momentum of the initiative.
- Leveraging media strategically to advance common goals at critical comments.
- Foresight to develop key relationships, shift program and system design, leverage data and external experts.
- Holding service participant needs at core of decision making.
- Clear direction is maintained, despite criticism and arising challenges.

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CONCLUSION

Naomi NICHOLS & Carey DOBERSTEIN

This book was produced with strategic intentions: our goal is to leverage collective expertise to produce an evidence base that supports policy and government decision makers, community organizers, institutional leaders (e.g. managers and directors) and funders to conceptualize, plan for and implement coordinated efforts to end homelessness in Canada. We see efforts to coordinate services, policies and governance strategies as the critical next step in a pan-Canadian effort to end homelessness.

For a long time, the predominant response to homelessness in Canada reflected a commitment to providing emergency food and shelter to people in crisis. Over the last few years, we have observed a dramatic shift in conversations about homelessness and community efforts to address it. A central precipitating change was linking up people who work in research settings, community-based organizations and all levels of government to combine efforts to understand the state of homelessness in Canada. It started with talking and working across disciplinary boundaries – sharing stories, building relationships and figuring out how to work together. From here people began collaborating on research projects to understand different causes and experiences of homelessness and assess efforts to address it. Staff and volunteers in community organizations began to engage with and then conduct research. Officials in government began to engage with and then request research. Faculty and students in universities began to focus on producing knowledge with (rather than about) communities and thinking as much about how to share research findings as they thought about producing them. As these people across Canada began working across disciplines and across sectors to understand and resolve homelessness, other shifts were observable.

As it became clear that street-involvement exacerbates the very exclusionary conditions that shape pathways into homelessness, people began to talk about the importance of homelessness prevention. Increasingly, policy, research and practice recognize that homelessness is not simply the result of individual failures but a confluence of structural and individual factors that manifest in extreme forms of social and political marginalization. Collectively, we now understand that street homelessness and institutionally mediated homelessness (e.g. shelter living) make it very difficult for people to take care of their physical and mental health, access labour market opportunities, establish trusting relationships, self-advocate or exercise their rights as political citizens.

As our understanding of homelessness improved, it also became clear that many of our attempts to address homelessness have actually been keeping people in a state of crisis that becomes increasingly difficult to

escape over time. As such, we began to look elsewhere for promising evidence-based solutions to homelessness. Community planning processes were engaged, centralized databases were created and Housing First approaches were rolled out across the country. Over the last decade, we have witnessed widespread paradigmatic shifts in how communities in Canada are thinking about and working to resolve homelessness.

This book was produced to support continued momentum for our collective efforts to make change. We set out to shine a light on the growing body of research about systems-level approaches to homelessness in North America as well as the growing number of initiatives being implemented by diverse groups of researchers, community agencies and different levels of government. What has emerged from this book has surpassed our expectations.

We deliberately organized the book into longer research-based chapters that distill general principles to be applied in the pursuit of different types of systems-level responses to homelessness as well as shorter descriptive vignettes that offer accounts of diverse systems-coordination efforts across Canada. In the introduction to the book, we highlighted key organizational themes used to structure the sections of this book: program and service-level collaboration; systems planning for targeted groups; inter-sectoral collaborations; and high-level governance challenges and opportunities. Beyond these overarching thematic areas that provide the overall structure for the book, the chapters in this volume suggest several common elements of a systems-level response to homelessness that are worth highlighting in this conclusion. The elements we elucidate below suggest an emerging theoretical framework, which we see guiding systems-level thinking, planning and working more generally.

The first element of systems-level work that the chapters in this volume highlight is the centrality of people to any process of structural reform, including efforts to align policy, procedure and practice. The work of planning, coordinating access, aligning professional language and culture and designing and implementing data collection processes and policies is always done by people. So while technical or structural coordination is essential to the development of a sustained systems integration endeavor, a process or policy can only ever be as effective as the people who activate and apply policies and procedures in the context of their work. For example, Hurtubise and Rose show us how the effective implementation of inter-professional teams (in this case composed of police and social services) require that people learn how to work across differences in workplace and professional culture. Bopp, Poole and Schmidt illuminate how a Community of Practice model can be used to support learning and working across professional differences. Nichols demonstrates how external coordination coupled with shared goals and/or commitments can be used within a collaborative structure to navigate conflicts and make collective decisions. Other chapters illuminate the importance of outwards-facing leadership (championing) provided by an agency or individual (e.g. Charette, Kuropatwa, Warkentin, & Cloutier; Puligandla, Gordon & Way). While still others point to leadership approaches that work within smaller grassroots networks (Evans; Nichols) and larger more complex collaborative governance structures (Doberstein; Doberstein & Reimer). For example, Evans argues that service delivery coordination is better supported by a community-based approach to governance characterized by distributed leadership, horizontal collaborative networks and partnerships than a traditional top-down managerial approach characterized by performance management targets and contractually organized service delivery frameworks. On the other hand, cross-sectoral coordination efforts require different (or additional) governance structures that link government departments or ministries. Learning, training, coaching, relationship-building, networking, outreach, public and community engagement, consensus building, knowledge exchange, participatory and inclusive approaches to research and data collection – all of these relational components of a systems-level reform initiative matter.

The second element the chapters in this volume highlight is the importance of conceptual coordination – that is, a shared conceptual framework to guide systems planning and implementation efforts. How we think about the problem of homelessness shapes how we proceed to solve it. Doberstein describes the conceptual shift that enables the associated discursive, practical and structural changes necessary for the development and implementation of a systems response. 'Systems thinking' invites us to see homelessness as a complex, multi-faceted problem that requires an equally complex solution. His work draws our attention to the wider policy arena that would enable a systems-response to homelessness – that is a policy response that enables joined up work across the child welfare, criminal justice, health, employment, social services, welfare and affordable housing systems. Kline & Shore as well as Buccieri illuminate how distinctive understandings of the problem of homelessness shape different pragmatic responses. For example, Buccieri suggests that framing homelessness as a public health issue would enable the type of integrated social and health care response that a long-term resolution of homelessness requires. Other chapters (e.g. Bopp, Poole & Schmidt; Kirkby & Mettler; LeMoine; Schiff & Schiff) remind us that it is essential to understand how homelessness is experienced by different groups of people in different geographic contexts; it is clear we must differentiate our responses accordingly. How we think about homelessness (its drivers, outcomes and social, political and economic implications) influences the type of response we imagine and the methods of intervention we employ.

The third key element in an effective systems-level response is the importance of structural supports to enable ongoing collaborative or joint work. While it is true that people are at the heart of a coordinated response, their collaborative efforts must be supported by explicit policy, procedural, programmatic and governance structures to maximize what any well-intentioned collective is able to accomplish. Beyond a willingness to work together, systems-level responses require inter-organizational, cross-sectoral and high-level governance mechanisms that enable day-to-day and big-picture integration of policies, processes, programs and practices. The chapters in this volume speak to the importance of shared assessment and referral tools, centralized access processes, formalized data sharing and communication procedures, structured opportunities for inter-professional learning and training, sufficiently collaborative funding and accounting procedures, shared definitions, systems planning practices, shared terms of reference, collaborative and/or aligned government structures.

Leading systems-planning researchers (Milaney & Turner) describe how systems planning was used in two different municipalities to implement a systems change effort to end homelessness. Evans, Doberstein and Reimer suggest distinctive governance structures that support joint work within a service delivery environment (Evans) and across ministries (Doberstein & Reimer). A number of chapters (e.g. Dressler; Frisna, Lethby & Pettes; DeMoine; Nichols; Norman & Pauly) highlight the importance of inter-organization communication and referral protocols, coordinated access and assessment strategies and other systemized processes (e.g. case management, collocated services and shared staffing models; inter-agency agreements; network structures; and centralized access processes) that support collaboration across service delivery organizations within and crossing sectors. A final group of chapters (e.g. Charette, Kuropatwa, Warkentin & Cloutier; Forchuk, Richardson & Atyeo; Hug) describe a diversity of housing partnership approaches that bring together cross-sectoral stakeholders to fund and deliver comprehensive housing supports.

The chapters in this book suggest a number of tangible things communities can do to support improved communication and joint-work across organizational contexts. It is also evident that efforts to improve service delivery coordination at the community level will not end homelessness. The chapters in this collection illustrate the high-level structural or

technical supports that implicate funders, governments and policymakers in the resolution of homelessness in Canada. For example, Belanger shows us how a policy construction of Aboriginal people as culturally, ethnically and politically 'other' than the general population and outside of provincial or territorial jurisdiction (tasked with responsibility for housing) means insufficient access to mainstream services and investment in housing infrastructure for Aboriginal people living on and off reserve. Norman and Pauly illuminate how a centralized housing access point is merely a centralized housing wait list without sufficient supportive and social housing stock in a given municipality. Doberstein and Reimer examine the role that inter-agency councils to end homelessness have played in supporting provincial or state-level integration and outline important considerations for effectively using inter-ministerial or inter-agency governance models to resolve complex problems.

Pleace, Knutagård, Culhane and Granfelt, who produced one of our two international case studies, provide an overview of a two-phase national response to homelessness in Finland. The response combined a Housing First approach with increases in social housing stock, improved access to preventative services and other supportive housing models to reduce chronic, episodic and hidden homelessness nationally. This case is exemplary insofar as it describes an effective effort to coordinate policy, practice and funding across the non-profit sector and all levels of government in the country that has significantly reduced – although not eradicated – homelessness. As well as highlighting mechanisms for supporting integration at the community level, the contributions in this volume speak to the need for an aligned policy response that spans ministries and levels of government. A comprehensive federal housing strategy can provide an overarching framework that supports policy coherence between municipalities and territories/provinces and ensures the equitable distribution of housing resources on a pan-Canadian scale, including First Nations reserves.

Finally, the chapters draw our attention to the ongoing data collection, management and assessment work that is required to enable productive inter-organizational and cross-sectoral work as well as some of the difficulties of managing and analyzing data across organizations and sectors. The fourth and final element of systems-level work is the use of data to capture and assess the efficacy of our collective effort. Clearly, a complex systems approach to preventing and solving homelessness requires sufficiently complex and adaptive methods for tracking the costs and outcomes of this work across time and space. Many chapters in this volume point to important considerations for the collection, use and analysis of data in complex systems. For example, the measurement challenges and possibilities associated with double and single feedback loops (Doberstein) or the accountability and accounting challenges posed by a collective impact approach, where investments in one sector may result in reduced expenditures elsewhere (Nichols).

Fewer chapters point us to comprehensive methods for addressing these data collection and management issues. Brydon's chapter on 'stock and flow' analyses is an exception. He offers practical analytic strategies for supplementing data collected during point in time counts of homelessness and for tracking flows into and out of homelessness in a given locale. A 'stock and flow' approach can be used to capture fluctuations in homelessness over time and identify wider systemic flows into homelessness that will require a collaborative data management response in order to fully account for them (e.g. economic trends, cost of housing, institutional discharge processes). In other words, stock and flow monitoring can serve to provide a fuller picture of the number of people experiencing homelessness across a complex system as well as highlight potential areas for collaboration with other ministries and/or agencies in order to collaboratively address flows related to migration and/or institutional discharge practices, for example.

A stock and flow methodology complements Kovacs-Burns and Gordon's discussion of the social determinants of homelessness. A clearer understanding of the interlocking social and structural factors that influence homelessness and housing security helps to identify potential flows into and out of homelessness in a particular setting. While not every community is resourced to undertake the type of stock and flow analysis that Brydon sketches for us, the chapter by Duchesne, Rothwell, Ohana and Grenier suggests a cross-sectoral solution to this capacity gap. They argue that community-academic research partnerships might be an effective strategy for using homelessness serving sector-generated administrative data and local knowledge to generate the longitudinal and complex analyses that a systems response to homelessness requires.

A central contribution of this volume is the synthesis of rigorous evidence on the structural factors (e.g. poorly coordinated institutional discharge processes) that influence pathways into homelessness, the criminalization of homelessness, the links between homelessness and poor health/wellness and the difficulties people face in their efforts to secure safe, affordable and appropriate housing in Canada. Of course, despite the vast amounts of evidence that illuminates the broad social, economic and health implications of a poorly coordinated response to homelessness, the lingering issue is that we do not yet have sufficient evidence that systems integration efforts actually reduce homelessness in a sustained way. It is also the case that we do not yet have adequate and accessible methodological strategies (as Brydon clearly points out) for measuring the effects of an intervention or set of interrelated interventions at a systems level.

There remains important research to be done, in other words, to assess the efficacy of various systems-level efforts to prevent and end homelessness. Our collective research-to-action agenda might look something like this: a) adopt a standard definition of homelessness that enables measurement and comparison on a pan-Canadian scale; b) standardize homelessness point in time count data collection processes and implement on a pan-Canadian scale; c) determine key flows into and out of homelessness; d) establish a definition for a functional zero, which will allow communities to assess whether they have ended homelessness; e) describe systems-level efforts to prevent and end homelessness on various scales (e.g. service delivery, municipal, provincial) and with various populations (e.g. chronically homeless men, families); and finally f) evaluate and compare the efficacy of various interventions for various populations in the context of a shared goal of preventing and ending homelessness in Canada.

By bringing some of the brightest minds together from various spheres of involvement in homelessness research, this collection has brought to light some of the significant achievements of this past decade to improve our collective response to homelessness. It is also clear that there is more work to do. We emerge from this project with every confidence that it will be done.

This book was produced with strategic intentions: our goal is to leverage collective expertise to produce an evidence base that supports policy and government decision makers, community organizers, institutional leaders (e.g. managers and directors) and funders to conceptualize, plan for and implement coordinated efforts to end homelessness in Canada. We see efforts to coordinate services, policies and governance strategies as the critical next step is a pan-Canadian effort to end homelessness.

Homelessness is a systemic problem involving numerous sectors, institutions and agencies and, therefore, requires more integrated system responses in terms of governance, policy and programs. The widespread homelessness experienced in our communities indeed reveals deep structural inequities in our economy and society that ought to be addressed, but also represents a systematic governance failure characterized by a lack of ownership of this issue in and across government. The growing scholarly and practitioner movement towards systems integration thus refers to strategies and frameworks to improve collaboration and coordination between people, organizations and sectors that touch upon homelessness, including some that may not conceive of themselves as directly related to the issue.

Systems integration may appear to be a daunting task given the complexity of the broader homelessness system and the multitude of governments, overlapping authorities and competing interests. Yet we have assembled three dozen case studies written by practitioners on the ground and researchers in the field to demonstrate that systemic change is possible at various levels of activity within the realm of homelessness and associated sectors. We do not need to wait for the perfect conditions to emerge to resolve governance and service inefficiencies – our day-to-day work is always where sustained change is derived and upon which further efforts and refinements are built.

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