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Ending Homelessness?

A Critical Examination of Housing First in Canada and Winnipeg

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Abstract

The Housing First model is an increasingly popular approach to housing homeless Canadians. Many studies have examined the benefits of Housing First, arguing that it is more effective than traditional methods of addressing homelessness. Far less attention has been paid to the challenges involved in operating Housing First programs, particularly in the Canadian context. This paper attempts to fill this research gap. To do this it discusses the limitations of the Housing First model, examining the difficulties associated with providing Housing First programs to participants with unique needs, as well as problems the Housing First model faces when operating in rural communities and areas experiencing a shortage of affordable and/or social housing. It contends that to understand the strengths and limitations of Housing First more high quality research needs to take place. Further, it argues that to be effective Housing First programs need to adapt to the unique circumstances that they operate in, and need to be a part of a wider, comprehensive homelessness strategy.

Introduction

Homelessness is a major problem in Canada. Each night approximately 35,000 Canadians experience visible homelessness, while as many as 50,000 live in hidden homelessness (Gaetz et al. 2014: 5). Homelessness also presents a challenge in Winnipeg, the October 2015 Street Census found 475 people absolutely homeless, and 1,252 provisionally accommodated people (Social Planning Council 2015). The Housing First (HF) model, which focuses on getting participants housed as quickly as possible, regardless of perceived readiness, is an increasingly popular approach to addressing homelessness. Studies have found that the HF model is far more effective than traditional approaches at keeping homeless people housed and improving their health. Yet research has only briefly touched on the difficulties associated with implementing HF programs. This paper attempts to fill this gap in the literature by examining several of the major challenges HF faces in the Canadian context, including the shortage of affordable and social housing, the lack of tertiary services available in rural communities, the difficulty of addressing the needs of the homeless population[1] as a whole and the complexities associated with serving women, youth and Aboriginal peoples. Further, it will consider the experiences of communities across Canada, focusing particularly on Winnipeg. Overall, the aim of this paper is not to argue that HF is ineffective or that it is not a reasonable method for addressing homelessness. Instead, it seeks to highlight: more research needs to take place to broaden our understanding of homelessness and HF; the HF model is not a silver bullet answer (by itself it will not be enough to end homelessness); and a one-size-fits-all approach to HF is not viable.

1 This paper makes reference to "homelessness" and Canada's "homeless population" throughout. I acknowledge that this is a simplification, and do not intend to imply that Canadians experiencing homelessness are a homogenous group.

Homelessness in Canada

The way that homelessness has been defined has evolved over time. Hulchanski and his colleagues have argued that, before the mid-1980s, homelessness as we currently understand it did not exist because Canada had an ample stock of affordable housing and a social safety net strong enough to ensure that everyone had a place to live. Instead, they suggest that traditionally people were considered to be "homeless" if they had a house, but not a stable, loving home (Hulchanski et al. 2009:1-4). For example, individuals who were transient, had no family support network and lived in low-income housing were labelled homeless.

The definition of homelessness began to shift during the 1980s as the decline of the welfare state, social housing cutbacks and an overall reduction in the availability of affordable housing resulted in many people finding themselves without any form of stable accommodation, let alone a home. A typical definition during this era considered homelessness to be characterised by "not having customary and regular access to a conventional dwelling" (Rossi 1989: 10). Today, homeless individuals who fall within this definition are considered visibly homeless. Visibly homeless populations include people who sleep out of doors, people living in temporary institutional accommodations and people staying in emergency shelters. Stephen Gaetz and his colleagues at the Homeless Hub at York University estimate that at any given time there are 35,000 visibly homeless Canadians, and that each year 235,000 Canadians experience visible homelessness (Gaetz et al. 2014: 5). Of this population, the majority are transitionally homeless, meaning that they are homeless only for a short period of time and generally manage to find permanent accommodation on their own. Yet between 5 and 15 percent of visibly homeless Canadians experience more extreme forms of homelessness, including episodic homelessness (when individuals continuously move in and out of homelessness) and chronic homelessness (when individuals experience long-lasting periods of homelessness) (Aubry et al. 2013: 910).

In recent years, researchers have attempted to broaden the interpretation of homelessness to include people who are relatively homeless. For example, in 2012 the Canadian Homelessness Research Network (CHRN) defined homelessness as, "the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of

acquiring it" (CHRN 2012: 1). This includes people who have access to shelter that lacks security or quality and people who are at risk of losing their housing due to financial difficulties. It also includes hidden homelessness: where individuals live, or temporarily couch surf, with friends or relatives because they cannot afford their own housing. There are an estimated 50,000 Canadians experiencing hidden homelessness at any given time (Gaetz et al. 2013b: 6). Overall, when considering homelessness, it is important to note that the categories of visibly homeless and relatively homeless are not mutually exclusive, and instead many homeless Canadians transition between the two. For example, an individual may spend one week living on the street and the next sleeping on a friend's couch. The flexible nature of homelessness is highlighted by the 2011 Winnipeg Street Health Report, which interviewed three hundred homeless individuals, finding that in the previous month:

- 84% stayed in an emergency shelter
- 31.6% stayed outside
- 29.6% stayed with friends or relatives
- 8.6% stayed in a treatment program
- 6.3% rented a room in a hotel
- 6.0% stayed in a rooming house
- 5.6% were in a hospital
- 2.3% were in jail
- 2.3% slept in a car
- 1.7% stayed in an abandoned building
- 1.7% found shelter in a business.
  (Gessler and Maes 2011: 14)

When discussing the demographics of Canadian homelessness, there are several points to keep in mind. First, while homelessness is largely an urban problem, it is also prevalent in many rural areas and in small communities. For example, in the case of a recent housing project in British Columbia, several communities of under 2,500 people, including Lillooet (population 2,324) and 100 Mile House (population 1,885), reported homeless populations of over thirty people (Greenburg 2007a). Second, while the most prominent demographic among homeless Canadians is single adult males between the ages of 25 and 55, who make up 47.5 percent of the homeless population (Gaetz et al. 2014: 40), the homeless population is comprised of people from all backgrounds, including families, women and youth. Third, a disproportionate number of homeless Canadians come from vulnerable populations, including people have who previously experienced abuse, people facing addictions and mental health challenges, members of sexual minorities and members of racial minorities, most notably individuals from an Aboriginal background. In Winnipeg, while approximately 10 percent of the general population is Aboriginal, studies have suggested that between 55 and 70 percent of the homeless population is Aboriginal (Gessler and Maes 2011: 10).

There are a number of factors that can lead someone toward homelessness. Many individuals find themselves homeless after experiencing a traumatic event. For example, a fire may burn down a family's apartment building or an economic downturn may cause an individual to lose their job, making it impossible for them to afford housing. An individual may also become homeless if they leave home to escape a domestic dispute and/or abuse. This reality is especially common among homeless women and youth. In many cases people become homeless because support or care systems fail. For example, when people are discharged from child welfare, hospitals, addictions facilities, psychiatric institutes or correctional facilities without receiving proper planning or support, their chance of becoming homeless increases exponentially (Gaetz et al. 2013b: 13).

The overrepresentation of individuals experiencing mental illness and/or addictions among the homeless population indicates that these characteristics are a significant obstacle when peo-

ple are attempting to find housing. Similarly, the overrepresentation of ethnic and sexual minorities suggests that discrimination can be a major influence leading individuals toward homelessness. This can be seen in the 2011 Winnipeg Street Health Report, in which many survey respondents claimed that before becoming homeless they had been discriminated against by their landlords. Among survey respondents, 40.9 percent thought that they were discriminated against due to their drug use and/or mental illness, 31.8 percent because of their source of income, 21.1 percent because of their ethnicity, 20.4 percent due to their gender, 9 percent because of a physical disability and 6.4 percent because of their sexual orientation. Overall, 30 percent of surveyed individuals claimed that they were evicted or had lost their homes after a conflict with their landlord (Gessler and Maes 2011: 11, 13).

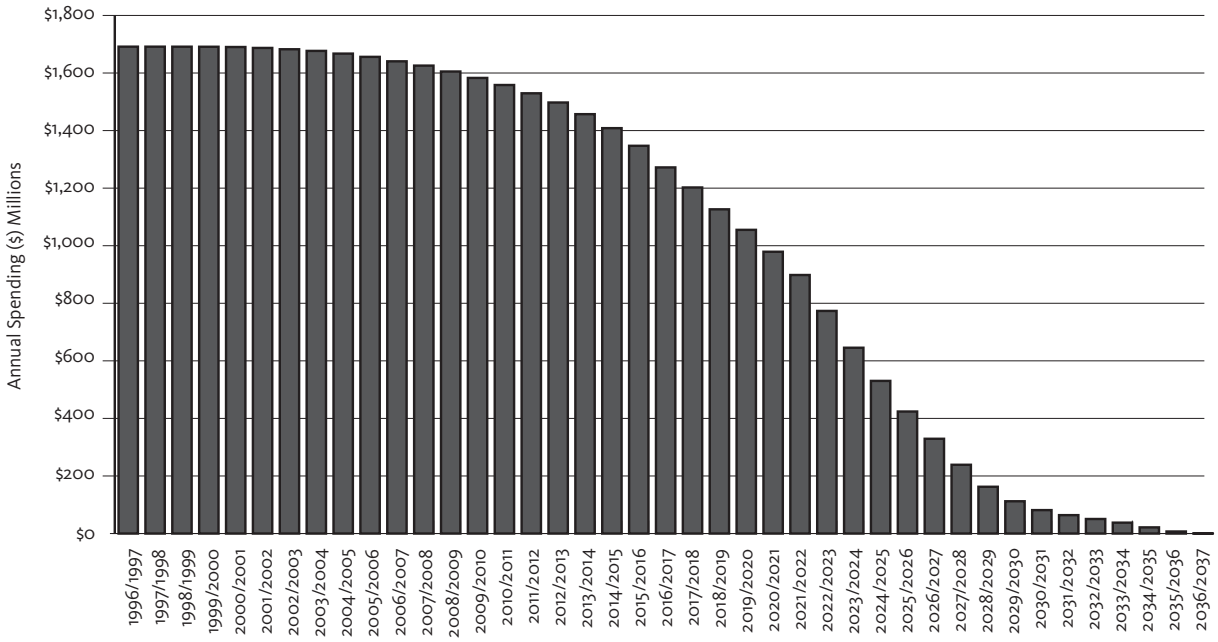
While the causes of homelessness are diverse, difficulty finding and maintaining housing is often the most significant factor. An oft-quoted line among homelessness stakeholders is that: "Homelessness may not be only a housing problem, but it is always a housing problem" (Dolbeare 1996: 34). This is especially relevant in Canada, as government policy has largely failed to address the housing needs of vulnerable groups. According to the Canada Mortgage and Housing Corporation (CMHC), housing is considered unaffordable if it consumes over 30 percent of a household's income. It has been estimated that 20 percent of Canadian households live in housing that is unaffordable according to this definition (Conference Board of Canada 2010: 4). The vast majority of these households are renting their primary residence. Yet, despite the fact that many renters are experiencing housing vulnerability and the fact that the average Canadian homeowner earns over twice as much as the average renter ($91,122 per annum as opposed to $43,794 per annum), a 2010 study found that homeowners received 92.6 percent of federal housing subsidies (Clayton 2010: i, ii).

Another factor that disadvantages renters is that, in many Canadian communities, there is a shortage of rental housing available. It is generally accepted that in a healthy rental environment, vacancy rates will stand around 3 percent (three of every one hundred rental units are empty and ready for occupation). Recent figures from the CMHC suggest that Canada's thirty-five largest centres fall slightly below this mark at 2.8 percent. A number of Canada's largest cities are far below the 3 percent target, with Vancouver experiencing vacancy rates of 1 percent, Calgary recording rates of 1.4 percent and Toronto recording rates of 1.6 percent (CMHC 2014: 1). In recent years Winnipeg has experienced an increase in rental vacancies, but with a vacancy rate of 2.5 percent, the city still falls well short of 3 percent. Overall, this is significant because if renters are unable to easily find housing, they are put at great risk of becoming homeless.

Housing shortages are an especially relevant challenge for low-income renters because since the 1980s there has been a reduction in the amount of affordable housing available on the private market. In large part this is because there is little financial incentive for profit-driven companies to build affordable rental housing, which generally produces a smaller return on investment than homes or condominiums targeted at middle- and upper-income demographics (Hulchanski 2007: 3). Hulchanski and his colleagues have argued that Canada's shortage of affordable housing is a major problem, and one that can be directly linked to the rise of homelessness (Hulchanski et al. 2009: 4–6).

Low income Canadians also receive less than adequate support in the way of non-market social housing. According to Hulchanski, Canada has the smallest social housing sector (which, under his definition, includes government-owned public housing, non-profit housing and non-profit housing cooperatives) of any western nation outside of the United States, with only 5 percent of Canadian households living in social housing

FIGURE 1 **Federal Operating Agreement Spending**



DATA SOURCE: Pomeroy 2014

(Hulchanski 2007: 1). Traditionally, the federal government has been the primary funder of social housing in Canada. This began after the Second World War when, as part of the newly formed welfare state, investments were made to provide social housing for Canadians in need. But in 1984, facing a challenging economic environment, the government began fiscal cutbacks to social housing programs, and in the mid-1990s, as a part of deficit cutting measures, funding diminished further. In 1993, the federal government ceased all spending on the construction of new public housing, and in 1997 managerial responsibility for existing social housing and social housing construction was transferred to the provinces. Despite this reassignment, the federal government has continued to provide over $1.3 billion annually to finance existing social housing units, but, as Figure 1 highlights, this funding is in the process of expiring and by 2037 federal transfers will cease almost entirely (Pomeroy 2014). Researchers have expressed concern that, as funding diminishes, social housing providers will not be able to afford operating and repair costs. This may lead to social housing projects being shut down or rents being increased (Ward 2011: 2).

Responses to Homelessness in Canada

In recent decades a comprehensive system has been developed to support Canada's growing homeless population. Typically reactive emergency services such as shelters, meal programs and hospital emergency departments have been used to address the immediate needs of the homeless. Moving out of homelessness has traditionally been approached using the Continuum of Care (CoC), or staircase model, where individuals transition toward having a home by moving through a series of steps (Peters and Craig 2012; Johnsen and Teixeira 2010). For example, people move from the streets, to shelters, to transitional housing and finally to permanent housing. As they progress, participants are introduced to a wider range of support programs and services, preparing them to move to the next stage. In this model, transitioning from one step to the next is generally reliant on the individual being perceived as "housing ready." This means that they have to demonstrate sobriety or behavioural control before they are provided with support to access their own home. If they are unable to do so, they do not progress or are removed from the process entirely.

In recent years, this approach has been criticized for a number of reasons. First, due to its reliance on emergency services, supporting homeless Canadians has become increasingly expensive, with current estimates putting the cost (including expenses related to health care, social services and justice) at $7 billion per year (Goering et al. 2014: 6). Furthermore, while meal programs and emergency shelters are valuable tools for addressing the daily needs of homeless individuals, they are reactive and do not prevent people from becoming homeless in the first place. The CoC model has also had questionable success in moving participants out of homelessness. This is highlighted by the results of the At Home/Chez Soi (AH/CS) project, conducted by the Mental Health Commission of Canada, which found that in the final six months of the project only 31 percent of participants receiving support under the CoC model were housed all of the time, with 23 percent housed some of the time and 46 percent never housed (Goering et al. 2014: 5).

Due to the problems associated with the CoC approach, many organizations have begun to address homelessness in a new way, using the HF model. The fundamental perspective of HF is that access to suitable housing is a basic human right and that housing is the first step towards

recovery for homeless individuals (Tsemberis and Eisenberg 2000: 488). In general, HF programs target the homeless populations that are seen to have the highest needs, particularly individuals suffering from mental illnesses and/or addictions and those who are chronically or episodically homeless.

Programs providing HF services generally adhere to several basic principles. First, participants are re-housed as quickly as possible, regardless of whether or not they are perceived as "housing ready." Second, HF programs attempt to provide housing with few strings attached: to receive housing, people do not have to be sober and do not need to seek further treatment or support. Often the only requirement is that, in the short term, the individual stays in contact with a worker from the HF organization. Third, within the limits of affordability and availability, HF organizations give participants choices regarding the type of housing they will receive. For example, participants may be given a choice between living in a privately rented apartment or in government-subsidized social housing. HF programs also attempt to provide participants with choice regarding where their housing will be located and whether or not they will have a roommate. Finally, once an individual has become housed, further services are optionally provided, particularly in the areas of community reintegration, substance abuse, physical and mental health, education and employment (Tsemberis and Eisenberg 2000: 488–489).

Pathways to Housing (PTH), a housing organization founded in New York City in 1992, is generally credited with having developed and popularized the model discussed above (Goering et al. 2013: 10). In Canada, the first large-scale HF project, Toronto's Streets to Homes program, was launched in 2005 and in recent years many other communities have launched their own HF initiatives. Between 2009 and 2013 the Canadian federal government financed the AH/CS project, the world's largest and most in-depth investigation into the effectiveness of HF, establishing pilot studies in five Canadian cities, including Winnipeg (Goering et al. 2013). In 2014 the federal government also renewed its Homelessness Partnering Strategy with an additional emphasis on HF principles (Government of Canada 2014). This has led to a large shift in funding toward HF projects and away from traditional approaches to addressing homelessness. According to the current Homelessness Partnering Strategy framework, large Canadian cities must spend at least 65 percent of the funding they receive on HF projects, medium-sized cities must spend 40 percent of their funding on HF and small communities, while no targets have been set, have been encouraged to adopt the HF approach (Foran and Guibert 2013: 7).

In large part HF has become popular because it has proven to be an effective and cost efficient way to keep homeless people housed. This can be seen in a number of international and domestic cases. For example, New York City's Pathways to Housing has reported a steady housing retention rate of 85 to 90 percent among HF program participants during its twenty-two years of operation (PTH 2013: 2). Further, in 2015 Medicine Hat became the first city in Canada to eliminate chronic homelessness, in large part thanks to the use of HF techniques (CBC 2015).

The AH/CS report has also highlighted the success of the HF model, specifically regarding participants experiencing mental illness. The report found that HF programs reduced participants' stays in psychiatric, general and emergency hospitals, in addition to reducing incarcerations and emergency shelter use. Considering this, HF was estimated to cost $14,177 a year for moderate-needs individuals, with a savings of $3.42 for every $10 spent, and $22,257 a year for high-needs participants, with a savings of $9.60 for every $10 spent. The greatest financial rewards were seen in the 10 percent of participants with the highest needs, with savings of $21.72 for every $10 spent (Goering et al. 2014: 23–26).

The AH/CS report also found that the HF model was more successful in reducing homelessness than the traditional CoC model. During the final six months of the study, 62 percent of HF recipients were housed all of the time, 22 percent were housed some of the time and 16 percent were never housed. This success rate is far higher than that experienced by people housed using the CoC model (which had housing rates of 31 percent, 23 percent and 46 percent, respectively) (Goering et al. 2014: 5). In the Winnipeg portion of AH/CS, 45 percent of HF participants were housed all of the time during the final six months of the project, compared to 29 percent of participants who received treatment using the CoC model (Distasio 2014: 5). These figures suggest that in Winnipeg HF was more effective than the CoC approach, but also that HF in Winnipeg was less effective than at other test sites. In part the lower housing rates experienced in Winnipeg can be explained by the city's low housing vacancy rates and the unique challenges of working with Aboriginal clients. These issues, as well as other challenges facing the HF model, will be discussed in detail in the following section.

Identifying Weaknesses and Looking for Solutions

Despite the fact that many studies have concluded that HF is an effective way to address chronic and episodic homelessness, HF is not without weaknesses. The following section will examine some of the research gaps that exist regarding HF. It will then look at several factors that can reduce the effectiveness of HF projects. Finally, it will provide suggestions as to how these barriers can be overcome.

Research Gaps

While research has generally supported the effectiveness of the HF, a number of the studies that have looked at the model have been of questionable quality and/or have only looked at small subgroups of the homeless population. In their HF literature review, Waegemakers Schiff and Rook (2012) found that many studies lacked methodological rigour. For example, a number of them were done internally by the organization running the program, with a small number of participants, over a relatively short period of time and at a single site. Many studies also lacked a control group for comparison, while others lacked quantitative data, instead using less precise qualitative tools such as interviews to examine outcomes. Waegemakers Schiff and Rook (2012) also found that HF research was generally not very diverse. Before 2008 the majority of studies looking at HF outcomes were written by Sam Tsemberis, founder of Pathways to Housing, and focused on that organization in particular. Also, while there was a great deal of research looking at the outcomes of the urban homeless population and individuals with mental illness and/or substance abuse issues, few studies looked at the outcomes of other subpopulations. In particular, Waegemakers Schiff and Rook (2012) found that rural homeless, youth, families, ethnic minorities and women had received less attention in the HF literature. Overall, while they concluded that evidence supported the effectiveness of HF, particularly for single adults with substance abuse issues and mental illnesses in urban areas with adequate rental stock, they questioned whether it should be considered a "best practice" without further high-quality research.

A strong first step toward improving the quality and scope of HF literature has been taken by the AH/CS final report (Goering et al. 2014), which was published in 2014, after Waegemakers Schiff and Rook's literature review. AH/CS was conducted using a control group in addition

to an experimental group and it recorded both qualitative and quantitative data. Also, while the project focused primarily on people experiencing visible homelessness who suffered from mental illness and/or addictions, it captured data on a large number of homeless Canadians from diverse backgrounds, having followed over two thousand individuals across five cities, including a number of ethnic minorities and women.

Still, in the wake of the AH/CS report, a number of questions regarding HF remain unanswered or inadequately answered. For example, what are the long-term impacts of HF projects on participants? What is the impact on the wider homeless population of funding being reallocated toward HF programs and away from traditional homelessness support services? And can HF be effective for populations other than single adults with substance abuse issues and mental illnesses in urban areas with adequate rental stock? Overall, if these questions are going to be answered, more high-quality research on the HF model is needed.

Housing Shortages, Support Services and Small Communities

A significant challenge associated with the HF model is that it generally relies on there being an ample stock of affordable housing available. This is problematic in the Canadian context because there is a severe shortage of social housing and affordable private-market housing in many Canadian communities. One impact of housing shortages is that they reduce the amount of choice that HF agencies can offer their participants. This can be seen in the City of Toronto's 2007 examination of the Streets to Homes program, which found that in Toronto's tight housing market 29 percent of participants reported having no choice in the type of housing they were offered, and 31 percent claimed that they were given no choice in location. The study also found that the low supply of affordable housing resulted in a reliance on shared accommodation, which was less desirable to participants and generally led to worse outcomes, when compared to individuals housed in private apartments (City of Toronto 2007: 18, 34).

A shortage of housing can also impede the ability of organizations to provide suitable accommodation within participants' budgets. This can once again be seen in the City of Toronto's report, which found that the average participant spent 41 percent of their income on rent, far above the 30 percent considered affordable by the Canada Mortgage and Housing Corporation, leaving 68 percent of respondents without enough money to live on after rent was paid. Further, the study found that many housing units lacked amenities. In particular, some participants found food storage and preparation difficult because their apartments lacked stoves, full-sized fridges or cupboard space (City of Toronto 2007: 38, 48, 100).

HF programs are also heavily reliant on the availability of tertiary and support services to help participants reintegrate into the community (Gaetz et al. 2013a: 6). In particular, many participants require access to employment help, health and addictions services and counselling. Due to poverty, many HF participants also rely on food banks and public transportation on a daily basis. HF participants generally receive support from case management teams (intensive case management or assertive community treatment) that are responsible for connecting participants to the services that they need. Yet, if these services are not available, it becomes increasingly difficult to ensure that participants remain healthy and housed.

Challenges related to affordable housing and access to support services are especially relevant in small and rural communities. In their 2011 study, Stewart and Ramage found that many Northern Ontario communities had a shortage of affordable housing and a lack of support services such as emergency shelters, public transportation and mental health services (Stewart

and Ramage 2011: 5). These findings were supported by Schiff and her colleagues, who argued that there were a number of barriers to successfully implementing HF programs in rural communities, including small homeless populations (often exhibiting a large range of acuities), as well as a lack of funding, health workers and housing (Schiff et al. 2014: 33). It has also been argued that in rural settings it can be difficult to find landlords willing to rent to HF program participants. This is because, due to the small populations of these communities, badly behaved tenants can easily gain notoriety with landlords (Greenburg 2007b: 10).

These concerns need to be addressed for HF programs to be effective. The first and most important step that needs be taken is building more affordable housing and social housing. This strategy is already an important aspect of several HF programs in Canada. For example, faced with increasing rents and decreasing housing availability, nine Calgary organizations involved in the city's HF initiative have partnered together with the goal of building social housing units for three thousand vulnerable and homeless Calgarians (Resolve Campaign 2014). Beyond this, if further housing is not built, it is vital that HF projects collaborate with other stakeholders, including governments, private landlords and social housing providers, to ensure that there is enough suitable housing available for program participants.

There are also a number of steps that can be taken to ensure that necessary support services are made available to participants. One approach that has been used by many HF programs is collaborating with other stakeholders in their community. For example, HF programs may partner with a local mental health organization to provide counselling to their participants. Further, they may form an agreement with the local municipality to provide program participants with city bus passes. In small and rural communities, an approach to service delivery that can help overcome challenges related to economies of scale is adopting a regional model, where one HF team works with participants from a number of communities within the same region (Schiff et al. 2014: 33–34). Another approach that holds promise for isolated communities is utilizing the Internet and telephones to offer long-distance counselling and mental health services. Yet, it is worth noting that this strategy is limited by the fact that many remote northern communities lack reliable Internet access (Schiff et al. 2014: 34).

With regard to addressing the challenge of landlords unwilling to rent to HF participants, a recent rural British Columbia HF project (Greenburg 2007b) offers a possible solution. The project found that it was very important to put measures in place to protect landlord interests and to ensure that they did not suffer undue financial loss as a result of participant actions. Further, the project used housing outreach workers who helped participants maintain housing, and mediated between participants and landlords when conflict arose.

Reactivity, Rhetoric and Challenges for the Wider Homeless Population

Another challenge HF faces is that there are some problems it is either ill-equipped to deal with or it fails to address altogether. One area where the HF model falls short is in preventing people from becoming homeless in the first place. By its very nature HF is a reactive approach, placing an emphasis on getting people who are already chronically and episodically homeless off the streets and keeping them housed. This is significant because no matter how many people are re-housed through HF programs, as long as the root causes of homelessness remain unaddressed, more Canadians will continue to find themselves without a home.

As HF has become more popular, a problematic rhetoric has also developed around homelessness and what it means to be homeless. Many

organizations and researchers have talked about HF as an approach that holds the potential to "end homelessness" (Gaetz et al. 2013a; Tsemberis 2010). Further, many Canadian communities, including Winnipeg, are currently engaged in the development and implementation of "plans to end homelessness," which are based around providing comprehensive support, including HF programs, to chronically and episodically homeless individuals (see CTFEH 2014). Yet, as was discussed earlier, individuals who are chronically and episodically homeless only make up a small percentage of the homeless population. Instead, the majority of those at risk are transitionally homeless or experience hidden forms of homelessness. Given this, the rhetoric surrounding the HF model can lead to a narrow understanding of homelessness that overlooks the needs of the majority of people living without a home.

The rise of HF has also presented a number of challenges for the wider homeless community and organizations that work with the homeless. One major challenge that organizations face is access to funding. In recent years, many funding bodies have increasingly devoted resources toward supporting HF programs. Further, when the federal government renewed its Homelessness Partnering Strategy in 2014, it mandated that most communities spend between 40 and 65 percent of what they received on HF projects (Foran and Guibert 2013: 7). Overall, HF programs are currently receiving a great deal of funding attention, but this is often at the cost of other emergency response and prevention services, which in many cases were already underfunded and overwhelmed. In many communities, as part of the transition toward HF, services such as community meal programs and emergency shelters have had their funding cut, leading them to scale back services or close their doors (CBC 2014; Pearson 2015; Richmond 2015). This is problematic because vulnerable Canadians often depend on having access to these programs on a daily basis, and programs are already struggling to fulfill this need. For example, according to the 2011 Winnipeg Street Health Report, over 50 percent of respondents said they had trouble accessing food at least once a week (Gessler and Maes 2011: 17). If funding continues to be reallocated towards HF and away from meal programs, figures like this are likely to rise even further.

Another limitation of relying primarily on the HF approach is that, because it does nothing to address issues surrounding the supply of and demand for affordable and social housing, providing program participants with accommodation can reduce housing availability for those not supported by HF initiatives (either because they are not eligible or because of a lack of program space). This is especially true in a context where there is a severe housing shortage. This can be seen in the example of the Winnipeg portion of the AH/CS study. Even though a relatively small number of people were involved in this HF initiative, conversations with participants have suggested that individuals who did not receive support through the program found it increasingly difficult to obtain housing, because much of the affordable stock was being occupied by HF participants (Peters and Stock 2014). Further, HF programs may disadvantage low-income renters because, as demand for affordable housing increases, landlords may raise rents or become more selective in who they rent to (Peters and Stock 2014).

Because HF does not work to prevent homelessness and struggles to address the needs of the entire homeless population, it is important that HF programs make up only a part of a comprehensive homelessness strategy. At the centre of any such strategy there should be a focus on addressing the root causes of homelessness, with the goal of preventing people from becoming homeless in the first place. The most important step in this direction would be a renewed focus at all levels of government on building more affordable and social housing. Additionally, further investment in programs aimed at providing

support to populations at risk of homelessness could significantly reduce the number of people who lose their homes. It is also important that, in addition to programs focused on re-housing, a number of safety net programs such as emergency shelters and meal programs remain in place to ease the transition of individuals from housed, to homeless, to being housed once again. Programs such as these are vital to the wider homeless and low-income community. As such, stakeholders need to consider the effect that the loss of these services will have before reallocating funding toward narrowly focused HF activities.

As Canada moves toward ending chronic and episodic homelessness using the HF model, it is also crucial that more is learned about hidden homelessness. To this point, the majority of research and homelessness policy has focused on the visible homeless population, with little attention being paid to individuals couch surfing or living with friends. A strong first step toward understanding hidden homelessness was taken by Eberle and her colleagues (2009) in their attempt to enumerate the hidden homeless population of Vancouver through a telephone survey. Current estimates of Canadian hidden homelessness are derived from these data, but because the study only looked at Vancouver, it is difficult to generalize its results. It would be a worthwhile endeavour to conduct further studies across Canada, to gain a better understanding of the true size of the hidden homeless population and the challenges they face. This understanding would allow organizations to work more effectively toward ending hidden homelessness as well as visible homelessness.

Aboriginal, High-Acuity, Women and Youth Participants

A final challenge faced by HF is that a number of homeless subpopulations, namely high-acuity participants, Aboriginal participants, women and youth, face unique barriers to being housed. Because of these barriers, many of these populations have experienced worse than average outcomes under HF programs. For example, among participants suffering from multiple mental illnesses and/or severe substance abuse issues, while HF has been more successful than the CoC model, housing retention rates have been below average (Johnsen and Teixeira 2010: 12). When discussing the impact of addictions, one American HF stakeholder said:

> The group that we lose in this programme, I would say almost all of them are because of addiction … Because it's independent apartments in the community, people with severe addiction problems tend to figure out ways to use the apartment as a commodity where … they'll get free drugs in order to allow for others to be there using. And so it becomes a lease violation, really, that triggers the attention of the landlords or the police or somebody, that ends up in them losing their apartment. (Johnsen and Teixeira 2010: 11)

The AH/CS study also experienced difficulties addressing the needs of high-acuity participants. The study found that, of the HF participants who did not receive stable housing after one year, participants typically had been homeless longer, were less educated, had more connections to street culture and were more likely to face cognitive impairment or serious mental health issues (Goering et al. 2014: 7).

In its evaluation of the Streets to Homes program, the City of Toronto (2007) found that Aboriginal individuals reported fewer improvements in their quality of life than the average participant, as can be seen in Figure 2. There are several explanations for why Aboriginal participants have experienced worse outcomes. In the study in question, Aboriginal participants tended to have been homeless for longer, had experienced more episodes of homelessness and were more likely to have substance abuse problems. This is significant because, as is discussed above,

TABLE 1 **Streets to Homes: Aboriginal Outcomes**

	Aboriginal	Non-Aboriginal
Improved health	60%	74%
Improved food	43%	73%
Reduced stress	48%	65%
Inproved sleeping	52%	75%
Improved personal safety	52%	80%

SOURCES: Graph Source: (Favlo 2009: 28); Data Source (City of Toronto 2007: 43)

high-acuity participants have tended to achieve worse outcomes with HF. The homeless Aboriginal population also tends to be highly mobile, which runs counter to HF's emphasis on establishing a home base (Peters and Robillard 2009: 653). Culture may also be a barrier that prevents Aboriginal participants from effectively utilizing HF services. A Winnipeg study (Deane et al. 2004: 240) found that, because of the importance placed on reciprocity within the Aboriginal community, Aboriginal people tended to rely on their own social networks for support, as opposed to mainstream organizations, which were seen as practicing charity. Furthermore, the history of colonialism and racism may cause Aboriginal participants to feel less comfortable working with non-Aboriginal organizations.

Youth also face a number of barriers that may limit the success of HF programs. One major issue that HF programs may experience when housing youth is the building of trust, especially if the young person has had bad experiences with authority figures in the past. If housed in a private apartment or in an unfamiliar neighbourhood, youth may also experience feelings of isolation, which can be crippling given the importance of peer groups to a young person's social development. Finally, youth may lack the maturity or skill sets required to run their own home and this may lead them to feel overwhelmed (Gaetz 2014: 7).

With regards to women, the major challenge that HF faces relates to access. This is because the large majority of homeless women are part of the hidden homeless population, as opposed to the visibly homeless population generally targeted by HF programs. According to Klodawsky (2006: 368), when compared to men, women are less likely to stay in shelters or on the streets. Instead they are more likely to couch surf or attach themselves to housed men. Women are also more likely than men to remain in precarious housing situations. For example, some women exchange sex for housing while others may choose to stay in abusive homes to retain custody of their children (Klassen and Spring 2015; Klodawski 2006: 366). Overall, because of the invisible nature of women's homelessness, the HF model may struggle to connect with, and address the needs of, homeless women.

If HF is going to equitably address the needs of all homeless Canadians, strategies must be developed to improve the outcomes of participants with unique challenges. For HF to be an effective tool for working with homeless women, an emphasis needs to be placed on making programs accessible, especially among women experiencing hidden homelessness. One way this can be done is by establishing strong lines of communication with other organizations that homeless women may use, such as shelters, health services, meal programs, women-centred resource programs and addictions centres.

When working with youth, there are several considerations that HF programs should keep in mind. First, it is important for HF organizations to acknowledge that youth may not be prepared to live independently. As such, it may

be necessary for youth to live in communal or transitional housing for a time, to allow them to build the skills required for independent living. In other cases, the best approach may be to re-establish connection with the youth's family, allowing them to move back home when ready (Gaetz 2014: 19–22). Second, an emphasis needs to be placed on building trust. Trust building is often a long and difficult process. Considering this, existing organizations with pre-established relationships with youth should generally be the ones implementing HF. Further, when connecting with youth, organizations should look to provide low-barrier and low-commitment supports, such as drop-in programs, to build trust and transition them into HF programs. Finally, to prevent feelings of isolation and loneliness, HF organizations should provide youth with opportunities for community engagement (Gaetz 2014: 13). For example, this can involve supporting and encouraging youth to join community organizations, volunteer, return to school or find a job.

With regards to working with high-acuity participants, lessons can be taken from the experiences of the Vancouver AH/CS program. As part of the city's HF initiative many high-needs individuals were placed in a congregate housing setting. In this environment clients were given their own room and bathroom, but would come together for daily meals and social activities such as crafts and sports. Clients were also given onsite access to social and health supports and were able to speak with program employees at a reception desk that was staffed twenty-four hours a day. Overall, the congregate housing model was found to be very effective at supporting high-acuity clients. This is highlighted by the fact that over 60 percent of congregate housing participants were stably housed for the entire six months preceding the writing of the project's final report. (Currie et al. 2014: 11–12, 17)

Canada's Housing First Toolkit, which builds on the lessons learned during the AH/CS project, also makes several suggestions with regards to how the needs of high-acuity participants can be addressed. First, the toolkit stresses the importance of creativity and flexibility among program staff. These characteristics are important considering that in many cases high-acuity participants can be unpredictable and difficult to work with. Second, the toolkit emphasizes the need for communication and collaboration. In particular, it argues that when working to address the challenges posed by high-needs participants, HF projects should be prepared to work with landlords and with experts in fields such as mental health, trauma and addictions (Polvere 2014: 82, 97).

When working with Aboriginal participants, culturally safe and appropriate service is vital. To achieve this, it is important that support is provided for Aboriginal-led housing organizations, that partnerships are encouraged between Aboriginal and non-Aboriginal organizations and that cultural training is provided to non-Aboriginal organizations (Peters and Craig 2014: 5). In the Winnipeg portion of AH/CS, 71 percent of participants were of Aboriginal descent, and because of this a great emphasis was placed upon providing culturally appropriate services. To accomplish this, the city's approach to HF was adapted to consider Aboriginal values and lessons, which were taken from a number of sources including the Medicine Wheel and the Seven Teachings. In addition, existing Aboriginal organizations — the Ma Mawi Wi Chi Itata Centre and the Aboriginal Health and Wellness Centre of Winnipeg — were contracted to provide HF services to Aboriginal clients. The Winnipeg AH/CS site also worked to educate its staff about Aboriginal culture and history. This was done by organizing talks by Aboriginal teachers and elders, and by having staff engage in traditional Aboriginal ceremonies (Distasio 2014: 10).

The final report of the Winnipeg site of AH/CS indicates that these measures were moderately successful at supporting Aboriginal clients. The report found that approximately 25 percent

of Aboriginal clients who received support using the CoC model were stably housed during the final six months of the study. In contrast, 50 percent of Aboriginal participants who worked with the Aboriginal Health and Wellness Centre of Winnipeg's HF program were stably housed for the duration of the study. For Aboriginal clients working with the Ma Mawi Wi Chi Itata Centre, this figure was 34 percent. Interestingly, among non-Aboriginal HF participants served by the Ma Mawi Wi Chi Itata Centre, 63 percent were able to achieve stable housing. Finally, among participants (some Aboriginal and some with other cultural backgrounds) who received HF support from the Wiisocaotatiwin service team, 40 percent were housed for the entirety of the projects final six months (Distasio 2014: 18). Two central trends can be identified in this data. First, when working with homeless Aboriginal peoples, HF appears to be more successful than the CoC model. Second, HF outcomes for Aboriginal peoples appear to be much less impressive than those seen among non-Aboriginal participant. Overall, this suggests that HF can be adapted to effectively work with Aboriginal populations, but also that the unique challenges faced by Aboriginal participants can be difficult to address.

Conclusion

The positive portrayal of the HF model in research, and its rapid adoption around the world, are testaments to the effectiveness of HF at housing individuals and keeping them housed. Yet, it is important to realize that there are still a number of gaps that exist in our understanding of HF, particularly with regards to its long-term effectiveness and its effectiveness when working with subpopulations including women, youth and those experiencing homelessness in a rural location. Further, there are still aspects of homelessness that are not fully understood. Specifically, little research has been conducted about Canada's hidden homeless population. Because of this, it is vital that further research on HF and homelessness is completed.

Another conclusion that can be drawn from this paper is that a one-size-fits-all approach to HF is not viable. Instead, HF programs need to represent the unique needs of the participants and communities they are serving. In rural areas, this may involve using a regional services model to achieve economies of scale. When working with youth, this may involve additional supports to provide individuals with the skills they need to live independently. When working with Aboriginal participants, this may involve engaging with Aboriginal service providers and using culturally appropriate measures of success.

Finally, this paper has argued that HF is not a silver bullet answer to homelessness. One reason for this is that it fails to address many of the core causes of homelessness, in particular the shortage of affordable and social housing in Canada. Further, the HF model is generally reliant on other programs (meal programs, counselling centres, emergency shelters, health and mental health services and employment, income and education programs) to support participants in their recovery and as they transition out of homelessness — programs that may disappear as funding is reallocated to HF. Finally, the HF approach may not be fully effective for all homeless individuals. Instead, some homeless subpopulations, such as people with an Aboriginal background and high-acuity participants, have experienced below average outcomes using the model. Overall, because of these factors, HF should not be seen as the approach that will "end homelessness." Instead, it should be seen as playing a role in a wider, comprehensive homelessness strategy that includes a renewed investment in social and affordable housing, programs targeted at populations at risk of becoming homeless, emergency support services and poverty reduction initiatives to support the sustainable transition to being stably housed.

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