VICTORIA INTEGRATED COURT

THE HOUSING PROBLEM

By Samira Hiscock & Emanuela Bocancea

I. INTRODUCTION

In 2007, the newly-formed Victoria *Mayor's Task Force* was charged with recommending and developing a new service model for better assisting residents experiencing addictions, mental illness, or homelessness. The resulting report found chronically homeless individuals consumed a large amount of social services, heavily used emergency and acute healthcare services, and their frequent contact with the police and justice system lead to many becoming chronic offenders.[1] To address these concerns, the immediate creation of Assertive Community Treatment (ACT) teams was recommended. ACT teams consist of multidisciplinary staff who provide integrated services for individuals living with complex mental illness and/or substance use disorders, including treatment, rehabilitation, and support services. As a result of the recommendation, four ACT teams were funded by the Vancouver Island Health Authority (VIHA).[2]

By 2009, attendance of these ACT team members in the courtroom led to the idea of the justice system supporting these community-led initiatives. As a result, the Victoria Integrated Court (VIC) was established in 2010. Today, individuals who come through the VIC are supported by all four ACT teams, the 713 Outreach Team, Community Living BC Community Response Team, or Forensic Services.[3] The VIC takes an integrated approach to dealing with mentally and/or substance disordered chronic offenders by bringing together community supports to better address the complex problems that contribute to and motivate criminal behavior, especially amongst those experiencing chronic homelessness.[4] To be eligible for the VIC, an accused person must meet the following criteria:

1. Demonstrate a willingness to address - with community support, including intensive supervision - the underlying causes of their criminal activity;
2. Have a history of substance addiction and/or mental disorder and unstable housing; and,
3. Be accepted as a client of an Assertive Community Treatment (ACT) team, or supported by another community service for an alternative plan of supervision in the community.[5]

A recurrent theme in the VIC reports since 2011 is the prevalence of housing gaps for offenders coming through the court.[6] Additionally, in our visit to the VIC, several discussions surrounded the

---

[1] Mayor's Task Force, "Breaking the Cycle of Mental Illness, Addictions and Homelessness" (19 October 2007), online: City of Victoria <http://www.victoria.ca/EN/main/city/mayor-council-committees/task-forces/homelessness.html>.
[2] The Pandora ACT team, the Victoria Integrated Community Outreach team (VICOT), the Downtown ACT team, and the Seven Oaks ACT team.
[3] The VIC also accepts individuals who are not being supported by any of these teams.
[4] For a detailed background to the VIC's formation and its practice and procedures see the initial 2011 report found at: Victoria Integrated Court, "Victoria Integrated Court Report 2011" (28 July 2011), online: Provincial Court of British Columbia <http://provincialcourt.bc.ca/about-the-court/specialized-courts#VictoriaIntegratedCourt> [*VIC reports*].
[5] *Ibid* at 14.
[6] *Ibid* see 2011, 2012, 2014, and 2015 reports.

difficulties with housing individuals with behavioral, substance abuse, mental health, or otherwise disruptive issues. This paper will present and discuss the housing problem and how it affects such individuals within the criminal justice system. First, we discuss the broader context of homelessness and the housing problem. Second, we examine "Housing First" – the widely-recognized best practice model for combatting homelessness. Third, we discuss the implementation of solutions such as Housing First, and the challenges and barriers entailed in such efforts. Fourth, we present the housing problem specific to Victoria and the community responses to address it. We conclude with a brief summary of how Victoria's responses square with the literature and present two recommendations for the VIC to address housing gaps.

II. THE HOUSING PROBLEM IN CANADA

Mass homelessness emerged in Canada during the 1980s, in the wake of economic structural shifts, widespread disinvestment in affordable housing, decreased spending on social support programs, and deinstitutionalization from psychiatric and other long-term health facilities.[7] Between 150,000 to 300,000 people in Canada experience homelessness each year, and in Vancouver alone more than 2500 people are homeless on any given night.[8] The number of homeless people has steadily increased across Canada, especially in BC where one study estimated that about 17,500 to 35,500 people were inadequately housed.[9] In 2013, the estimated annual cost of homelessness in Canada was $7 billion.[10]

It has been recognized around the world that stable, adequate housing is a basic determinant of health.[11] Homelessness and transient housing negatively impact both physical and mental health, and are associated with an increased spread of infection (such as HIV and tuberculosis), higher rates of mental illness and substance abuse, and increased mortality.[12] Recent demographic aging trends suggest that chronic health conditions are becoming increasingly prominent for homeless health services as the

---

[7] Stephen Gaetz et al, *The State of Homelessness in Canada 2016* (Toronto: Canadian Observatory on Homelessness Press, 2016) [Gaetz et al, *State of Homelessness*] at 4; Canada, Parliamentary Information and Research Service, "Exploring the Circle: Mental Illness, Homelessness and the Criminal Justice System in Canada", by Tim Riordan (Ottawa: Library of Parliament, April 23, 2004) [Riordan, "Exploring the Circle"] at 7.

[8] Sahoo Saddichha et al, "Homeless and incarcerated: An epidemiological study from Canada" (2014) 60:8 International Journal of Social Psychiatry 795 [Saddichha et al, "Epidemiological Study"] at 795; Gaetz et al, *State of Homelessness*, *supra* note 7 at 5 estimated that at least 235,000 Canadian experience homelessness in a year.

[9] Reinhard M. Krausz, "British Columbia Health of the Homeless Survey Report" (Vancouver: University of British Columbia, 2011) [Krausz, "Homeless Survey"] at 3.

[10] L. Polvere et al, *Canadian Housing First Toolkit: The At Home/Chez Soi Experience* (Calgary and Toronto: Mental Health Commission of Canada and the Homeless Hub, 2014) [Polvere et al, *Toolkit*] at 11.

[11] Ruth Elwood Martin et al, "Homelessness as viewed by incarcerated women: participatory research" (2012) 8:3/4 International Journal of Prisoner Health 108 [Elwood Martin et al, "Incarcerated Women"] at 108.

[12] *Ibid.*

population ages.[13] Homelessness disrupts social bonds and impairs the development and maintenance of personal relationships that are critical for getting off the street. Street culture becomes a way of life, and one's personal identification as a "homeless person" is entrenched over time by interactions with the public that perpetuate preconceived ideas and fears about homeless people based on stereotypes.[14]

But homelessness is not evenly distributed across society. Certain demographic sectors are disproportionately vulnerable to housing instability, including youth, LGBTQ individuals, women, indigenous people, immigrants and refugees, and criminal offenders.[15] As noted by Echenberg and Jensen (2009), "[t]he paths to homelessness are as complex and varied as the homeless population itself."[16] A number of factors have been identified as primary contributors to homelessness, including mental illness and substance abuse, marital breakdown and a history of abusive relationships, poverty, transitions out of institutionalized care, inadequate social assistance and affordable housing, a changing labour market and decreased living wages, increasing income inequality, victimization and trauma, and public policy regulations.[17]

(i) Housing Instability & the Criminal Justice System

"*A shelter is an external jail with more yard time.*"[18]

"*Sir, are you aware that you are serving a life sentence on the installment plan?*"[19]

Although there is now a substantial body of literature on homelessness, specific research on the relationship between homelessness and incarceration is relatively recent. Homelessness and incarceration appear to be interrelated phenomena. On one hand, individuals who experience homelessness face an increased risk of becoming involved with the criminal justice system, while on the other hand, offenders face an increased risk of becoming homeless upon their release from prison. The passing of "anti-

---

[13] Alberta, Alberta Health Services, *Literature Review and Best Practices for the Housing and Supports Framework; Housing and Supports Initiative; and Creating Connections: Alberta's Addiction and Mental Health Strategy*, by Celina Dolan et al (Edmonton: Alberta Health Services and Government of Alberta, 2012) at 6.
[14] *Ibid*.
[15] *Ibid* at 7-8.
[16] *Ibid* at 15.
[17] *Ibid*.
[18] Stephen Gaetz & Bill O'Grady, "Homelessness, Incarceration, and the Challenge of Effective Discharge Planning: A Canadian Case" in J. Hulchanski et al, eds, *Finding Home: Policy Options for Addressing Homelessness in Canada* (Toronto: Cities Centre, University of Toronto, 2009), online: <homelesshub.ca/resource/73-homelessness-incarceration-challenge-effective-discharge-planning-canadian-case> [Gaetz & O'Grady, "Discharge Planning"] at 20. The statement was made by an Ontario releasee from prison, who is currently homeless.
[19] An Alberta Provincial Court judge in Evansburg, AB (a circuit court location) speaking to a chronic offender, whom she sees regularly in the courtroom as he cycles in and out of the criminal justice system.

homeless" legislation in various local jurisdictions, such as the *Safe Streets Act* in Vancouver (2004) and Ontario (2000), has only fueled this revolving door of the criminal justice system.[20] These laws criminalize activities such as panhandling and sleeping in public spaces, which predominantly target homeless people and land many of them in prison. One study reported that the rate of recent homelessness among inmates is 7.5 to 11.3 times higher than among the general population (after adjusting for age, ethnicity, and gender).[21] Although some studies have indicated that homelessness is not necessarily predictive of recidivism,[22] a lack of stable housing does increase criminogenic risk.[23] Moreover, the Canadian Mental Health Association has argued that underfunded and insufficient local mental health services have also contributed to the increased criminalization of people with mental disorders.[24]

In 2003-2004, Canada's incarceration rate was at its lowest since 1981-1982, but by 2007, Canada had the fifth-greatest incarceration rate in the world, a trend partly driven by "get tough on crime" policies and "law-and-order" approaches to the criminal justice system which increased the prison population and lengthened sentences.[25] But what happens when all of these offenders are released back into the community? Everyone agrees that successful reintegration and prevention of recidivism are desired outcomes after prison. But there are significant systemic barriers to achieving these goals. Homelessness and residential instability have been identified as perhaps the greatest challenges facing offenders in their path to reintegration.[26] Individuals released from prison experience a combination of social, economic, and psychological barriers that hamper their ability to successfully reintegrate.[27]

A study from Washington State found that most released offenders return to impoverished communities in high crime, unsafe urban areas with a shortage of affordable housing. Landlords are reluctant to rent to ex-criminals, living with family members is problematic due to poverty or strained relationships, and histories of mental illness and drug abuse hamper their ability to maintain employment and gain the financial means required to keep a stable residence.[28] For these reasons, offenders usually

---

[20] Gaetz & O'Grady, "Discharge Planning", *supra* note 18 at 2.
[21] Julian M. Somers et al, "Housing First Reduces Re-offending among Formerly Homeless Adults with Mental Disorders: Results of a Randomized Controlled Trial" (2013) 8:9 PLOS One 1 [Somers et al, "Housing First"] at 2.
[22] N. Broner, M. Lang & S.A. Behler, "The effect of homelessness, housing type, functioning, and community reintegration supports on mental health court completion and recidivism" (2009) 5:3-4 J Dual Diagn 323.
[23] M. Makarios, B. Steiner & L.F. Travis, "Examining the predictors of recidivism among men and women released from prison in Ohio" (2010) 37:12 Crim Justice Behav 1377.
[24] Riordan, "Exploring the Circle, *supra* note 7 at 9.
[25] Gaetz & O'Grady, "Discharge Planning", *supra* note 18 at 1.
[26] Faith E. Lutze, Jeffrey W. Rosky & Zachary K. Hamilton, "Homelessness and Reentry: A Multisite Outcome Evaluation of Washington State's Reentry Housing Program for High Risk Offenders" (2014) 41:4 Criminal Justice and Behavior 471 [Lutze, Rosky & Hamilton, "Reentry Housing Program"] at 472; See also E. Gunnison & J.B. Helfgott, "Factors that hinder offender reentry success: A view from community corrections officers" (2011) 55 International Journal of Offender Therapy and Comparative Criminology 287; C.G. Roman & J. Travis, "Where will I sleep tomorrow? Housing, homelessness, and the returning prisoner" (2006) 17 Housing Policy Debate 389.
[27] Lutze, Rosky & Hamilton, "Reentry Housing Program", *supra* note 26 at 471-472.
[28] *Ibid* at 472.

struggle to find independent living arrangements, so many are forced to rely on halfway houses, or work release centers if they qualify, a small number can go from prison into a treatment facility, but otherwise they end up homeless.[29] Other US studies have found that frequent address changes during the first year post release increase the likelihood of breaching parole and landing back in prison.[30] Research in the US indicates that about 10% of parolees are homeless right after release in large urban areas, and among those with substance addictions the rate is 30%.[31]

For Canadian indigenous people, the criminal justice system has effectively become the emergency response to the homelessness crisis.[32] From 2007 to 2016, although the federal prison population increased by less than 5%, the number of indigenous prisoners increased by 39%. The incarceration rate of indigenous people has increased every year over the last thirty years. Indigenous people constitute less than 5% of the Canadian population, but make up over one quarter (26.4%) of the federal prison population, and indigenous women comprise 37.6% of the female inmates.[33] Indigenous people are disproportionately targeted by the Canadian criminal justice system, and this fact is inextricably tied to their increased rate of homelessness. Research has shown that housing which supports the culture, spiritual practices, and teachings of indigenous peoples is key to a successful reintegration strategy, and this includes culturally sensitive treatment for addictions.[34] But such indigenous-specific housing models and treatment programs are still under-represented among available support services.[35] The BC *Health of the Homeless Survey* found that although indigenous people had rates of mental disorder similar to non-indigenous people, they were more likely to have attempted suicide over the past year and had higher rates of alcohol dependence. Indigenous people also suffered from higher rates of Fetal Alcohol Spectrum Disorder (FASD) and anemia, and had experienced more abuse during childhood and adulthood. 70% of the homeless indigenous people in BC had been in the child welfare system (significantly higher than the non-indigenous homeless population), and this was closely tied to the rate of

---

[29] Valerie A. Clark, "Predicting Two Types of Recidivism Among Newly Released Prisoners: First Addresses as 'Launch Pads' for Recidivism or Reentry Success" (2016) 62:10 Crime & Delinquency 1364 [Clark, "Reentry Success"] at 1367.

[30] Lutze, Rosky & Hamilton, "Reentry Housing Program", *supra* note 26 at 474. A study in Georgia found that every address change increased the possibility of arrest by 25%.

[31] Christopher Moraff, "'Housing First' Helps Keep Ex-Inmates Off the Streets (and Out of Prison)" *Next City* (July 23, 2014), online: <https://nextcity.org/daily/entry/housing-first-former-prisoners-homelessness> [Moraff, "Housing First"].

[32] Gaetz et al, *State of Homelessness*, *supra* note 7 at 52.

[33] All of these statistics about incarcerated indigenous people come from Canada, Office of the Correctional Investigator, "Annual Report of the Office of the Correctional Investigator 2016-2017," by Ivan Zinger (Ottawa, Office of the Correctional Investigator, June 28, 2017), online: <www.oci-bec.gc.ca/cntrpt/annrp/annrpt20162017eng.aspx#s11>.

[34] AB, *Literature Review*, *supra* note 13 at 8.

[35] Alberta, Alberta Health Services and Government of Alberta, *Creating Connections: Alberta's Addictions and Mental Health Strategy, Addiction and Mental Health Housing and Supports Framework* (Edmonton, Government of Alberta and Alberta Health Services, June 2014) [AB, *Addictions and Mental Health*] at 7, 26.

abuse suffered by indigenous people and the earlier ages at which they became homeless.[36] These findings suggest that radically different interventions are needed to address the vulnerabilities and challenges faced by Canada's indigenous communities. This should be a key feature in the reconciliation process.

A revealing study engaged women inmates in BC prisons in participatory research, with the aim of gaining insights into the relationship between housing and recidivism.[37] The study was unique because it allowed the women to share their own views and concerns about homelessness, housing, and their criminal conduct. 62% of the participants stated that housing upon release from prison had been a problem in the past.[38] Most cited financial barriers, others mentioned the inevitability of homelessness.[39] 63% of those who had been previously incarcerated self-reported that homelessness contributed to their recidivism.[40] They cited desperation and survival, and the lack of basic needs stemming from homelessness leading to crime, and they described how the lack of a home to which to return inevitably led them back into street life, drug use, and crime. In the words of one inmate: "[e]very time I have been released I have always started out on the street – being left on the street it's easy to fall back into the street life – no place (to live) means back on drugs and do crime to support it – it's a vicious cycle."[41] Quite revealingly, only 12% of previously incarcerated women reported that they had received housing information while in prison, and in those few cases it had come from an alcohol and drug counselor.[42]

---

[36] Krausz, "Homeless Survey", *supra* note 9 at vii.
[37] Elwood Martin et al, "Incarcerated Women", *supra* note 11.
[38] *Ibid* at 109. This factor was most commonly reported by women with shorter sentences (five months or less) and those living on Vancouver Island.
[39] *Ibid* at 109-110. Some illustrative quotes from inmates (self-reported on the questionnaire): "Rents too high, lack of references – never have enough cash – no income – released with five bucks and nowhere but the street – How are you supposed to live with that?"; "Social Assistance gave me a hard time when applying for rent – hard to get on welfare and to stay on. It's hard to get a place when you're released with nothing – There isn't housing available – Not having housing prior to coming to jail or any family to go to upon release – I didn't know anything was available – You get out and no one to share (cost) with."
[40] A response that was more common for women with five or more prior incarcerations, six or more years since their first incarceration, and who resided in Vancouver Island or the Fraser Valley.
[41] *Ibid* at 110-111. Some illustrative quotes from inmates (self-reported on the questionnaire): "Without a place to go – desperation takes over, that or fear."; "Gotta do what you gotta do to survive. Need $ for place to sleep and food – turn to crime to survive – you live day to day."; "If I had my own home, I would have felt some of the security I had before I left jail. Stability is a big thing for me."; "Not having anywhere to go took me back to where I knew the people. Once you're there the life style compensates for any feelings or feeling of belonging. You drown yourself in drugs to not feel. Then, you need to support that habit to stay numb and start selling dope or your body."; "I had nowhere to live so I was not able to gain employment therefore I stole someone's money to survive."; "I was on the street again. I had to make money by selling dope because if you don't have a (home) address no one will hire you."; "Without a place to live it's hard to sleep and without sleep it's hard to get work."; "If I had a place to live when I get out I would try my hardest to get a job and stay clean. I hate this life. I hate having nowhere to go."; "Had to lie to get an apartment from welfare money – I had to lie about my name to landlord as I had my name black listed as criminal."; "I had nowhere else to go – I had to go live back where I was when I got arrested (a meth shack) and was influenced and tempted minutes after I got home."; "Me reoffending is a huge part of having no home – to live in hotels, I go and do dope, sell drugs."
[42] *Ibid* at 112.

Overall, the women who lived on Vancouver Island and the Fraser Valley prior to their arrest were significantly more likely to report that finding housing upon release was a problem and that homelessness contributed to their return to crime.[43]

(ii) Mental Disorders and Substance Abuse

Across all demographics, research has demonstrated that mental disorders, substance abuse and homelessness are co-constituting in complex ways. The intersection between mental health and criminal justice has been described as a "new frontier" for health sciences research.[44] People suffering from mental disorders are over-represented in the criminal justice system worldwide, and the problem has only grown over time.[45] Progressive deinstitutionalization from psychiatric and other long-term health facilities, starting in the 1960s, has significantly reduced the hospital population, while increasing the number of mentally ill people who are out in the community. But this process was not accompanied by a corresponding increase in the availability of community-based support and treatment services.[46] Exacerbating the problem, in the 1990s some jurisdictions in Canada restricted the availability of social assistance and defunded social housing, placing more individuals at risk of becoming homeless, and making it harder for homeless people to find housing and access the (mental) health services necessary to reintegrate into society.[47] Inadequate health and social services have also meant more pressure on hospitals, police, and emergency services, a process which ultimately affects all sectors of society adversely.[48]

In Canada, reported symptoms of serious mental illness experienced by federal offenders at the time of admission increased by 71% for females and 61% for males from 1997 to 2010.[49] According to the 2011-2012 Annual Report of the Correctional Investigator, 36% of Canadian federal offenders required psychiatric or psychological follow-up at the time of admission, while 69% of female and 45% of male inmates received mental health care services while incarcerated.[50] The *Cowper Report* estimated that 56% of the people incarcerated in BC suffer from diagnosed substance abuse or some other type of

---

[43] *Ibid* at 113.
[44] Somers et al, "Housing First", *supra* note 21 at 1.
[45] *Ibid*. An estimated 1 million individuals with mental disorders are involved in the US criminal justice system.
[46] Riordan, "Exploring the Circle", *supra* note 7 at 7; British Columbia, BC Justice Reform Initiative, *A Criminal Justice System for the 21st Century: Final Report to the Minister of Justice and Attorney General Honourable Shirley Bond*, by D. Geoffrey Cowper QC (Victoria: BC Justice Reform Initiative, August 27, 2012) [BC, *Cowper Report*] at 151.
[47] Riordan, "Exploring the Circle", *supra* note 7 at 8.
[48] *Ibid* at 9.
[49] CAMHS 2013, 2
[50] CAMHS 2013, 2

mental disorder.[51] It is also well known that the prison environment contributes to the recurrence, worsening, or emergence of mental illness or substance abuse problems.[52] Those who enter prison with an existing mental health problem tend to have fewer personal resources to be able to cope with stressors, which can lead to an exacerbation of their disorder.[53]

Individuals with 'concurrent disorders' – those who suffer simultaneously from substance addictions and mental illness - also referred to as "SAMI" (for "Substance Abuse and Mental Illness") – are at the greatest risk for homelessness and incarceration, and thus face the greatest challenges to reintegration. A diagnosis of concurrent disorders occurs when at least one disorder of each type can be established independent of the other, and the conditions are not part of a cluster of symptoms resulting from one disorder.[54] SAMI individuals are more likely to be arrested for mischief, minor theft, disturbance, and failure to appear in court. They are also less capable of understanding, remembering, and complying with conditions of release, fueling the revolving door of the criminal justice system.[55] People with concurrent disorders are more likely to lose contact with friends and family and maintain employment, ending up without any community support. Due to significant stigmatization and misunderstanding about people with such conditions, the wider community often fears and rejects them, although they may pose no risk to public safety.[56] Simon Fraser University's Centre for Applied Research in Mental Health and Addictions estimated that it costs Vancouver's criminal justice and health systems about $100 million per year to deal with the mental illness and addictions crisis.[57]

In addition to the primary contributors to homelessness facing the general offender population discussed previously, SAMI individuals face a number of additional risk factors, including deinstitutionalization, inadequate discharge planning and community follow-up, and insufficient social and health supports.[58] SAMI also exposes homeless people to a greater risk of adverse health effects, including overdoses and infectious diseases.[59] Treating people with concurrent disorders is far more challenging than treating either type of problem on its own, and there are insufficient programs available that are designed to address the demands of this growing population.[60] Moreover, very different types of

---

[51] BC, *Cowper Report*, *supra* note 46 at 151-152.
[52] Riordan, "Exploring the Circle", *supra* note 7 at 10.
[53] *Ibid*.
[54] AB *Literature Review, supra* note 13 at 12, adapted from the US Substance Abuse and Mental Health Services Administration's Co-occuring Center for Excellence.
[55] BC, *Cowper Report, supra* note 46 at 152.
[56] *Ibid*.
[57] Vancouver, "Caring for All: Priority Actions to Address Mental Health and Addictions", Mayor's Task Force on Mental Health and Addictions, Phase 1 Report (Vancouver: City of Vancouver, September 2014) [Vancouver, "Mayor's Task Force"] at 10.
[58] AB, *Literature Review*, *supra* note 13 at 15.
[59] Saddichha et al, "Epidemiological Study", *supra* at note 8 at 798.
[60] BC, *Cowper Report*, *supra* at note 46 at 152.

medical and social interventions are needed to address different types of disorders, Fetal Alcohol Spectrum Disorder[61] vs schizophrenia, for example. There are clearly significant practical challenges to developing effective intervention strategies for these people.[62]

Data from Vancouver showed that approximately 50-80% of homeless people have a history of mental illness, suffer from substance abuse problems, have histories of incarceration, and are therefore far more likely to become (or stay) involved with the criminal justice system.[63] A 2007 study reported that of all the people in BC suffering from substance abuse or mental illness, a sobering 30% were estimated to be living in unstable housing.[64] One study reported that 76% of provincially sentenced women in BC over a six-year period suffered from substance abuse or mental illness compared to only 53% of men over the same period, and that 37% of the women suffered a non-drug-related concurrent mental illness compared to only 21% of men.[65] Among women, housing instability is associated with higher rates of substance use and depression, and there is a disproportionately higher mortality rate among young women.[66] Such evidence suggests that SAMI may have disproportionately worse effects on certain demographics, such as women. The 2014 Vancouver *Mayor's Task Force Report* noted that two thirds of the city's homeless population is in urgent need of sufficient addictions and mental health supports.[67] A 2013 *Hotel Study* in Vancouver's Downtown Eastside (DTES) reported that around 2000 people with serious addictions and mental health issues living in single-room occupancy hotels were not getting the treatment they needed – a population that was characterized by increased morality rates and the prevalence of infectious diseases, substance dependence, mental illness, and brain injury.[68]

The BC *Health of the Homeless Survey* (2011) further revealed a particularly horrific and complex situation. The study found extremely high rates of multiple concurrent disorders among the province's homeless (or unstably housed) population, of which 93% had at least one current disorder.[69] The most common disorders were alcohol/drug addiction, agoraphobia, major depression, posttraumatic stress disorder (PTSD), and general anxiety disorder. Of those, 60% were at some risk of suicide at the time of their assessment, while more than one third had tried to commit suicide in the past. Polysubstance abuse was typical – participants reported using a median of three psychotropic substances over past 30 days. A third suffered from five or more chronic conditions, and 62% had experienced past head injuries.

---

[61] Hereinafter, "FASD".
[62] *Ibid*.
[63] Saddichha et al, "Epidemiological Study", *supra* at note 8 at 795. For more specific statistics for Vancouver, see also BC, *Cowper Report*, *supra* at note 46 at 152.
[64] Elwood Martin et al, "Incarcerated Women", *supra* note 11 at 109.
[65] *Ibid*.
[66] *Ibid* at 108-109.
[67] Vancouver, "Mayor's Task Force", *supra* note 57 at 6.
[68] *Ibid* at 8.
[69] Krausz, "Homeless Survey", *supra* note 9 at vi.

But only 63% saw a doctor (a number significantly lower than the general Canadian population), while 34% reported a time over the past twelve months when they did not get the healthcare they urgently needed. More than half had visited an emergency room in the past year. Many reported a history of severe psychological trauma (with many having experienced multiple traumatizations): over half had experienced physical, emotional, and sexual abuse, and emotional neglect in childhood, which was followed by high rates of re-victimization through physical, emotional and sexual abuse in adulthood. Women had higher rates of mental disorders than men, especially PTSD and depression, and suffered from more severe substance abuse.[70] and suicidal tendencies, and they were more likely to have used an emergency room in the past year. Those who first became homeless under the age of 25 had experienced higher rates of childhood trauma. Almost half had been in the child welfare system.

New research is starting to complicate this picture even further by showing numerous other factors that co-constitute SAMI, homelessness, and criminal behaviour. An epidemiological study using data from the BC *Health of the Homeless Survey* in Vancouver (N=250), Victoria (N=150), and Prince George (N=100) compared incarcerated homeless people with non-incarcerated homeless individuals with the aim of identifying the vulnerabilities and factors that characterize those homeless people who end up in the criminal justice system. The results found that incarcerated homeless people were more often male (66.6% vs. 52.3%), had more likely been in foster care (56.4% vs. 35.5%), had greater substance abuse problems, especially crack cocaine (69.6% vs. 30.1%) and crystal meth (78.7% vs. 21.3%), suffered from higher rates of depression (57%) and psychotic disorders (55.3%), and had experienced higher rates of childhood emotional and sexual abuse.[71] Based on the results pertaining to foster care and childhood abuse, the study suggested that homeless individuals who were traumatized early in life (through emotional or sexual abuse), put into foster care, rendered homeless, exposed and initiated into substance abuse and re-traumatized on multiple occasions in adult life (especially through adult sexual abuse), were rendered vulnerable to mental disorders and incarceration.[72] The study sample included individuals with criminal records related to drug use, theft, or sex work, which is aligned with research showing that the offences committed by homeless people are predominantly minor crimes directly resulting from their efforts to survive on the streets with insufficient resources.[73] One of the issues the study highlighted was the fact that the criminal justice system did not recognize the crimes committed as substantially related to the untreated mental or substance-related disorders of the offenders.[74]

Courts, police services, and correctional facilities are poorly equipped to address this complex

[70] *Ibid* at vi-vii for a summary of these results.
[71] Saddichha et al, “Epidemiological Study”, *supra* note 8 at 795.
[72] *Ibid* at 798.
[73] *Ibid* at 798.
[74] *Ibid* at 799.

tangle of social and medical problems, since they cannot adequately substitute for the health and social services that such individuals require.[75] Law enforcement officers have restricted powers under provincial mental health legislation, and they are typically not trained to deal with the complex needs of SAMI individuals. And yet in some communities, the amount of time that police officers spend dealing with mentally ill individuals has doubled, which means they often end up fulfilling the role of *de facto* mental health workers.[76]

(iii) Housing Stability Should Be a Top Priority

The Government of Canada very recently affirmed that housing is a human right.[77] Although education, employment, social integration, community engagement, and treatment for mental health and substance abuse problems are all critical for successful societal integration, these factors cannot make a difference without housing.[78] Appropriate, stable, safe housing to meet one's needs is the *sine qua non* for helping any individual reach their full potential and live a fulfilling life. As summarized by Lutze, Rosky & Hamilton (2014),[79]

> Housing is important because it can provide a sense of security that gives social and psychological refuge from external threats and enhance overall well-being. A home provides a place of consistency and control to engage in the day-to-day routines important to building social networks and establishing an identity of personal worth. Residential stability provides a base from which to seek employment, focus on treatment, establish a social network within the community, and to comply with community supervision. Conversely, homelessness and housing instability increases the likelihood of social stigma, exposure to antisocial peers, victimization by others, and "shadow work" that exists outside of the formal economy such as panhandling, scavenging, and street vending that is criminalized in many jurisdictions. Crimes such as theft, prostitution, and drug sales are also more likely. Therefore, homelessness and housing instability generally place ex-offenders in social contexts and situations that are highly correlated with treatment failure (especially for substance abuse and mental illness), violation of supervision, and recidivism. (…) Housing stability therefore serves as a conduit to access and build the social capital necessary to sustain long term reintegration into the community. Averting homelessness or transience by providing stable housing is likely to reduce exposure to deviant peers, social stigma, and the violation of public order laws related to living and working on the street and increase exposure to pro-social networks, constructive activities, and a sense of safety and well-being conducive to participating in treatment and other services.

Speaking specifically about the importance of ensuring stable housing for SAMI individuals, Somers et al (2007) concluded from a literature review,

---

[75] Riordan, "Exploring the Circle", *supra* note 7 at 8.
[76] *Ibid*, referring to a study in Ontario.
[77] CNHS, 8
[78] Moraff, "Housing First", *supra* at 31.
[79] Lutze, Rosky & Hamilton, "Reentry Housing Program", *supra* note 26 at 472-473 (in-text citations removed from quote).

> Stable housing is a fundamental need for all people, but this is especially true for individuals with substance use and mental disorders who also require varying levels of support commensurate with their needs. The preponderance of evidence indicates that supportive housing is an essential component of an effective overall therapeutic and rehabilitation strategy for individuals with dual diagnoses, and with careful planning and consultation, these programs can function well and be perceived as an asset to their communities and neighbourhoods. (…) The treatment of substance use and mental disorders cannot therefore be meaningfully considered in the absence of appropriate housing. [80]

Adding to this perspective, Wood, Samet & Volkow (2013) stated (emphasis added),[81]

> The development of addiction medicine as a formal medical subspecialty also has the potential to begin the slow process of public education required to treat those who are alcohol or drug addicted **with compassion and care, and to move away from over-reliance on punitive approaches that have not served the interests of patients, public health, or taxpayers**.

In another survey of literature spanning 15-20 years of research, Dolan et al (2012) concluded that the provision of housing, as well as tailored support services:[82]

- Reduces hospital visits, admissions and the duration of hospital stays among homeless individuals and overall public system spending is reduced by nearly as much as is spent on housing.
- Results in greater reductions in the use of institutional services (hospitalizations and jails/prisons) than participants in comparison groups.
- Was associated with substantial increases in outpatient services and days spent in housing. Reductions in cost of inpatient/emergency and justice system services generally offset the additional costs.

Ensuring that everyone has stable housing is a social, medical, economic, and moral (from a human rights perspective) imperative. But there are significant challenges to establishing conclusive recommendations about the most effective housing models because such interventions are "socially complex services", which are difficult to operationally define and categorize.[83] The needs of homeless people and ex-prisoners differ from those of the general population, and the supports and services that are provided along with housing must be tailored to address the residual effects of trauma experienced while homeless

[80] Vancouver, "Housing for People with Substance Use and Concurrent Disorders: Summary of Literature and Annotated Bibliography", by Julian Somers et al, Centre for Applied Research in Mental Health and Addiction, Faculty of Health Sciences, Simon Fraser University (Vancouver: Simon Fraser University, January 2007) [Somers et al, "Concurrent Disorders"] at 2.
[81] Evan Wood, Jeffrey H. Samet & Nora D. Volkow, "Physician Education in Addiction Medicine" (2013) 310:16 JAMA 1673 at 1674.
[82] AB, *Literature Review*, *supra* note 13 at 4.
[83] *Ibid* at 5.

or incarcerated, and to support individuals who are on probation.[84]

A comprehensive affordable housing policy is a responsibility that must be shared between all levels of government, in conjunction with local communities.[85] The literature survey by Dolan *et al* found that although the cost savings are shared by all government levels (which fund emergency shelters, prisons, police services, emergency rooms, and mental health facilities), the upfront investment for housing subsidies and supportive services are not typically made by the same parties that will save money from their implementation.[86] The *Cowper Report* also concluded that supportive housing is more cost-effective than the institutional settings and emergency shelters currently used to deal with mentally ill or addicted individuals.[87]

III. HOUSING FIRST – THE BEST PRACTICE MODEL

Traditional approaches to combat homelessness involved moving homeless people in a step-by-step process through treatment, rehabilitation, and transitional housing before they 'graduate' to permanent housing when they are deemed ready (and when housing becomes available).[88] This approach was based on the expectation that individuals 'ready' themselves for housing by voluntarily addressing their problems first (mental health, addictions) – this is also known as the "Treatment First" (TF) or "Treatment as Usual" approach.[89] TF is a highly regulated service model, and included expectations of compliance with abstinence rules and treatment.[90]

But a more recent "Housing First" (HF) intervention model, which developed out of the very successful Pathways to Housing program established in New York City in 1992, is now widely recognized as best practice.[91] It was first implemented in Canada in the Streets to Homes program in Toronto in 2005, and then was applied in many communities across the country (starting with Vancouver, all of Alberta, and a growing list of other places, including Victoria).[92] In contrast to the traditional TF model, where permanent housing is the end-point, HF starts by providing rapid access to permanent

---

[84] *Ibid* at 6.
[85] *Ibid* at 8.
[86] *Ibid* at 4.
[87] BC, *Cowper Report*, *supra* note 46 at 153.
[88] Stergiopoulos, Vicky, et al, "Effect of Scattered-Site Housing Using Rent Supplements and Intensive Case Management on Housing Stability Among Homeless Adults with Mental Illness: A Randomized Trial" (2015) 313:9 JAMA 905 [Stergiopoulos et al, "Scattered-Site Housing"] at 906.
[89] Stephen Gaetz, "A Framework for Housing First" in Stephen Gaetz, Fiona Scott & Tanya Gulliver, eds, *Housing First in Canada: Supporting Communities to End Homelessness* (Toronto: Canadian Homelessness Research Network Pres, 2013) 1 [Gaetz, "Framework"] at 2.
[90] *Ibid*.
[91] *Ibid*, 3-4, for a history of HF and how it emerged. See also AB, *Addictions and Mental Health*, *supra* note 35 at 6 for a short overview of HF.
[92] Gaetz, "Framework", *supra* note 89 at 4.

housing, along with various support services. Gaetz, Scott & Gulliver's *Housing First in Canada: Supporting Communities to End Homelessness* (2013) provides the definitive overview of the HF model in the Canadian context, with the aim of providing practical guidance for its implementation across the country.[93] Gaetz defined HF in a nutshell as follows (emphasis added), "Housing First is a **recovery-oriented** approach to homelessness that involves moving people who experience homelessness into **independent and permanent housing** as quickly as possible, with **no preconditions**, and then providing them with **additional services and supports** as needed."[94]

The philosophy driving HF is the belief that everyone deserves to be housed because housing is a human right, and that safe, stable housing is a precondition for recovery.[95] Thus, as a rights-based intervention, housing is not contingent upon 'compliance' (such as sobriety or abstinence) or 'readiness'. It is typically operationalized like this:

1. Homeless people are offered the option of housing, but without any conditions on behavioural, lifestyle, or treatment expectations (i.e. no expectations of abstinence).
2. Clients who choose to participate are able to provide some input about the location and type of housing that they would prefer, within the constraints of what kind of affordable housing is available in that community. There is a basic standard that the housing be of reasonable quality.
3. Clients are housed as quickly as possible, in order to minimize their time spent on the streets or in emergency services.
4. After they are housed, ongoing supports and services are made available and offered to those who want and need them, including rent supplements, case management, assistance with developing connections within the community, addictions and mental health support, etc. [96]

For those with addictions issues, some may choose to live in 'wet' housing that permits them to keep using, while others may choose abstinence-only housing. Consumer choice and self-determination are key principles of HF, which seeks to provide individualized and client-driven support services which are voluntary, culturally-appropriate, and portable.[97]

In conjunction with housing supports, HF also provides clinical supports (aimed at enhancing mental health and social care), and complementary supports (i.e. income supports, life skills, assistance with enrolling in educational programs, finding employment, accessing training, or engaging with the community).[98] The model is usually operated through interdisciplinary Assertive Community Treatment (ACT) teams, and Intensive Case Management (ICM). ACT teams provide resource-intensive support services 24/7 to small caseloads of clients who require the highest degree of assistance and support. Their job is to ensure that clients do not become isolated, or destructive to the point of jeopardizing their housing, that they are not left without contacts for any additional supports, and to provide encouragement

[93] Gaetz, Scott & Gulliver, *Housing First*, *supra* note 89.
[94] Gaetz, "Framework", *supra* note 89 at 2.
[95] *Ibid* at 15.
[96] *Ibid* at 2 for these operational steps.
[97] *Ibid* at 6.
[98] *Ibid* at 11.

to those who enter treatment for mental health and substance abuse problems.[99] They typically include peer support workers, whose experience of homelessness can be a crucial resource to facilitate recovery and provide support.[100] ICM can also be team-based and constitutes a less intensive intervention and a less costly treatment option for clients who do not require the service intensity of ACT. They can help clients develop plans, enhance life skills, address (mental) health concerns, engage in meaningful activities, and develop social relations.[101] The case studies in Gaetz, Scott & Gulliver (2013) have shown the importance of "wrap-around" services and "systems-responses" in conjunction with housing. HF cannot be implemented by the housing sector alone, it requires active collaboration and partnership with many organizations and governmental agencies.[102]

To meet the needs of a diversity of clients, HF models typically operate through a variety of housing types, which are normally divided into two broad categories: "scattered-site" housing and "single-site" or "congregate" housing. Scattered-site housing, which was first pioneered by the Pathways to Housing program in New York City, engaged private landlords in the community to provide ordinary housing to clients through the provision of rental supplements. The program provided basic furnishings and supplies to set up the home, and supplements ensured that no more than 30% of their income was spent on rent. In the words of Sam Tsemberis (who worked with Pathways to Housing):[103]

> It is not specialized housing, it is ordinary housing. What makes it different and what makes it effective is that people are also provided with lots of good services (...) For people who have spent years excluded, in group homes, hospitals, jails, shelters, and other large public service settings, having a place of their own, their own home, has a huge appeal. (...) Our overall goal is recovery and full integration into the community.

The scattered-site housing model gives clients more choice, is less stigmatizing, and carries the added benefit of allowing the private sector to absorb the capital costs of housing.[104] Single-site or congregate housing involves many units in one building. This model allows support services to be delivered more efficiently, is less isolating, and provides the opportunity for tenants to develop a sense of community. This was used in the Common Ground program pioneered in New York and constituted part of the HF approach first adopted in Vancouver.[105] Although congregate housing may be more suitable for some clients, the effectiveness of this model has not been proven. Finally, some clients with acute and chronic

---

[99] Jeannette Waegemakers Schiff & John Rook, "Housing First – Where is the Evidence?" (Toronto: Homeless Hub, 2012) [Waegemakers Schiff & Rook, "Evidence"] at 6.
[100] Gaetz, "Framework", *supra* note 89 at 8.
[101] *Ibid* at 8.
[102] Tanya Gulliver, "Introduction – Housing First" in Gaetz, Scott & Gulliver, *Housing First*, *supra* note 89 at 1.
[103] Gaetz, "Framework", *supra* note 89 at 3, where Tsemberis is quoted.
[104] *Ibid* at 10-11.
[105] *Ibid*.

(mental) health needs may require Permanent Supportive Housing, which provides a more integrated model of housing and services (where the clinical service provider is the landlord).[106]

Research in the US, Canada, and elsewhere has proven the effectiveness of HF in providing permanent housing and supports to people who were traditionally considered to be "hard to house", and this includes chronically homeless individuals with or without SAMI problems.[107] The world's largest and most in-depth evidence-based assessment of HF's effectiveness was the *At Home/Chez Soi* study funded by the Mental Health Commission of Canada, which ran from 2009 to 2013, and was supported by $110 million of federal funding.[108] HF projects were designed in Moncton, Montreal, Toronto, Winnipeg, and Vancouver, with the aim of understanding the benefits and challenges of implementing the model in the context of specific sub-populations, and sought to assess the effectiveness of the HF intervention for homeless people with serious mental illnesses.[109] The study concluded that HF can be effectively implemented in cities of different size and composition, that HF rapidly ends homelessness, that HF is a sound investment, that HF is *not* 'housing only', that having a home and accessible support services can lead to other positive outcomes above and beyond those provided by existing services (such as quality of life and community functioning), that HF can change lives in many ways, and that getting HF right is essential to optimizing outcomes.[110] The project also identified that for many clients, the first three months of being housed can be the most challenging, and are therefore the most critical for the recovery and retention of housing.[111]

Another study based on the *At Home/Chez Soi* project specifically assessed the effectiveness of scattered-site housing and ICM among mentally ill homeless people (who were compared to participants receiving the 'usual care' through existing housing and support services in their communities).[112] The outcome they measured was the percentage of days stably housed during a 24-month period, and secondary outcome measured was quality of life (assessed by a questionnaire). The results showed that the intervention group in the scattered-site housing was stably housed for longer than the 'usual care' group, and although they did not note a significant difference in generic quality of life, significant gains in condition-specific quality of life was seen among the scattered-site group (relating to leisure, living

---

[106] *Ibid*.
[107] *Ibid* at 1, 3. The Pathways program was extensively evaluated, which provided strong data to demonstrate its effectiveness. See Waegemakers-Schiff & Rook, "Evidence", *supra* note 99 for a literature review of the evidence for HF's effectiveness.
[108] P. Goering et al, "National At Home/Chez Soi Final Report" (Calgary: Mental Health Commission of Canada, 2014) [Goering et al, "At Home/Chez Soi"]
[109] *Ibid* at 6.
[110] *Ibid* at 5 for a summary of the main findings, including the quantitative and qualitative data that support these results.
[111] Gaetz, "Framework", *supra* note 89 at 9.
[112] Stergiopoulos et al, "Scattered-Site Housing", *supra* note 88.

situation, and safety).[113] The findings highlighted the effectiveness of scattered-site housing with ICM services for reducing homelessness among mentally ill people whose conditions are not severe enough to require ACT support. The study's results were in line with the findings of similar studies conducted in the US.[114]

Finally, it is clear that HF also saves money. The Wellesley Institute's Blueprint to End Homelessness (2007) found that the average monthly cost of housing homeless people in a shelter bed was $1932, in a provincial jail was $4333, and in a hospital bed was $10,900. But Toronto's monthly cost for rent supplements (for scattered-site housing) was $701 and $199.92 for social housing.[115] The *At Home/Chez Soi* study also found that by targeting high needs/high service homeless clients, HF can save money, debunking the myth that chronically homeless people have too many problems and needs to be cost-effectively housed.[116]

(iv) Housing First and the Criminal Justice System

In general, most of the HF literature does not specifically address or even mention the specific population of individuals who are engaged in the criminal justice system. This is perhaps surprising considering the fact that HF is premised on the idea that housing is a right for all people, and that housing interventions should be client-centred and tailored to the wishes and needs of different individuals and sub-populations. Indeed, as noted in previous sections, homelessness, substance abuse, and mental illness all intersect with the criminal justice system in undeniable ways. So, if HF approaches aim to end homelessness, they cannot do so without directly confronting and addressing the needs of those in the criminal justice system. This gap in the HF literature is therefore problematic and self-defeating, and may perhaps reflect the broader public fear, stigmatization, and general revulsion at criminal offenders and ex-prisoners. People tend to have a 'tough-on-crime' mentality about locking up criminals and 'throwing away the key', or they simply do not like the idea of housing released offenders in their communities, which is precisely what is needed for proper reintegration into society. It is noteworthy that the HF projects in the *At Home/Chez Soi* study also did not specifically target individuals who were involved in the criminal justice system, which is probably why they concluded that HF (as implemented) only had a small effect on study participants regarding their justice contacts. The final report did mention this

[113] *Ibid* at 911-914.
[114] *Ibid* at 911-912. They cite the similar results of a single-site randomization study done by the US Department of Housing and Urban Development and Veteran Affairs Supportive Housing, which showed that rent supplements and ICM provided greater housing stability and increased social networks for homeless veterans who suffered from mental health or substance abuse problems. Another similar study from New York City reached similar results about the effectiveness of scattered-site housing with ACT.
[115] Gaetz, "Framework", *supra* note 89 at 14.
[116] *Ibid* at 14.

shortcoming and stated that there may be a benefit to a future HF model tailored to the specific needs of legally involved clients.[117] They did, however, note that involvement with the criminal justice system is lengthy and complex, and that the two-year follow-up employed in the study was insufficient to show the downstream effects of housing stability within the context of those involved with the justice system.[118]

In his overview of the HF framework, Gaetz notes that HF reduces involvement with police and the criminal justice system because housing stability decreases criminal involvement and thereby reduces the opportunities for contact between homeless people and the police on the streets.[119] A few studies that have specifically looked at housing interventions for offenders have indicated their effectiveness in reducing recidivism and providing housing stability. A study from 2008 examined the original research data from the proto-HF Pathways to Housing program in New York, with the aim of assessing whether housed homeless people were more or less likely to commit a crime (violent or non-violent).[120] Although the study did not find that HF immediately reduced criminal activity, the research was hampered by its reliance on self-reporting of criminal activity, and it was unclear if sub-reporting in any sub-group could have impacted the results. But they did find a relationship between psychological symptom severity and the commission of non-violent crimes, suggesting that the likelihood of an individual committing a crime increased with homelessness and with increased severity of mental health problems.[121] A more recent study examined whether HF reduces recidivism among formerly homeless adults with mental disorders.[122] They compared individuals who were randomly assigned to 'treatment as usual' (control group), scattered-site HF, and congregate HF. Interestingly they also linked the administrative data about justice system events, allowing them to assess prior histories of offending in order to test the relationships between housing status and offending over the two year period of the study. The majority of the participants (67%) already had convictions, mostly for property offences (mean of 8.07 convictions per person in 10 years prior to start of the study). The results showed that the scattered-site HF model was associated with significantly lower numbers of sentences than 'treatment as usual', and that congregate HF marginally reduced sentences. This was the first randomized controlled trial to demonstrate the effectiveness of scattered-site HF for reducing recidivism among mentally ill homeless offenders.

Although HF programs for released prisoners have been incredibly successful in the US, these programs are relatively scarce. The New York-based Fortune Society has run a successful transitional

---

[117] Goering et al, "At Home/Chez Soi", *supra* note 108 at 22.
[118] *Ibid* at 22-23.
[119] Gaetz, "Framework", *supra* note 89 at 13.
[120] Sean N. Fischer et al, "Homelessness, Mental Illness, and Criminal Activity: Examining Patterns Over Time" (2008) 42 Am J Community Psychol 251.
[121] *Ibid* at 261.
[122] Somers et al, "Housing First", *supra* note 21.

housing facility in West Harlem since the 1990s, from which hundreds of ex-offenders have graduated.[123] It is known as "The Castle", and the program's success was so astonishing (with recidivism as low as 1%) that the city supported the society in opening another facility, "Castle Gardens" in 2010.[124] A similar program is run in six cities by the Delancey Street Foundation from San Francisco.[125] New York's Corporation for Supportive Housing's Returning Home Initiative partnered with the US Department of Corrections and various city agencies to create the Frequent User Service Enhancement (FUSE) program, which provides apartments to an estimated 200 homeless people who had four prison and four shelter stays in the previous five years. A two-year evaluation has indicated that FUSE has generated $15,000 in savings per individual by reducing prison and shelter visits. Nearly two dozen other US cities are now replicating the program, including Washington DC and Chicago.[126]

A recent study examined the effects of five categories of post-release housing placements on recidivism for newly released state prisoners in Minnesota.[127] Private residential housing (in single-family homes, apartments, or townhouses), transitional housing (halfway houses or short-term housing provided by correctional or community agencies), work release centers (Department of Corrections-leased housing for offenders on work release status), shelters (temporary emergency housing, including homeless shelters and motels), and residential treatment facilities (inpatient facilities) were compared.[128] Results showed that re-arrest was highest among those released to emergency shelters (45%), while revocation rates were highest for those who were released into transitional housing (50%). The lowest re-arrest rates were in work release centers (26%) and the lowest revocation rates were in private residential housing (25%).[129] Going from prison directly to an emergency shelter (a homeless shelter or a motel) increased the likelihood of being rearrested by 34%. The higher rates of revocations in correctional-based housing and treatment facility was noted to likely be a product of a higher degree of direct monitoring, and it seemed clear that the best option was housing in private residences, especially if family members or social support was present.[130] Although this study was not specifically focused on assessing a HF approach, its findings align with the HF research that shows the effectiveness of scattered-site housing within the community. And yet, as Clark was right to point out, "Recidivism cannot be the lone measuring stick of

[123] Moraff, "Housing First" *supra* at 31; Fortune Society, online: <https://fortunesociety.org>.
[124] Moraff, "Housing First" *supra* at 31.
[125] *Ibid*; Delancey Street Foundation, online: <http://www.delanceystreetfoundation.org>.
[126] Moraff, "Housing First" *supra* at 31; "NYC FUSE – Evaluation Findings", *CSH: The Source for Housing Solutions*, online: <www.csh.org/csh-solutions/serving-vulnerable-populations/re-entry-populations/local-criminal-justice-work/nyc-fuse-program-key-findings/>.
[127] Clark, "Reentry Success", *supra* note 29. See also at 1365 for survey of other existing literature on housing offenders.
[128] *Ibid* at 1375-1376.
[129] *Ibid* at 1380-1381.
[130] *Ibid* at 1391.

successful programs."[131] Reintegrating ex-prisoners into the community requires more than just preventing recidivism, and preventing recidivism requires a holistic approach that addresses the individual's entire range of concerns, needs, and desires, of which stable housing should be the top priority.

The multiple challenges that confront people released from prison requires a coordinated response between police, the community, institutional corrections, social services, treatment providers, and government agencies, which includes considerations of the ex-offender's needs, and of any public safety concerns.[132] Lutze, Rosky & Hamilton (2014) call such coordinated approaches "wraparound services", in which housing is at the center.[133] This conceptualization is reminiscent of the physical blanket that is actually wrapped around an accused who successfully reaches the end of their probation or sentence in a BC First Nations Court, to symbolize the community support that is literally wrapped around them.[134] The survey of various coordinated 'wraparound service' programs for ex-prisoners found that the Serious and Violent Offender Reentry Initiative (and similar programs) significantly reduced recidivism and offered significantly more services than traditional supervision.[135] But not all coordinated response were a success – New York's Greenlight Project, for example, did not lead to a decrease in rearrests, and one study suggested that this may have been due to budget constraints and the staff's unwillingness or inability to implement the HF model as it was intended.[136]

Few HF interventions target high risk offenders who would otherwise have been homeless, so Lutze, Rosky & Hamilton's (2014) study sought to evaluate the effectiveness of providing HF (which they call "housing centred intervention") with wraparound services to high risk/need offenders who had no place to live upon release from prison.[137] This was an evaluation of the Re-Entry Housing Pilot Program (RHPP) in Washington State that aimed to reduce recidivism and foster reintegration.[138] Unlike other studies, they used a large sample size, and extended the follow-up period beyond the duration of the program to assess downstream effects up to three years post-release. The RHPP, which was created by state legislation, statutorily provides up to one year of housing support to offenders who qualify and who

---

[131] *Ibid* at 1393.
[132] Lutze, Rosky & Hamilton, "Reentry Housing Program", *supra* note 26 at 474.
[133] *Ibid*.
[134] This is based on the BC Provincial Court's Chief Judge Thomas Crabtree's presentation in our Access to Justice class.
[135] Lutze, Rosky & Hamilton, "Reentry Housing Program", *supra* note 26 at 474-475.
[136] *Ibid* at 475; J.A. Wilson & R.C. Davis, "Good intentions meet hard realities: An evaluation of the Project Greenlight Reentry Program" (2006) 5 Criminology & Public Policy 303.
[137] Lutze, Rosky & Hamilton, "Reentry Housing Program", *supra* note 26 at 476.
[138] Although the RHPP was not specifically identified as a HF program, it shares a lot of features with HF models, albeit with some distinctions, as will be notes in the discussion.

are willing to work towards the mandates goals.[139] The program operates with the Community Justice Centers of the Department of Corrections and provides housing along with a range of support services (in this sense it is similar to a basic HF model). Participants live in heavily subsidized apartments (usually with roommates), but they are required to engage in treatment, gain employment, and work towards becoming self-sustainable (aspects that depart from traditional HF models).[140] When compared against offenders who risked homelessness and who had traditional supervision, the researchers found significant reductions in new offences and readmissions to prison among the RHPP group, but no significant effect on parole revocations. Periods of homelessness significantly increased the risk of recidivism to more than two or three times the rate of those in stable housing. "These findings strongly suggest that policymakers need to move beyond conceptualizing residential status as a fixed event, but instead as a fluid and volatile state of being for offenders that is an ongoing threat to successful reentry and long term reintegration."[141] They concluded that providing housing, together with wraparound services, increases the likelihood of successful integration into the community after release from prison.[142] Stable housing for released offenders also reduced violations of public order laws related to living and working on the street and thus improves community safety. It also provides a personal sense of security and well-being that is conducive to voluntary participation in treatment and other services, while also exposing ex-prisoners to pro-social networks.[143]

One interesting observation was that that RHPP may have performed so much better because, as volunteers for the program prior to release from prison, participants had a greater intrinsic motivation to change. Indeed, some prisoners declined to meet with the RHPP case management team because of the strict rules about required treatment participation, employment and abiding by "house" rules.[144] This self-selection bias and limitation illustrates the need for a HF approach that does not impose any precondition to being housed. Most of the prisoners who declined the chance of regulated RHPP housing did so knowing they would likely end up homeless instead.

Despite its widely recognized status as the 'best practice' model for combatting homelessness, HF has been critiqued for the under-representation of people with addictions in HF study samples.[145] And very few housing interventions for people who are mentally ill and homeless have been evaluated for their

---

[139] Lutze, Rosky & Hamilton, "Reentry Housing Program", *supra* note 26 at 476. It was created by Washington State Bill ESSB 6157.
[140] *Ibid* at 476.
[141] *Ibid* at 483.
[142] *Ibid* at 485.
[143] Moraff 2014
[144] Lutze, Rosky & Hamilton, "Reentry Housing Program", *supra* note 26 at 483-488.
[145] Somers et al, "Housing First", *supra* note 21 at 6.

effects on crime or public safety.[146] One study, however, examined participants who were enrolled in the *At Home/Chez Soi* study in Vancouver, and found that HF programs, and especially scattered-site models, reduce offending and recidivism among people who were previously homeless and who have current mental disorders.[147] Two thirds of the sample in this study also met the criteria for SAMI. But a substance abuse problem was not predictive of recidivism, which indicates that non-abstinence-based HF options for people with concurrent disorders can effectively improve public safety. Overall, the results showed that both scattered-site and congregate accommodations can reduce recidivism when compared to the traditional TF model, regardless of the participant's diagnostic status. This demonstrates the primacy of addressing criminogenic risks shared by mentally ill people who are homeless – including exposure to crime, poverty, victimization, untreated mental disorders, food insecurity, and lack of opportunities for legal employment – over the traditional approach of triaging the offence risk on the basis of specific symptoms or diagnoses.[148]

The BC *Cowper Report* mentioned the effectiveness of one housing program, which revealed that once mentally ill clients were stably housed, the use of police detoxification by program participants was decreased by 75%, arrests were reduced by 56%, and incarceration went down by 68%.[149] A UK research report showed that young offenders were significantly hampered in their ability to get their lives back on track by gaps in the provision of appropriate, stable housing during the crucial transition from custody to the community. The findings concluded that supported accommodation for young offenders on release from custody can produce savings of more than £67,000 over a three-year period, by preventing the expensive cycle of recidivism.[150] The Canadian Mental Health Association believes that one of the most important goals should be increased collaboration between police officers and mental health providers, since the most effective intervention for chronic offenders is integrated triaging, involving both health and justice professionals. In the words of the *Cowper Report*, "Using skilled professionals, the community utilizes the legal system's right to control an individual's behaviour as a way of facilitating the individual's access to services, which is likelier to lead to a safe more fulfilling life."[151]

---

[146] *Ibid* at 2.
[147] *Ibid* at 6; Stefanie N. Rezansoff et al, "Beyond recidivism: changes in health and social service involvement following exposure to drug treatment court" (2015) 10:42 Substance Abuse Treatment, Prevention, and Policy 1 at 7-8.
[148] Somers et al, "Housing First", *supra* note 21 at 7.
[149] BC, *Cowper Report*, *supra* at 46 at 153.
[150] Jane Glover & Naomi Clewett, *No Fixed Abode: The housing struggle for young people leaving custody in England* (Essex: Barnardo's, 2011) at 4.
[151] BC, *Cowper Report*, *supra* at 46 at 154.

(v) Effective Discharge Planning for Released Prisoners

The first step in designing a HF intervention strategy for criminal offenders should begin while they are still incarcerated, through effective discharge planning, to establish an integrated continuum of services and care that ensures no one is released onto the street.[152] As mentioned previously, in the participatory research study of women in BC prisons, only 12% of previously incarcerated women reported that they had received any housing information while in prison prior to being released, and in those few cases it had come from an alcohol and drug counselor.[153] A study was conducted in 2005-2006 to assess the nature of discharge planning in provincial correctional institutions, to examine the key similarities and differences between the prison population and non-incarcerated homeless people in Canada, and to evaluate how inmates and releasees experience discharges, with the aim of identifying ways in which to improve the discharge planning process.[154] The study interviewed male inmates and releasees in Ontario and BC, as well as corrections personnel ("planners") involved in the discharge planning process.[155] The releasees were either stably housed, underhoused (in precarious or temporary housing, or in treatment), or homeless (sleeping outdoors or in temporary shelters).[156] The results found incongruities between policy and practice – between those who provide and receive discharge planning. Although Ontario's correctional services included in their mandate "to ensure that correctional programs meet the identified needs of offenders and promote successful reintegration", the Ontario government has no mandate or responsibility to provide community services or programs to a released prisoner who has completed their sentence, or who is released from remand.[157] Only those who are given conditional releases (i.e. parole, or work release) may receive certain community supports.

Due to changes in Ontario's criminal justice policy regarding corrections since the 1990's, marked by a shift towards reduced costs and "no-frills" prisons, there has been reduced program support for discharge planning (including programs geared to employment and counselling), a reduction in parole and conditional release programs (the average number of convicts on parole in Ontario dropped from 1,800 to less than 200 between 1993-1994 and 2004-2005), the elimination of halfway houses and transitional housing programs for ex-prisoners, and an increase in the remand population.[158] The increased number of people in remand, and the increased time on remand (a rise from an average of 22 to 34 days),

---

[152] AB, *Addictions and Mental Health*, *supra* note 35 at 4.
[153] Elwood Martin et al, "Incarcerated Women", *supra* note 11 at 112.
[154] Gaetz & O'Grady, "Discharge Planning", *supra* note 18. See also Stephen Gaetz & Bill O'Grady, *The Missing Link: Discharge Planning, Incarceration and Homelessness*, prepared for the Housing and Homelessness Branch of the John Howard Society of Ontario (Toronto: John Howard Society of Ontario, 2006), which is an earlier more lengthy report on the topic of discharge planning for releasees who are at risk for homelessness.
[155] *Ibid* at 3.
[156] *Ibid* at 3-4.
[157] *Ibid* at 4-5.
[158] *Ibid* at 6-7.

means that even people who are not ultimately convicted can have their lives disrupted, which may include the loss of housing and employment while they await their day in court. Homeless people in remand are more likely to stay imprisoned because bail conditions usually require a home and employment.[159] When they are released from remand, they are usually not eligible for the programs that may be available to sentenced releasees.

The nature of discharge planning varies with each institution, and is provided by corrections personnel and community-based groups, with the latter providing both counselling in prison regarding discharges, and certain transitional supports in the community.[160] Due to large caseloads and a shortage of resources (in both prison and the community), the majority of discharge planning constitutes merely the sharing of information and does not involve intensive planning that establishes contact with appropriate and necessary community supports.[161] In particular, supports for securing post-release housing are limited. Most releasees are simply given a list of homeless shelters and hostels in the area where they will be released.[162] Prisoners are on their own from there, and, unsurprisingly, many end up homeless, and eventually back in prison.

Moreover, only 35% of the inmates, all of whom were incarcerated under sentence (not remand) and most of whom were approaching release, reported having discussed any type of discharge plan with a staff member at the prison.[163] In both BC and Ontario, it seems those who had a history of hard drug abuse (heroin, crack, cocaine) were more likely to be targeted for discharge planning, indicating that drug counsellors were probably involved in this process to some degree.[164] Moreover, indigenous inmates had less contact with discharge planners than non-indigenous inmates (only 1 of 7 of indigenous people reported pre-release contact), which may be related to the fact that indigenous inmates were less likely to have used hard drugs and more likely to have an alcohol dependency.[165] It seems drinking problems do not garner the same attention as hard drug problems.

40% of stably housed releasees had seen a discharge planner prior to release, 45% of underhoused releasees had received discharge planning (the higher number reflecting a higher number in treatment),

---

[159] *Ibid* at 7.
[160] *Ibid* at 5. Community groups include the John Howard Society and the Ontario Multi-Faith Council on Spiritual and Religious Care.
[161] *Ibid* at 8-9. Some exceptions include additional discharge planning support from counsellors for convicted sex offenders or prisoners who have been identified as requiring support for anger management or substance abuse. Some employment supports can also involve more intensive planning, especially for those prisoners who have completed an in-prison apprenticeship program, which allows them to leave prison with a job lined up (with Ontario Works), secured housing, and monitoring by the Education Department for the first eight weeks.
[162] *Ibid* at 9.
[163] *Ibid* at 10.
[164] *Ibid* at 10-11.
[165] *Ibid* at 11.

and only 29% of homeless releasees had talked to a staff member about a release plan.[166] All those releasees who had received some type of discharge planning were asked about how effective it had been in terms of housing, employment, family reunification, health and substance abuse. Some said the planning had been very helpful,[167] and the area in which it was most effective was substance abuse.[168] But the vast majority of releasees had not received any discharge planning when they were released, and many ended up homeless.[169] Few of the releasees reported a high degree of stable housing since their release from prison.[170] Many releasees specifically mentioned that release planning should consider the area where the individual will be released, in order to avoid releasing them into a "bad" environment full of drugs and crime.[171] They all recognized that access to housing was a fundamental first step for successful reintegration.[172] Unsurprisingly, those who had found stable housing were far more likely to be employed (40%) than those who were homeless (22%) or underhoused (17%), and those who had some kind of shelter were more likely to access welfare and disability support than homeless releasees.[173] Moreover, one third of all releasees self-identified as having a disability, but only 20% were on government benefits (and mostly welfare, not disability benefits), and 29% self-reported a past diagnosis of a serious mental disorder (including schizophrenia, bipolar disorder, personality disorder, and FASD).[174] The releasees noted that being discharged without sufficient funds, transportation, or clothing

---

[166] *Ibid* at 12.
[167] *Ibid* at 13. A BC releasee (currently housed) who found it helpful: "The John Howard Society [representative] helped with getting access to my vehicle and my personal property that had been seized by police. She made arrangements with a friend of mine and contacted three detachments of the RCMP and acted as a liaison and arranged from my friend to be able to go down and pick everything up. I didn't know about JH before, so it opened the door for getting help for things that were sort of beyond my control at that time."
[168] *Ibid.*
[169] *Ibid* at 13-14. Some revealing quotes from study participants: "No discharge planning – that's it, you're free to go, gave me a token and told me to go." (Ontario releasee − currently homeless); "No [discharge plan]. I've been to jail when I was younger, 15-16 times – never once has anyone ever asked me where I lived. This is how I ended up on the streets several times." (Ontario releasee − currently homeless); "Never in my life have I ever been in a prison in Toronto where someone has offered to assist me in finding things like housing before I get out of jail." (Ontario releasee − currently homeless).
[170] *Ibid* at 14.
[171] *Ibid* at 15. Some revealing quotes from study participants: "They should give people a choice, like if you want to go into a place where there's not a lot of drugs around... I don't want to go into a house where people are smoking crack and drinking Listerine and doing all kinds of crazy behaviour. That doesn't do anything good for you. It brings you down even more." (Ontario releasee – currently housed).
[172] *Ibid*. Some revealing quotes from study participants: "Housing planning should be mandatory. If they keep wondering why people re-offend, they shouldn't be allowed to release anybody who has no address to go to. ... Every person in jail [should have] a case worker and they should be on getting somewhere to live, even if it's just a halfway house. The crime rate would drop significantly, just from re-offenders." (British Columbia releasee – currently underhoused); "Having somewhere to go instead of being released onto the street is important. People that get released from jail don't really have nothing, and they have no place to go. And they're right back into the crime. I know when I got released before, I got released from the courthouse, and, you're kind of out there, and you do whatever to survive, right?" (British Columbia releasee – currently housed).
[173] *Ibid* at 16.
[174] *Ibid* at 17.

put them in a challenging situation, emphasizing the importance of providing material supports at the time of release.[175] All of the participants were aware that the absence of housing support increases their risk of homelessness, substance abuse, recidivism, and reincarceration, and they all argued for the necessity of adequate discharge planning and transitional support services.[176]

In 2010, BC's *Integrated Offender Management/Homelessness Intervention Project* (IOM/HIP) program was developed and piloted in the Lower Mainland and Victoria, which was initiated by the Ministry of Social Development and Social Innovation, in partnership with the Ministry of Health, BC Housing, Community Living BC, and various local health authorities.[177] It encompasses collaborative case planning and management procedures between Community Corrections and Adult Custody, with the goal of ensuring that BC Corrections can work towards successful reintegration, "by providing consistent structure and accountability in the development of case supervision plans for offenders who are currently incarcerated and are transitioning to community supervision."[178] Various surveys were conducted as part of the project's regular evaluations. The "return to custody" survey (RTC) targeted IOM/HIP clients who returned to custody (and who had been part of IOM/HIP as part of their prior release).[179]

The RTC survey revealed that more than half (52%) did have stable housing prior to being returned to custody, but more than 40% did not.[180] When asked to comment on preventative strategies that

---

[175] *Ibid*. Some revealing quotes from study participants: "[When I was released] some money would have been nice. Some $200– 300, because I was released on a Saturday on a long weekend, the bus ticket was all paid for ... but [nothing] to buy personal things, deodorant, toothbrush, all that... basic things." (Ontario releasee – currently underhoused); "One of my friends was in the clothes he came in with. And he was released in the winter, and went in the summer..." (Ontario releasee – currently housed).

[176] *Ibid* at 19. Some revealing quotes from study participants: "They should have more people going around in the jails and helping people. People's heads aren't in the right place at the time of release. Nowhere to go, no assistance, so you just spend the money ... at the bar." (Ontario releasee – currently homeless); "Make sure inmates have a place to go or live, give inmates counselling to not get back in trouble and to look at why you were in there. Have welfare appointments ready for them." (British Columbia releasee – currently housed); "While there, you are given clothes, food, shelter, and you become sober. Upon release, you are given just the sobriety and a piece of paper... we didn't have follow-through with the drug counselling, mental health counselling, life management skills, how you manage your time and money, and, possibly teach us how to make resumes." (Ontario releasee – currently homeless); "They should contact social services tell them/verify his identity in order for a releasee to get a welfare check upon release. They should not release you on Friday or a weekend." (Ontario releasee – currently homeless).

[177] British Columbia, Ministry of Justice, "Integrated Offender Management Return to Custody Survey Report", by the Performance, Research and Evaluation Unit of the Strategic Operations Division of B.C. Corrections (Victoria, Ministry of Justice, Fall 2013) [BC, "Return to Custody"] at 6. See also British Columbia, Ministry of Justice, "Integrated Offender Management Impact Analysis: Research Report", by the Performance, Research and Evaluation Unit of the Strategic Operations Division of B.C. Corrections (Victoria, Ministry of Justice, Winter 2013/2014); British Columbia, Ministry of Social Development and Social Innovation & Ministry of Justice, "IOM/HIP Pilot Project Evaluation and Final Report", by the Ministry of Social Development and Social Innovation, Ministry of Justice, BC Housing, and the Performance, Research and Evaluation unit of the Strategic Operations Division of B.C. Corrections (Victoria, Ministry of Justice, Winter 2013/2014).

[178] BC, "Return to Custody"*, supra* note 177 at 5.

[179] *Ibid* at 8.

[180] *Ibid* at 9. One client reported having had both stable and unstable housing, and some other participants did not respond to this question.

might have helped them avoid returning to prison, among other things, many referenced lack of housing, work and social support, and one third indicated that they would have liked more help in finding housing (including "private affordable housing" and "housing not in my neighbourhood").[181] In the exit survey, which was administered to IOM/HIP clients who were being released into the community, 96% said they had found the case planning process useful, 91% agreed or strongly agreed that having the jail and probation staff work together benefited them, and one third (33%) reported that the long term planning (including plans for shelter and other programs) was the most helpful part of the IOM/HIP process, while only 9% specified housing and relocation support as the most useful.[182] But when asked what part of the process they had found the least helpful, several participants indicated that acquiring housing should be a greater portion of the program services.[183] When asked to comment on what other assistance they would have liked to receive, 21% noted that they would have liked some other form of help, and of these 25% specified that they would have wanted additional assistance with housing through the IOM program.[184]

The study findings make a strong case for a reinvestment both within prisons and the community to create effective discharge planning that supports prisoner re-entry and reintegration.[185] As emphasized by the HF approach, the discharge planning process and available supports should consider the specific needs and wishes of different individuals, and the provision of stable housing should be a priority. Homeless shelters and soup kitchens are not mandated or capable of tackling the issue of prisoner re-entry – this responsibility falls on corrections services and the government. But as Gaetz & O'Grady (2009) accurately observed,[186]

> Perhaps the most important barrier that needs to be overcome before any meaningful change can occur in social and criminal justice policy is the politics that surround corrections and homelessness in Canada today. (...) [T]he media and general public are normally silent when community supports for inmates, such as halfway houses, are reduced or eliminated. When the harm reduction programs such as safe injection sites or needle exchange programs are promoted by local health officials, the response from the public and some media outlets is often that of hostility and contempt. (...) The public is much more likely to hear reports of inmates who are free on bail committing heinous crimes, than they are to read about the costs involved in incarcerating inmates while in remand. […] As such, it is our contention that unless the issues of prisoner reintegration and homeless receive the level of political attention that they deserve, urgent calls for action on discharge planning will fall upon deaf ears.

---

[181] *Ibid* at 16-17.

[182] British Columbia, Ministry of Justice, "Integrated Offender Management Participant Exit Survey Report: Survey Results", by the Performance, Research and Evaluation Unit of the Strategic Operations Division of B.C. Corrections (Victoria, Ministry of Justice, Winter 2014), at 8-9.

[183] *Ibid* at 10.

[184] *Ibid* at 12-13.

[185] *Ibid* at 20-21.

[186] *Ibid* at 21.

IV. ADDRESSING THE HOUSING PROBLEM

(vi) Canada's National Housing Strategy – a glaring omission

On November 22, 2017, as part of a National Housing Strategy (NHS), Canada's federal government announced that it is committing $40 billion to reducing homelessness by 50% in ten years.[187] The targets include the creation of 100,000 new housing units, the repair and renewal of 300,000 existing units, the removal of 530,000 households from housing need, the protection of 385,000 households from losing an affordable home, and the support of 300,000 households through the Canada Housing Benefit. The NHS specifies that it will prioritize those who have the greatest need, citing women and children fleeing family violence, seniors, indigenous peoples, people with disabilities, those dealing with mental health and addiction problems, veterans, and young adults. The federal government states that "Housing Rights are Human Rights", and the NHS will create (among other things) a new Community-Based Tenant Initiative to fund local organizations that assist people in housing need, so that they are better represented and able to participate in housing policy and project decision-making, as well as a new public engagement campaign aimed at reducing stigma and discrimination by highlighting the benefits of inclusive communities and housing.[188]

But what is glaringly absent from this entire plan (the website, and the document) is any specific mention of those involved in the criminal justice system.[189] Considering that provinces, like BC, are now in a position to receive substantial federal funding towards housing programs (under the Enhanced Federal-Provincial/Territorial Partnerships), it is imperative that the unique needs of this population are not forgotten or ignored. Indeed, the first step towards destigmatizing and demarginalizing the "criminal" population is to acknowledge it publicly and identify it as a priority for housing interventions, through important initiatives like the NHS. Only then can Canadian society begin to make progress towards reintegrating offenders, reducing recidivism, increasing public safety, and stopping the revolving door of the broken criminal justice system. If housing is a human right, *ipso facto* this applies to all Canadians, especially those who are the most vulnerable, marginalized, and stigmatized.

(vii) Courts Addressing the Housing Problem

In recent years there has been the beginnings of a shift away from purely 'coercive' criminal

---

[187] Canada, Government of Canada, "Canada's National Housing Strategy: A place to call home", online: <https://www.placetocallhome.ca>.
[188] *Ibid* at 8.
[189] In fact, individual searches for the words "criminal", "justice", "offender", "prison", and "incarcerated" yielded zero hits anywhere within the 41-page document.

justice responses (e.g. supervision, arrest, sanctions, revocation to prison) towards more 'coordinated' and 'integrated' responses to community reintegration, which include social services (housing, food, clothing), treatment (for substance abuse and mental health) and community support for recently released inmates.[190] But there are real barriers preventing courts from being able to do much to address the unmet housing needs of those who revolve between the court, prison, and streets. For example, problem solving courts that require participants to obtain employment and permanent housing tend to have a higher success rate in reducing recidivism than those that do not, but the means by which any particular court could impose this requirement and the extent to which an offender could satisfy it is unclear, since finding employment and housing require the coordination of multiple agencies and the availability of local services.[191] Of the seven problem-solving courts in Clackamas County, Oregon, worked with the local housing committee of the federal Department of Housing and Urban Development, along with two local non-profit organizations, to create a permanent, staffed six-unit housing facility for female court participants who had children.[192]

Across the United States, the American Bar Association (ABA)'s Commission on Homelessness and Poverty has implemented the Homeless Court Program (HCP), which has now created over 50 homeless courts across the nation.[193] The HCP is typically located within homeless shelters and provides a non-threatening environment in which participants can resolve criminal charges or outstanding warrants which may function as barriers to housing, treatment, and employment. Rather than getting fined or thrown in prison, homeless participants voluntarily participate in community-based treatment or services. Among the key policy principles guiding the HCP, the ABA has stated that "the process and any disposition therein should recognize homeless participants' voluntary efforts to improve their lives and move from the streets towards self-sufficiency, including participation in community-based treatment or services," and "[d]efendants who have completed appropriate treatment or services prior to appearing before the Homeless Court shall have minor charges dismissed, and, where appropriate, may have more serious misdemeanor charges before the court reduced and dismissed. Where charges are dismissed, public access to the record should be limited."[194]

---

[190] Lutze, Rosky & Hamilton, "Reentry Housing Program", *supra* note 26 at 472.
[191] M.A. Campbell, D. Canales & J. McTague, "Problem Solving Courts: An Evaluation Guide and Template," report prepared for the Canadian Council of Chief Judges, Centre for Criminal Justice Studies (Saint John: University of New Brunswick, December 2016) [*Problem Solving Courts*] at 4.
[192] United States, Center for Court Innovation, "Principles of Problem-Solving Justice", by Robert V. Wolf (New York: US Department of Justice, Bureau of Justice Assistance, 2007) at 6.
[193] American Bar Association, Commission on Homelessness and Poverty, "Homeless Courts", online: <https://www.americanbar.org/groups/public_services/ homelessness_poverty/initiatives/homeless_courts.html>
[194] American Bar Association, Commission on Homelessness and Poverty, "Lawyers Working to End Homelessness and Poverty", online: < https://www.americanbar.org/content/dam/aba/administrative/homelessness_poverty/ CHPOnepager_november2015.authcheckdam.pdf>; American Bar Association, Commission on Homelessness and Poverty, "Homeless Courts: Taking the Court to the Street", online: <https://www.americanbar.org/content/dam/

(viii) Challenges to Addressing the Housing Problem

It is challenging to implement HF in a tight rental market where there is insufficient housing stock without sacrificing the core principal of client choice.[195] Thus implementation requires simultaneous government investment in increasing the supply of affordable housing. Indeed, the scalability of the HF model depends to a large extent on a sufficient supply of safe, affordable housing, or robust rent supplement programs that allow clients to use expensive market housing in a tight market. There is also some evidence to indicate that some people with severe addictions may struggle in HF without insufficient supports in place.[196] 'Hard to house' clients are also challenging, especially those with arson histories or those prone to violence, because they may be more readily evicted and they could alienate private landlords, and it may require "extraordinary effort" to find appropriate housing and supports for them.[197]

Moreover, housing programs need to be evidence-based to ensure success, and they need to be designed with each specific community and client population in mind, since no standardized recommendations for housing models can be generalized to all contexts.[198] In general, there is a recognized dearth of specialized housing programs for young people, indigenous people, women, and those engaged in the criminal justice system, and there is the over-arching challenge of providing sufficient supports in conjunction with housing to address a range of addiction and mental health problems, victimization and traumas, and to facilitate community engagement. An often-overlooked issue, for example, is the value of pets for many homeless people, many of whom prefer homelessness with their companion animals over housing that requires them to give them up.[199] In addition to companionship, for people who often have no human social network, animals also offer comfort, and sense of responsibility and safety. One only has to consider the many 'pet therapy' initiatives currently implemented around the world in hospitals, schools, and senior residence facilities to understand the power of animal companionship in promoting human well-being.

An aging baby boomer population also means a growing demographic of aging homeless individuals. Those who are aging in supported housing do not have access to health services and housing designs that were built specifically to support aging in place, meaning that many will be forced to move out of housing that has been so helpful to them at a vulnerable time in their lives when their changing

---

aba/administrative/homelessness_poverty/5b%20Homeless%20Court%20One-Pager%20%20updated.authcheckdam.pdf>

[195] Gaetz, Stephen & Tanya Gulliver, "Lessons Learned" in Gaetz, Scott & Gulliver, *Housing First, supra* note 89 [Gaetz & Gulliver, "Lessons Learned"] at 2.

[196] *Ibid* at 3.

[197] *Ibid* at 11.

[198] AB, *Addictions and Mental Health*, *supra* note 35 at 5.

[199] AB, *Literature Review*, *supra* note 13 at 8.

needs increasingly can no longer be met by traditional support services.[200] Proactively designing housing initiatives to account for the changing needs and abilities of individuals as they age could help address this (called "universal design"), but this is challenging and expensive to implement.[201] There are also systemic barriers that prevent information sharing, coordination, and easy planning across Human Services, Health, Justice, and Education systems, all of which have different programs and procedures, and program-specific mandates with inflexible rules.[202] To begin addressing this issue, the *Cowper Report* mentioned a plan to make BC's medical data more available in order facilitate for more informed treatment of chronic offenders, but privacy and consent issues are still being worked out.[203]

On the one hand, the literature unequivocally shows that housing programs are most likely to succeed if they are located within natural communities, and when they provide real opportunities for community interaction and integration.[204] But the biggest hurdle is public and community resistance, usually based on fears about an increase in crime or a decline in property values, and these views are particularly sharpened with respect to criminal offenders and those with substance abuse or mental disorders.[205] The phenomenon is known by the acronym NIMBY, for "Not In My Back Yard".[206] NIMBY fears are usually heightened in proportion to the size of facility and the number of clients that it will serve, the seriousness of clients' criminal histories, and the likelihood that clients would encounter local residents in public spaces or on public transportation.[207] But studies have debunked these fears, showing no negative impact on safety or property values from the creation of a housing program in the community.[208] Research shows that local residents and neighbours have nothing to fear from the modestly sized and attractively designed housing developments that today form the bulk of newly built affordable housing. In fact, one literature review found no published studies reporting increases in crime flowing from the creation of supported housing.[209] Suggested solutions to NIMBY include addressing neighbourhood concerns at the design stage of the process, and approaching the community from a positive perspective of 'contribution to the community' rather than trying to mitigate the proposal as a

---

200 *Ibid* at 6.
201 *Ibid*.
202 AB, *Addictions and Mental Health*, *supra* note 35 at 7.
203 BC, *Cowper Report*, *supra* note 46 at 154.
204 AB, *Literature Review*, *supra* note 13 at 117.
205 Somers et al, "Concurrent Disorders", *supra* note **Error! Bookmark not defined.** at 3-4; AB, *Literature Review*, *supra* note 13 at 117.
206 See Myra Piat, "The NIMBY Phenomenon: Community Residents' Concerns about Housing for Deinstitutionalized People" (2000) 25:2 Health & Social Work 127 for a study on NIMBY. The study qualitatively examined the dynamics of a community's opposition to group homes in Montreal. For a history of NIMBY see at 127.
207 AB, *Literature Review*, *supra* note 13 at 117.
208 Somers et al, "Concurrent Disorders", *supra* note **Error! Bookmark not defined.** at 3-4.
209 AB, *Literature Review*, *supra* note 13 at 119.

‘liability’.[210] An interesting recommendation calls for housing initiatives to “change the rules of engagement” by challenging planning rules and protocols that exclude affordable housing in order to replace them with “more inclusionary and universal zoning principles”.[211] Essentially local communities need to be convinced that they have a duty to come together to help their most vulnerable members, which requires a shift in perspective that recognizes marginalized, ill, victimized, criminalized, homeless individuals as community members.[212]

V. THE HOUSING PROBLEM IN VICTORIA

Victoria is one of Canada’s most expensive cities. Its high rents and low vacancy rates create significant challenges for addressing the issue of chronic homelessness.[213] Between 2007 and 2015, the private market average rental rate for a one-bedroom unit increased by nearly 21% from $716 to $870.[214] At odds with this was the freezing of the shelter allowance for individuals receiving Income Assistance at $375 during that same period.[215] However, even if there had been an increase in this allowance, the extremely low vacancy rate of 0.6% in 2015 presented a further barrier to accessing private market housing.[216] As of February 2016, there were 1,387 homeless individuals in the Greater Victoria Area (GVA).[217] Based on the resources available at that time, had the vacancy rate been around 3% and all supportive housing units were empty, there would still not have been enough units to stably house those individuals.[218]

---

210 *Ibid*.
211 *Ibid* at 121. For example, UK planning policies require a certain proportion of new housing developments to be available for affordable sales or rentals, thus effectively ‘hard-wiring’ the affordability of housing into the planning process.
212 For example, this is what sparked the creation of BC First Nations Courts – the sense of obligation among indigenous communities to come together and help such individuals within their communities. Chief Judge Crabtree talked about this in his lecture in the Access to Justice class.
213 For the remainder of the paper, the term “chronic homelessness” or “chronically homeless” will be used as an all-encompassing term for individuals currently experiencing chronic (6+ months in past year) or episodic homelessness (3+ episode in past year) and also have disabling conditions such chronic physical or mental illness and/or substance abuse issues.
214 Regional Housing First Program, “Process Mapping Project – Map and Final Report” (August 2016), online: Capital Regional District <https://www.crd.bc.ca/project/regional-housing-first-program> [*Supplemental*] at 9.
215 *Ibid*, at 9.
216 *Ibid*, at 9.
217 Regional Housing First Program, “More Than a Number: 2016 Greater Victoria Point in Time Count Summary” (February 2016), online: Capital Regional District <https://www.crd.bc.ca/docs/default-source/housing-pdf/pitcount-report26apr2016.pdf> at 6: This study was conducted on the night of February 10, 2016. Of the 1,387 individuals, 192 were unsheltered, 353 were emergency sheltered, 842 were provisionally accommodated, and 65 were turned away.
218 *Supplemental, supra* note 213 at 9.

(ix) Housing Gaps in the Greater Victoria Area

By May 2016, recognition of the ever-increasing gap between supply and demand led to $60 million in funding[219] to create new housing projects that address the needs of the GVA's chronically homeless population. As a result, the Capital Regional District (CRD),[220] the BC Housing Management Commission (BC Housing), and VIHA, who through Island Health is committed to providing health support services, partnered with the Greater Victoria Coalition to End Homelessness (Coalition)[221] to identity housing priorities for investment. They conducted a Process Mapping[222] project in order to better understand the complex relationship between housing, health, and community support services within the GVA.[223] The accompanying *Supplemental Report* identifies adequate availability of supportive,[224] supported,[225] and rent supplement[226] programs as "fundamental to assisting individuals in moving from being unstably housed to having safe, stable and affordable housing."[227]

In assessing the existing supply[228] of supportive and supported housing, as provided through the Centralized Access to Supported Housing (CASH), Our Place Supported Housing, Pacifica Housing Supported Housing facilities, and Victoria Cool Aid Supported Housing Facilities, the common thread was high waitlists and low turnovers.[229] Unsurprisingly, lack of access to supportive housing was

---

219 Capital Regional District, "Regional Housing First Program" (August 2016), online: <https://www.crd.bc.ca/project/regional-housing-first-program>: This funding will be allocated over five years. $30 million was approved by the Capital Regional District and the other $30 million was committed through VIHA and the BC Housing Management Commission by the Province from the Provincial Investment in Affordable Housing Program.

220 The CRD is a local government that delivers services for residents in 13 municipalities and three electoral areas on southern Vancouver Island and the Gulf Islands.

221 The Coalition was formed as a society in 2008 with a mission to end homelessness in the GVA. It consists of service providers, non-profit organizations, all levels of government, businesses, postsecondary institutions, the faith community, people with a lived experience of homelessness, and members of the community.

222 Coalition Reports, "Community Plan – Phase 1" (30 August 2016), online: Greater Victoria Coalition to End Homelessness <http://victoriahomelessness.ca/get-informed/coalition-reports/>: "Process Mapping is defined as examining and mapping the journey of individuals in their efforts to access various aspects of the housing and health/social support systems as they move from one static situation to another" at 7.

223 *Supplemental, supra* note 213, at 44, Appendix B.

224 Supportive Housing refers to facilities for homeless or at high risk of becoming homeless individuals. Support services are intended to address the mental and physical well-being of the individual and are available on-site daily or on a 24/7 basis. Most will have experienced ongoing mental illness or addiction.

225 Supported Housing refers to individuals living in the private market who may or may not receive rent supplements. They have regular or emergency support services through Island Health Funded programs such as ACT teams or Intensive Case Management Teams.

226 Rent supplements are income subsidies provided by BC Housing or Island Health. Allows individuals to secure rental units that would otherwise be unaffordable. These individuals may have regular or emergency support services through Island Health Funded programs such as ACT teams or Intensive Case Management Teams.

227 *Supplemental, supra* note 213, at 9: The Supplemental Report was "prepared with the input received from health, housing, and community stakeholders; interviews with people who have lived experience of homelessness; focus groups; and a day-long, collaborative workshop in May and June 2016" at 5.

228 *Ibid*, at 29: see appendix A: This assessment took place as of May 2016.

229 *Ibid*, at 10: see tables 11-13.

repeatedly identified as a housing gap specifically detrimental to individuals experiencing chronic homelessness. There is also a lack of long-term housing for chronically homeless 50+ individuals experiencing age-related cognitive decline,[230] and the non-existence of "No Eviction" housing for individuals who have "multiple disorders, no family support, forensic history, limited education, and recurring patterns of violent, abusive behavior."[231] Additionally, the report emphasized that the extreme lack of available and affordable rental units within the GVA presents significant challenges for increasing the use of supported housing. Even if units become available, an individual without a history of chronic homelessness will almost always be chosen over one who does. Though the report commends the work of *Streets to Homes* as they have invested significant outreach work into establishing and maintaining relationships with landlords to combat this problem,[232] it was noted that such entities often compete with other providers for the limited supply of private housing – a situation that only worsens when college and university students are competing in the GVA market.

Furthermore, the report assessed the degree to which the overall system was meeting the six principles under the Homelessness Partnering Strategy (HPS) HF approach.[233] It concluded that the GVA was "weak with respect to its ability to operate a system that adequately reflects these principles."[234] The principles include: (1) rapid housing with supports, (2) offering clients choice in housing, (3) separating housing from other services, (4) providing tenancy rights and responsibilities, (5) integrating housing into the community, and (6) strength-based and promoting self-sufficiency.[235] Primarily due to the lack of housing supply, both (1) and (2) were assessed as requiring significant improvement. To achieve (1)

---

[230] *Ibid*, at 16: Individuals exhibiting SAMI is difficult enough to address, however, 50+ individuals add a further complexity and is a growing population within the GVA. Without long-term housing for this group of individuals, the current system of referring them to housing without embedded clinical supports is especially problematic.

[231] *Ibid*, at 16: Though the VIC does not deal with youth, another other repeatedly identified gap was low-barrier supportive housing for youth (i.e. only abstinence based housing exists), this points to an area where preventative measures should be taken since as the report identifies, these vulnerable youths often drift into the street culture and often find themselves chronically homeless adults. The Coalition has issued several reports identifying this issue and implemented strategies for addressing it: see <http://victoriahomelessness.ca/get-informed/coalition-reports/>.

[232] *Streets to Homes*, a pilot project in 2010, recognized that landlords are frequently reluctant to rent to individuals newly off the streets because of a perceived risk to their property and financial interests. They mitigated these risks by paying rent directly to landlords and having the financial resources to pay for the repair of any potential damages. As of January 2012, the pilot was proved successful and the program was officially transferred to the Pacifica Housing Society.

[233] The HPS is a community-support program aimed at preventing and reducing homelessness and is funded by the Government of Canada. The HPS advocates the HF approach and requires communities to adopt HF strategies in their plans to address homelessness though they do retain some flexibility to invest beyond those strategies given they are complementary: see <https://www.canada.ca/en/employment-social development/services/funding/homeless/homeless-terms-conditions.html#purpose>; In the GVA, the Coalition acts as the Community Advisory Board for the HPS and the CRD holds the Funding Agreement with the Government of Canada. Both the CAB and CRD work closely to ensure programs are delivered in a manner consistent with the HPS Community Plan 2014-2019: see <https://www.canada.ca/en/employment-social development/programs/communities/homelessness/smallcommunities.html>.

[234] *Supplemental, supra* note 213, at 23.

[235] *Ibid*, at 6 and 23-24.

chronically homeless individuals should be able to receive assistance to secure housing with no delay and move-in or re-house if necessary. Principle (3) acknowledges that the requirement of acceptance of any services, including sobriety, is an unacceptable prerequisite for accessing or maintaining housing in addressing the needs of the chronically homeless. The report held the GVA generally had good adherence to this principle as the "current system can be adaptable to individuals' needs."[236] However, it was noted the fixed nature of some supports within programs may leave individuals ineligible as their assessed needs may be too high or too low for the program.[237] Similarly, principle (4) generally had good adherence but the prevalence of *program agreements* as opposed to *tenancy agreements* was of concern. Additionally, though principle (5) was assessed as having generally good adherence, it was noted the system needs more distributed housing options to enhance integration. To meet this principle, more attention must be given to implementing scattered-site housing so as to encourage community building through social integration and in effect minimize stigma.[238]

The report concludes with the following nine key areas of improvement for consideration:[239]

1. Ideally, one *big tent* would be created to centralize access, and the assessment system. The aim is to reduce inefficiencies and duplications, and, ultimately, improve the flow-through for people to get to stable, independent housing. A revision, and subsequent expansion, of the CASH system to reduce inefficiencies should be considered. This program is meeting its mandate as a clinically-based assessment program, but should be augmented to assess and assist individuals who have higher and lower needs.
2. A similar effort needs to be instituted to coordinate an effective system of services delivery. This should be driven by a review of existing housing and services, and supported by an outcomes-based action strategy.
3. There needs to be greater effort to ensure a balance between tolerance and abstinence housing in the region.
4. Over time, the recently updated CASH website will go a long way to addressing issues around lack of transparency. However, as noted in the body of the report, some additional communications activities could be considered.
5. At a minimum, there needs to be a harmonization of data collected by supportive housing providers. Ideally, one impartial organization should take ownership of collecting, maintaining, and reporting data on numbers of beds/units, waitlists, turnovers, and reasons for ending tenancies.
6. There needs to be more respite beds available for supported housing individuals who fall into a crisis, along with at least one month's rent to maintain the housing as the individual recovers.
7. Once a person does become independently housed, after leaving the supportive/supported housing system, there should be regular follow-up for a year or longer.
8. A number of non-profit and social housing providers in the region own and/or administer affordable housing units that are not directly subsidized by BC Housing. These providers should consider opening up a percentage of their portfolios to individuals who have regular contact with support services. The current lack of supply in the private market makes this vitally important.

---

[236] *Ibid*, at 23.
[237] *Ibid*, at 23.
[238] Employment and Social Development Canada, "Housing First Approach", online: Government of Canada <https://www.canada.ca/en/employment-social-development/programs/communities/homelessness/housing-first/approach.html>.
[239] *Supra* note 213, at 26-27.

9. Some consideration should be given to coordinating, and adequately funding peer mentoring. Those with previous lived experience of being homeless make a huge difference to people who are unstably housed – they offer help, hope, and a warm hug.

(x) The Community Plan – 2016-2021

Following the Process Mapping Project, a Community Plan (CP) was developed.[240] It merges the work of HPS, the Creating Homes, Enhancing Communities (CHEC) plan,[241] and aims to guide investments from the Regional Housing First Program (RHFP).[242] The CP is focused on the specific population of chronically homeless individuals.[243] The CHEC plan was published in 2015 and based on 2014 data, but its estimate of 367 individuals within the GVA experiencing chronic homelessness forms the basis for the CP and the corresponding RHFP capital investment.[244] The CP updated the data, which had numbered chronically homeless individuals accessing shelters at 175 in 2015/16.[245] They further factored in an annual population growth rate of 5.6%, increasing the total to 234 individuals. In addition to these 234, the CP incorporates a cohort of approximately 74 individuals who were identified by the Priority One Task Force (POTF).[246] The POTF focused on a group of individuals whose lack of success with the existing heath, social services, and housing system, many of whom were banned from shelters and/or housing, pointed to "the importance of considering housing and support service needs on an individual basis in combination with targeted, intensive and specialized multi-stakeholder approached to better support this population."[247] Both Island Health and the VIC collaborated on identifying these individuals.[248] Therefore, for the purpose of the CP the target population totals 308 individuals from the POTF cohort and the chronic shelter use population.

---

[240] *Supplemental, supra* note 213.
[241] Coalition Reports, "Creating Homes, Enhancing Communities" (30 August 2016), online: Greater Victoria Coalition to End Homelessness <http://victoriahomelessness.ca/wp-content/uploads/2015/04/GVCEH_CreatingHomesEnhancingCommunities_Apr2015.pdf> [*Creating Homes*]: In 2015, the Coalition published *Creating Homes, Enhancing Communities*, which was a plan to address chronic homelessness in the GVA.
[242] Coalition Reports, "Community Plan – Phase 2" (9 August 2017), online: Greater Victoria Coalition to End Homelessness <http://victoriahomelessness.ca/get-informed/coalition-reports/> [*Phase 2*] at 22, Appendix 2: RHFP is a capital funding program adopted by the CRD in 2016 to guide its housing mandate, specifically in supplying interventions for chronic homelessness.
[243] Chronically homeless individuals may be unsheltered, emergency sheltered, provisionally accommodated, or insecurely housed: for a detailed description of these terms see <http://www.homelesshub.ca/sites/default/files/COHhomelessdefinition.pdf?_ga=2.199986475.482340695.1512869958-1505993572.1512086542>.
[244] *Creating Homes*, *supra* note 240.
[245] *Supplemental, supra* note 213, at 5: see footnote 10 for a detailed description of how this data was updated.
[246] *Phase 2, supra* note 241: For its full report see 23-39.
[247] *Supplemental, supra* note 213, at 9.
[248] *Ibid*, at 9.

The CP has three phases,[249] assessed annually, that set out a path to housing and supporting every chronically homeless individual in the GVA by 2020/21. Housing placement is expected to take place over a five-year period though the first new-builds may not be available until late 2018/19.[250] The placements will be available through either prioritization of existing supportive housing stock or new-builds funded by the RHFP. Phase 1 of the CP concluded in September 2017.[251] The objective was to house and support 50 individuals experiencing chronic homelessness, and secure a total of 88 units through an open procurement process with the targeted occupancy of 2018/19. Both targets were exceeded. A total of 111 chronically homeless individuals were housed (29 from POTF and 82 from HPS) and 113 net new units were announced (50 for chronically homeless individuals[252] with rates set at shelter limits[253] and 63 at affordable rental levels[254]).[255]

The recommendations for Phase 2, Year 1 focus on the particular needs of three key population segments, namely Indigenous Peoples, youth, and the POTF cohort. Following Phase 1, the POTF cohort has decreased from 74 individuals in need of housing to 41.[256] This is a trend the CP intends to keep going. The Phase 2 report highlights that data for shelter use patterns for those meeting the definition of chronically homeless shows an annual growth rate of 4.9% for non-Indigenous individuals as opposed to a 27.6% for Indigenous individuals.[257] To address this, the CP specified that where new individuals are offered housing, 36% should identify as Indigenous resulting in 30, 24, 23, and 23 Indigenous individuals being housed over the next four years.[258] Furthermore, the report calls for the community to work to better meet the HF strategy which includes the implementation of a residence-based managed alcohol program for Indigenous individuals experiencing chronic homelessness.[259]Additionally, the report notes that though youth are often among the "hidden homeless", there are youth accessing the shelter system pointing to a systemic issue requiring informed intervention as 46% of 683 chronically homeless people

---

[249] *Ibid*, at 1-2: For a summary of these phases.
[250] *Ibid*, at 13.
[251] For a full overview of Coalition activities and projects, see the Coalition Strategic Plan 2016 – 2021: <Victoriahomelessness.ca>.
[252] *Phase 2, supra* note 241: 32 units will be created within the Victoria Cool Aid Society's redevelopment of an existing supportive housing development at 210 Gorge Rd. East, and 18 will be created in the Island Women Against Violence upgraded buildings at Crofton Brook on Salt Spring Island.
[253] Regional Housing First Program, "Implementation Plan", online: Capital Regional District <https://www.crd.bc.ca/project/regional-housing-first-program> at 2: Currently $375/month.
[254] Affordable rates are those that are less than 30% of total before-tax household income.
[255] *Phase 2, supra* note 241, at 3.
[256] *Ibid*, at 14: 29 were successfully housed while sadly 4 passed away.
[257] *Ibid*, at 6.
[258] *Ibid*, at 20.
[259] *Ibid*, at 18.

surveyed said they experienced homelessness while under the age of 25.[260] As a result, a pilot initiative for early identification and assessment of at-risk should is being developed for the GVA.

For 2017/18, the CP outlines the need for 110 individuals to be housed in existing supportive housing and based on the finding of an annual turnover of approximately 18% within the CASH system during the Process Mapping Project, it is projected that turnover will open up sufficient spots.[261] As for new-builds, the CP calls for approval for 30 supported housing units, and 56 affordable housing units. According to anecdotal reports, approximately 20% of supportive housing residents would choose more independent housing with a lighter form of support if available.[262] Therefore, an increase in affordable housing,[263] which will include support transitions for individuals leaving existing supportive housing, is expected to further open access to existing supportive housing.

VI. CONCLUSION AND RECOMMENDATIONS

Although in conducting our research the VIC was mentioned for its involvement in identifying individuals for the POTF's cohort, the VIC, like the offenders it works with, is glaringly absent from the literature and reports identifying and addressing housing gaps for the chronically homeless within the GVA. The work of the Coalition may in fact have a positive effect on the individuals the VIC is struggling to house even without much VIC involvement. However, we suggest there may be missed opportunities here. Though the VIC likely deals with a very similarly constituted group of chronically homeless individuals as the CP, there are specific difficulties facing those individuals who are also chronic offenders that the CP has not actively prioritized. For example, when clients experience the risk of losing their housing the availability of respite beds is of great concern, as is an increase in low-barrier housing or a system of reintegration for clients leaving treatment so they do not find themselves back in low barrier housing or on the streets only to relapse. The work of the CP recognizes the need for these services but it is not necessarily a priority.

Though several of the VIC Reports pointed out the need for establishing evaluative methods, this appears to not have been done.[264] We recommend further research in this area via utilization of law or graduate students or arranging a special project with Pro Bono Students Canada. The recent report developed for the Canadian Council of Chief Judges, *Problem Solving Courts: An Evaluation Guide and Template*, provides a through and thoughtful starting point for establishing an evaluation guide.[265] Though

[260] *Ibid*, at 8: youth are defined as aged 13-25 by the Coalition.
[261] *Supplemental, supra* note 213, at 14.
[262] *Ibid*, at 15.
[263] *Phase 2, supra* note 241, at 16: These units will be provided at shelter rates to individuals on social assistance.
[264] *VIC Reports*, *supra* note 5.
[265] *Problem Solving Courts, supra* note 190.

difficulty undoubtedly arises when courts attempt to assess whether their program is having a direct impact on reducing or plays a causal role in improving an outcome such as recidivism, evaluation methods could be used to assess broader quality of life outcomes such as housing stability. Moreover, housing data already on hand for past and present VIC offenders may be a promising area for determining specific patterns or gaps that once complied could perhaps attract greater financing or support for HF programs specific to offenders, an area this paper has highlighted is lacking.

There is significant work being done in the GVA to address the needs of the chronically homeless. Furthermore, there has been a commitment by all levels of government to increase funding to address the issue of homelessness across Canada. The housing issues facing the VIC are not insurmountable. The VIC has a unique opportunity, through a representative involved in the community plan consultation process and/or through the creation of a report identifying specific evidence-based housing gaps for chronic VIC offenders, in order to ensure VIC offenders are having their immediate and long-term needs met.

BIBLIOGRAPHY

Alberta, Alberta Health Services and Government of Alberta. *Creating Connections: Alberta's Addictions and Mental Health Strategy, Addiction and Mental Health Housing and Supports Framework* (Edmonton, Government of Alberta and Alberta Health Services, June 2014).

Alberta, Alberta Health Services. *Literature Review and Best Practices for the Housing and Supports Framework; Housing and Supports Initiative; and Creating Connections: Alberta's Addiction and Mental Health Strategy*, by Celina Dolan et al (Edmonton: Alberta Health Services and Government of Alberta, 2012).

American Bar Association, Commission on Homelessness and Poverty. "Homeless Courts", online: <https://www.americanbar.org/groups/public_services/homelessness_poverty/initiatives/homeless_courts.html>.

American Bar Association, Commission on Homelessness and Poverty. "Homeless Courts: Taking the Court to the Street", online: <https://www.americanbar.org/content/dam/aba/administrative/homelessness_poverty/5b%20Homeless%20Court%20One-Pager%20%20updated>.

American Bar Association, Commission on Homelessness and Poverty. "Lawyers Working to End Homelessness and Poverty", online: <https://www.americanbar.org/content/dam/aba/administrative/homelessness_pover y/CHPOnepager_november2015.authcheckdam.pdf>.

British Columbia, BC Justice Reform Initiative. *A Criminal Justice System for the 21st Century: Final Report to the Minister of Justice and Attorney General Honourable Shirley Bond*, by D. Geoffrey Cowper QC (Victoria: BC Justice Reform Initiative, August 27, 2012).

British Columbia, Ministry of Justice. "Integrated Offender Management Impact Analysis: Research Report", by the Performance, Research and Evaluation Unit of the Strategic Operations Division of B.C. Corrections (Victoria, Ministry of Justice, Winter 2013/2014).

British Columbia, Ministry of Justice. "Integrated Offender Management Participant Exit Survey Report: Survey Results", by the Performance, Research and Evaluation Unit of the Strategic Operations Division of B.C. Corrections (Victoria, Ministry of Justice, Winter 2014).

British Columbia, Ministry of Justice. "Integrated Offender Management Return to Custody Survey Report", by the Performance, Research and Evaluation Unit of the Strategic Operations Division of B.C. Corrections (Victoria, Ministry of Justice, Fall 2013).

British Columbia, Ministry of Social Development and Social Innovation & Ministry of Justice. "IOM/HIP Pilot Project Evaluation and Final Report", by the Ministry of Social Development and Social Innovation, Ministry of Justice, BC Housing, and the Performance, Research and Evaluation unit of the Strategic Operations Division of B.C. Corrections (Victoria, Ministry of Justice, Winter 2013/2014).

Broner N.; M. Lang & S.A. Behler. "The effect of homelessness, housing type, functioning, and community reintegration supports on mental health court completion and recidivism" (2009) 5:3-4 J Dual Diagn 323.

Campbell, M.A.; D. Canales & J. McTague. “Problem Solving Courts: An Evaluation Guide and Template,” report prepared for the Canadian Council of Chief Judges, Centre for Criminal Justice Studies (Saint John: University of New Brunswick, December 2016)

Canada, Government of Canada. “Canada’s National Housing Strategy: A place to call home”, online: <https://www.placetocallhome.ca>.

Canada, Office of the Correctional Investigator. “Annual Report of the Office of the Correctional Investigator 2016-2017,” by Ivan Zinger (Ottawa, Office of the Correctional Investigator, June 28, 2017), online: <www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20162017-eng.aspx#s11>.

Canada, Parliamentary Information and Research Service. “Exploring the Circle: Mental Illness, Homelessness and the Criminal Justice System in Canada”, by Tim Riordan (Ottawa: Library of Parliament, April 23, 2004).

Capital Regional District, “Regional Housing First Program” (August 2016), online: <https://www.crd.bc.ca/project/regional-housing-first-program>.

Clark, Valerie A. “Predicting Two Types of Recidivism Among Newly Released Prisoners: First Addresses as ‘Launch Pads’ for Recidivism or Reentry Success” (2016) 62:10 Crime & Delinquency 1364.

Coalition Reports, “Community Plan – Phase 1” (30 August 2016), online: Greater Victoria Coalition to End Homelessness <http://victoriahomelessness.ca/get-informed/coalition-reports/>.

Coalition Reports. “Community Plan – Phase 2” (9 August 2017), online: Greater Victoria Coalition to End Homelessness <http://victoriahomelessness.ca/get-informed/coalition-reports/>.

Coalition Reports. “Creating Homes, Enhancing Communities” (30 August 2016), online: Greater Victoria Coalition to End Homelessness <http://victoriahomelessness.ca/wp-content/uploads/2015/04/GVCEH_CreatingHomesEnhancingCommunities_Apr2015.pdf>.

Delancey Street Foundation, online: <www.delanceystreetfoundation.org>.

Elwood Martin, Ruth *et al*, “Homelessness as viewed by incarcerated women: participatory research” (2012) 8:3/4 International Journal of Prisoner Health 108.

Employment and Social Development Canada. “Housing First Approach”, online: Government of Canada <https://www.canada.ca/en/employment-social-development/programs/communities/homelessness/housing-first/approach.html>.

Fischer, Sean N. *et al*, “Homelessness, Mental Illness, and Criminal Activity: Examining Patterns Over Time” (2008) 42 Am J Community Psychol 251.

Gaetz, Stephen & Bill O’Grady. “Homelessness, Incarceration, and the Challenge of Effective Discharge Planning: A Canadian Case” in J. Hulchanski et al, eds, *Finding Home: Policy Options for Addressing Homelessness in Canada* (Toronto: Cities Centre, University of Toronto, 2009), online: <homelesshub.ca/resource/73-homelessness-incarceration-challenge-effective-discharge-planning-canadian-case>.

Gaetz, Stephen & Bill O'Grady. *The Missing Link: Discharge Planning, Incarceration and Homelessness*, prepared for the Housing and Homelessness Branch of the John Howard Society of Ontario (Toronto: John Howard Society of Ontario, 2006).

Gaetz, Stephen & Tanya Gulliver. "Lessons Learned" in Stephen Gaetz, Fiona Scott & Tanya Gulliver, eds, *Housing First in Canada: Supporting Communities to End Homelessness* (Toronto: Canadian Homelessness Research Network Pres, 2013).

Gaetz, Stephen *et al*, *The State of Homelessness in Canada 2016* (Toronto: Canadian Observatory on Homelessness Press, 2016).

Gaetz, Stephen; Fiona Scott & Tanya Gulliver, eds. *Housing First in Canada: Supporting Communities to End Homelessness* (Toronto: Canadian Homelessness Research Network Press, 2013).

Gaetz, Stephen. "A Framework for Housing First" in Stephen Gaetz, Fiona Scott & Tanya Gulliver, eds, *Housing First in Canada: Supporting Communities to End Homelessness* (Toronto: Canadian Homelessness Research Network Pres, 2013).

Glover, Jane & Naomi Clewett. *No Fixed Abode: The housing struggle for young people leaving custody in England* (Essex: Barnardo's, 2011).

Goering, P. *et al*, "National At Home/Chez Soi Final Report" (Calgary: Mental Health Commission of Canada, 2014).

Gulliver, Tanya. "Introduction – Housing First" in Stephen Gaetz, Fiona Scott & Tanya Gulliver, eds, *Housing First in Canada: Supporting Communities to End Homelessness* (Toronto: Canadian Homelessness Research Network Pres, 2013).

Gunnison, E. & J.B. Helfgott. "Factors that hinder offender reentry success: A view from community corrections officers" (2011) 55 International Journal of Offender Therapy and Comparative Criminology 287.

Krausz, Reinhard M. "British Columbia Health of the Homeless Survey Report" (Vancouver: University of British Columbia, 2011).

Lutze, Faith E.; Jeffrey W. Rosky & Zachary K. Hamilton. "Homelessness and Reentry: A Multisite Outcome Evaluation of Washington State's Reentry Housing Program for High Risk Offenders" (2014) 41:4 Criminal Justice and Behavior 471.

Makarios, M.; B. Steiner & L.F. Travis. "Examining the predictors of recidivism among men and women released from prison in Ohio" (2010) 37:12 Crim Justice Behav 1377.

Moraff, Christopher. "'Housing First' Helps Keep Ex-Inmates Off the Streets (and Out of Prison)" *Next City* (July 23, 2014), online: <https://nextcity.org/daily/entry/housing-first-former-prisoners-homelessness>.

New York Fortune Society, online: <https://fortunesociety.org>.

"NYC FUSE – Evaluation Findings", *CSH: The Source for Housing Solutions*, online: <www.csh.org/csh-solutions/serving-vulnerable-populations/re-entry-populations/local-criminal-justice-work/nyc-fuse-program-key-findings/>.

Piat, Myra. “The NIMBY Phenomenon: Community Residents’ Concerns about Housing for Deinstitutionalized People” (2000) 25:2 Health & Social Work 127.

Polvere, L. *et al*, *Canadian Housing First Toolkit: The At Home/Chez Soi Experience* (Calgary and Toronto: Mental Health Commission of Canada and the Homeless Hub, 2014).

Regional Housing First Program. “Implementation Plan”, online: Capital Regional District <https://www.crd.bc.ca/project/regional-housing-first-program>.

Regional Housing First Program. “More Than a Number: 2016 Greater Victoria Point in Time Count Summary” (February 2016), online: Capital Regional District <https://www.crd.bc.ca/docs/default-source/housing-pdf/pitcount-report26apr2016.pdf>.

Regional Housing First Program. “Process Mapping Project – Map and Final Report” (August 2016), online: Capital Regional District <https://www.crd.bc.ca/project/regional-housing-first-program>.

Rezansoff, Stefanie N. *et al*, “Beyond recidivism: changes in health and social service involvement following exposure to drug treatment court” (2015) 10:42 Substance Abuse Treatment, Prevention, and Policy 1.

Roman, C.G. & J. Travis. “Where will I sleep tomorrow? Housing, homelessness, and the returning prisoner” (2006) 17 Housing Policy Debate 389.

Saddichha, Sahoo *et al*, “Homeless and incarcerated: An epidemiological study from Canada” (2014) 60:8 International Journal of Social Psychiatry 795.

Somers, Julian M. *et al*, “Housing First Reduces Re-offending among Formerly Homeless Adults with Mental Disorders: Results of a Randomized Controlled Trial” (2013) 8:9 PLOS One 1.

Stergiopoulos, Vicky *et al*, “Effect of Scattered-Site Housing Using Rent Supplements and Intensive Case Management on Housing Stability Among Homeless Adults with Mental Illness: A Randomized Trial” (2015) 313:9 JAMA 905.

United States, Center for Court Innovation. “Principles of Problem-Solving Justice”, by Robert V. Wolf (New York: US Department of Justice, Bureau of Justice Assistance, 2007).

Vancouver. “Caring for All: Priority Actions to Address Mental Health and Addictions”, Mayor’s Task Force on Mental Health and Addictions, Phase 1 Report (Vancouver: City of Vancouver, September 2014).

Vancouver. “Housing for People with Substance Use and Concurrent Disorders: Summary of Literature and Annotated Bibliography”, by Julian Somers et al, Centre for Applied Research in Mental Health and Addiction, Faculty of Health Sciences, Simon Fraser University (Vancouver: Simon Fraser University, January 2007).

Waegemakers Schiff, Jeannette & John Rook. “Housing First – Where is the Evidence?” (Toronto: Homeless Hub, 2012).

Wilson, J.A. & R.C. Davis. “Good intentions meet hard realities: An evaluation of the Project Greenlight Reentry Program” (2006) 5 Criminology & Public Policy 303.

Wood, Evan; Jeffrey H. Samet & Nora D. Volkow. "Physician Education in Addiction Medicine" (2013) 310:16 JAMA 1673.