Service Delivery Plan

2014-2015

Medicine Hat Community Housing Society

Medicine Hat Community Housing Socie

I. SUMMARY OF COMMUNITY STATUS

The Community

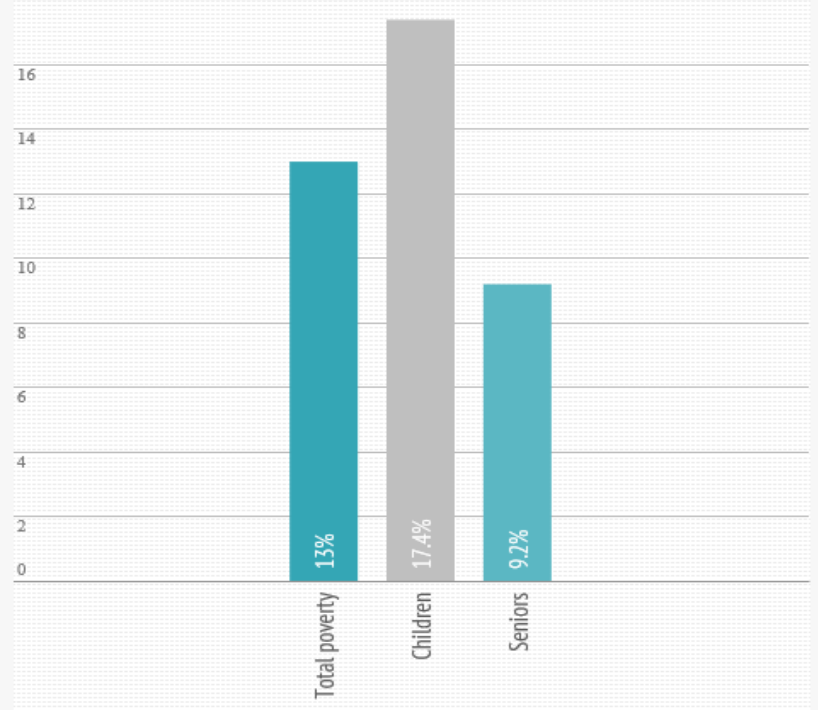
Data from the 2011 National Household Survey (NHS) shows the following trends:

- **Aboriginal People**: 4.6% (3,295) of the population of Medicine Hat had an Aboriginal identity, compared to 6.2% in Alberta. The Aboriginal population is younger than the non-Aboriginal population.[i]
- **Immigration**: 5,145 (7.2%) of the population of the Medicine Hat census agglomeration (CA) were foreign-born (immigrants). In comparison, the proportion of the population of Alberta who were immigrants was 18.1%.[ii]
- **Recent Immigrants:** Of the immigrants living in Medicine Hat in 2011, 1,070 came to Canada between 2006 and 2011. These recent immigrants made up 20.8% of the immigrants in Medicine Hat.[iii]
- **Visible Minorities:** 3,030 individuals in the Medicine Hat belonged to a visible minority group, accounting for 4.3% of its total population. In comparison, visible minorities comprised 18.4% of Alberta's population. The largest visible minority groups living in Medicine Hat were Black, South Asian and Latin American.[iv]
- **Education**: The share of the adult population that had completed a high school diploma as their highest level of educational attainment was 26.9%, and 20.7% had completed neither high school nor any post-secondary certificates, diplomas or degrees.[v]
- **Employment:** 36,845 people were employed and 2,805 were unemployed for a total labour force of 39,650 in May 2011. The employment rate was at 63.9% and the unemployment rate was at 7.1%. The median employment income was $49,992 for these workers.[vi]
- **Income**: The median after-tax income of economic families in Medicine Hat in 2010 was $70,291, the median for couple families was $75,866 and for lone-parent families, $42,884. For persons living alone or with non-relatives only, the median after-tax income was $25,707. [vii]
- **Income Distribution: About** 6.0% percent of the population aged 15 years and over had total income that put them in the top 5% and 0.8% in the top 1%. The percentage of the population in the lowest income decile group was 8.6. The percentage of the population in the highest decile group was 10.3%.[viii]

Poverty

About 13% (9,310) of Medicine Hatters are living in poverty - a rate higher than the Alberta average. Data from the 2011 National Household Survey (NHS) shows that based on the after-tax income Low-Income Measure, the proportion of the population in low income in Medicine Hat was 13.1%, above Alberta rate of 10.7%.[ix]

This figure is considerably higher than the estimate presented in the *Moving From Charity to Investment: Reducing the Cost of Poverty in Medicine Hat* report for 2010 of 7,360.[x]



Children have the highest poverty rates. Notably, those under 18 had the highest poverty rates (17.4%) while seniors were lower than the average (9.2%).[xi]

Income status[xii]	**Medicine Hat (CA)**	**Alberta**	**Canada**
Total - Persons in private households for low income (count)	71,070	3,519,390	32,386,170
Proportion in low income (based on LIM-AT) (%)	13.1	10.7	14.9
Under 18 years (%)	17.4	13.4	17.3
Under 6 years (%)	18.7	14.1	18.1
18 to 64 years (%)	12.3	10.2	14.4
65 years and over (%)	9.2	7.8	13.4

Homelessness Risk

While poverty has been associated with notable negative outcomes at the individual and societal levels, including health, educational attainment, public safety, etc., it is important to note that not all Medicine Hatters who live in poverty are at risk of homelessness. A closer look at the interaction of income and shelter costs with additional intersecting barriers to housing stability is needed.

Recent studies on homelessness risk suggest that it is likelier to occur when a predictable combination of risk factors is present and a number of protective factors are absent. Particular risk factors at the individual and structural levels are present in both at risk and homeless populations:

1) an imbalance in the income and housing costs,
2) chronic health issues, particularly mental health, disabilities/physical health,
3) addictions,
4) experiences of abuse and trauma, and
5) interaction with public systems, particularly correctional and child intervention services.

By contrast, identified protective factors that moderate risk for homelessness include healthy social relationships, education, access to affordable housing and adequate income.[xiii]

To this end, the Canada Mortgage and Housing Corporation (CMHC) measure of Core Housing Need lends a closer look at shelter costs in Medicine Hat and points to a better understanding of the at risk population.

According to the CMHC, affordable dwellings cost less than 30% of before-tax household income. Households which occupy housing that falls below any of the dwelling adequacy, suitability or affordability standards, and which would have to spend 30% or more of their before-tax income to pay for the median rent of alternative local market housing that meets all three standards, are said to be in Core Housing Need.

One out of five households were paying more than 30% of their income on shelter. Almost 22% of Medicine Hat households paid 30% or more of household total income toward shelter costs; a proportion lower than the Alberta average (23.7%).[xiv] By contrast, in 2006, the proportion of Medicine Hatters in this situation was 10.3%, a notable increase compared to 2011.[xv]

The number of households living below the affordability standard has increased. There were 6,560 households paying more than 30% of their income on shelter according to the 2011 NHS[xvi]; this is notably higher than the figure of 2,755 households according to the 2006 Census.[xvii] Even more concerning is the figure reported in the 1991, when 985 were counted in this category. While the two data sources cannot be directly compared due to different methodologies, the indicators reported by the NHS raise important questions regarding affordability trends in Medicine Hat.

	Total Households	Households Paying more than 30% on Shelter (total, percent of total)	
2011	29,955	6,560	21.9%
2006	26,850	2,755	10.3%
2001	22,815	1,775	7.8%
1996	20,310	1,820	9.0%
1991	18,750	985	5.3%
Note: Data for 2011 is from NHS for households paying more than 30% on shelter. Data from 1991-2006 is from CMHC, using Census data, for households below affordability standard (also paying more than 30% on shelter).			

Renters are likelier to be in need of affordable housing. A lower proportion of owner households paid 30% or more compared to tenant households in Medicine Hat (16.8% for owners versus 37.4% for renters). There were 2,704 renter and 3,818 owner households in this situation. The average monthly shelter cost for tenant households was $829, this was lower than the average monthly shelter cost for owner households of $992.[xviii]

Housing indicator[xix]	Housing tenure	Medicine Hat (CA)	Alberta	Canada
Percentage of households spending 30% or more of 2010 total income on shelter costs	**Total**	21.9	23.7	25.2
	Owner	16.8	18.4	18.5
	Renter	37.4	38.6	40.1
Average monthly shelter cost ($)	**Total**	952	1,252	1,050
	Owner	992	1,314	1,141
	Renter	829	1,079	848

Renters were likelier to live in housing in need of major repairs. While 6.0% of households reported living in dwellings that required major repairs, the proportion was lower for owners than renters (5.0% for owner-occupied dwellings and 9.3% for renter-occupied dwellings).[xx]

The housing need gap between Aboriginal and non-Aboriginal households is increasing. Breaking the Census 2006 data down to examine the impact of Aboriginal status on housing outcomes, the prevalence of Core Housing Need among Aboriginal people in Medicine Hat was 11%, almost double the average. Notably, this has jumped by 7% since 2001.

The waitlist for social housing is climbing. The MHCHS waiting list for affordable housing numbered 340 households as of June 2012; this has increased to more than 350 by the spring of 2014.[xxi]

Persistent housing affordability challenges increase homelessness risk, particularly for low income renters. CMHC reports that over the three-year period 2005 to 2007 some 27% of individuals who were ever (at least one year) in Core Housing Need, remained in this situation

all three years.[xxii] While no benchmark for Medicine Hat for persistent Core Housing Need could be obtained, using the Canadian figure, we estimate that about 6% (1,760) of Medicine Hatters are experiencing persistent core housing need due to affordability challenges. Renters are likelier to be in persistent core housing need, compared to homeowners.

Unfortunately, there is no current data with which to estimate the size of the population at risk for homelessness. Using the 2012 Municipal Census[xxiii], we estimate that the prevalence rate of absolute homelessness in Medicine Hat is 1.4%, or 881 people who become homeless (shelter or rough sleeping) throughout the year. This means that for every 1 person who becomes homeless, there are as many as 2 who are at risk due to persistent housing affordability challenges. Interestingly, this is the same estimated rate as that of Calgary, where a reported rate ranged between 1.3% and 1.5%, averaging 1.4%.[xxiv]

Based on these figures (persistent Core Housing Need and absolute homelessness prevalence), an estimated 1,700-1,800 Medicine Hatters could be at risk. This group should be the target of prevention measures to ensure risk for homelessness is mitigated.

Housing Market Trends

Strong labour opportunities draw migration, putting pressure on limited rental stock. According to the *CMHC Rental Market Report* in October 2013, vacancy rates decreased across Alberta. Gains in net migration fueled by strong employment gains pushed vacancy rates down across rental markets, including Medicine Hat's, year over year.[xxv]

Vacancy rates are declining and rents are on the rise. Ongoing investment in the oil sands supported increased rental rates as migrants were drawn to the region; Medicine Hat's vacancy rate declined by 1.1% from October 2012 to October 2013, bringing it down to 3.9%. The highest decreases in vacancy rates occurred in the 3-bedroom units, which dropped nearly half year-over-year. In terms of rental costs, rates increased minimally by an average of $23 from 2012 to 2013, though decreasing vacancies will likely add upward pressure moving forward.[xxvi]

No new rental units are being added, despite demand. Despite increasing demand, the number of purpose-built rental units decreased from 2,391 in 2012 to 2,364 in 2013.[xxvii]

	Vacancy Rates			Rental Rates		
	12-Oct	13-Oct	Change	12-Oct	13-Oct	Change
Bachelor	3.8%	12.3%	8.5%	$529	$519	-$10
1 Bd	5.4%	4.3%	-1.1%	$611	$632	$21
2 Bd	4.6%	3.3%	-1.3%	$702	$727	$25
3 Bd+	8.5%	4.5%	-4.0%	$797	$815	$18
Total	5.0%	3.9%	-1.1%	$672	$695	$23
CMHC Rental Market Statistics Fall 2013, Vacancy and Availability Rates (%) in Privately Initiated Rental Apartment Structures of Three Units and Over						

The Homeless Situation

Medicine Hat has not historically participated in Point-in-Time (PIT) Homeless Counts. October 2014 will mark the first year that this community will participate alongside the 7 Cities in a common PIT count. The Count will be based on the National HPS count requirements in terms of a common date and methodology. The relationship and information sharing that occurs at the local level between the CBO and the shelter providers has created an exemplary model to replicate. Information about shelter stayers is shared between providers in the spirit of collaboration for those in need to create an improved system of care.

The Transformation to Housing

One of the most important changes our community has made has been the shift towards system planning guided by the housing first philosophy.

In the past, those experiencing homelessness were expected to deal with the issues that contributed to their homelessness, such as mental illness or addictions, before they were housed. With housing first, our priority is to rapidly move people experiencing homelessness into appropriate housing with supports. Once housed, they are better able to work on the issues that contributed to their homelessness.

Over the past four years, our community has learned a tremendous amount from implementing housing first. Our housing first programs have successfully re-housed 764 program participants, with an average of 72% being successfully exited into housing stability.

As year four ends and year five of Our Plan to End Homelessness begins, it is evident throughout the past four years that the community based approach to ending homelessness is having phenomenal results; both from a program delivery perspective, and from a systems perspective. 508 individuals and their 256 children have connected with our programs and have been successfully housed throughout the community. These individuals have come through our doors with a wide array of experiences and tremendous resiliency. 111 individuals reported that

their primary residence before entering the housing first programs as an emergency shelter. We are proud to say that this community has worked collaboratively and diligently to successfully house the top 40 shelter space utilizers in Medicine Hat. Through the CBOs strong relationship with the emergency shelter, the goal of ending homelessness through connecting with individuals with appropriate services within 21 days of their shelter stay is a reality. Not only is this being accomplished, but our new refocused Plan sets an even higher expectation – 10 days.

30% of individuals housed by our housing first programs experienced chronic homelessness and 70% experienced episodic homelessness. Of those that were chronically homeless, 42 were on the street for 5 years or more. 37% of individuals that entered the program were fleeing or had been exposed to family violence – both men and women -, and 24% had been involved with foster care at some point in their lives. What these numbers tell us is that our approach to ending homelessness is targeting the right populations: the chronic and episodically homeless, and those in most need.

It is a pleasure to walk along side these individuals as they work toward their housing stability. Of the 411 exits from the housing first programs from April 1, 2009 to March 31, 2014, 291 participants (71%) have successfully graduated from the housing first program. Due to their successful housing journey, 152 children also have a place to call home. Upon exit, of those successful graduates (n=291), 55% of participants graduated into market housing while 26% graduated into subsidized housing. The majority of participants were within 36-50 years of age (34%) at time of graduation. 22% of participants were either had full time or part time employment.

A strong component of the housing first philosophy is that the program is non-compliance based which means that service participants have choice. There is choice of tenancy, choice of lifestyle, and choice to discontinue services. 44% of unsuccessful exits (n=120) were due to participants choosing to not continue with the program. 12% of unsuccessful exits were due to “other” which of those, 71% of participants stated that they were relocating. 19% of the participants stated that they were very satisfied to satisfied with the program in terms of getting them housed.12% of participants were undecided at time of exit interview and 69% left the question unanswered.

Since its inception on April 1, 2012, the Graduate Rental Assistance Initiative (GRAI) has provided 78 unique service participants with the ongoing financial support they required to maintain their housing stability after graduation. There have been cases that participants do not require GRAI any longer due to their circumstances, such as finding full time employment and are able to sustain their tenancy on their own. There are still a number of individuals that remain in the Housing First program far beyond what the program was designed for. Even with GRAI available to assist with ongoing rental support, these individuals cannot exit the program successfully. For many of these individuals, Permanent Supportive Housing options are needed as these individuals demonstrate an inability to live independently without an ongoing subsidy and appropriate supports.

Changes to our centralized intake and assessment process in August 2013 resulted in more streamlined and consistent access to our housing and support services. Most importantly, it allowed us to bring the human factor back into the equation. While the use of the Service Prioritization Decision Assistance Tool (SPDAT) score was used to prioritize individuals on the waitlist for housing first services, it ironically, did not provide enough context about individuals' homelessness. The impetus for change occurred when reviewing the waitlist: an individual in shelter for 32 days and scoring a 43 on the SPDAT was prioritized over an individual in shelter for 364 days and scoring a 42 on the SPDAT. The context of this situation would not have been realized, or changes made to how we as a community prioritize, if the CBO and centralized intake did have information from the shelter about duration of stay in shelter. The 'new' approach implemented at the local level has taught us a new way to frame, prioritize and match participants' need (both duration and intensity) to program delivery.

Strong partnerships and communication between our program case managers and landlords have been critical to this success, as has our ability to leverage community and public system resources including the Food Bank, Income Supports, AISH, Alberta Health Services, the Police Services, and correctional services.

Public System Impact

Medicine Hat's success reaffirms research findings and other communities' experience with housing first from a cost-savings perspective as well.[xxviii] In a study of homelessness in four Canadian cities, Pomeroy reports that institutional responses to homelessness including prison and psychiatric hospitals can cost as much as $66,000 - $120,000 per year.[xxix] This is significantly higher than the cost of providing housing with supports, estimated to cost between $13,000 and $18,000 annually.

Our experience confirms that it is less costly to provide appropriate housing and support to a person experiencing homelessness than maintaining the status quo approach that relies on emergency and institutional responses. The following chart demonstrates the impact housing first has had on reducing public system use, and therefore costs.

Utilization of Public Systems in housing first (2009-2013) N=198			
	Intake	**12 Month Assessment**	**Estimated Reduction**
Days in Hospital	1,967	956	-51%
EMS Interactions	236	208	-12%
ER Use	698	412	-41%
Days in Jail	1,582	828	-48%
Police Interactions	529	448	-15%
Court Appearances	242	260	+7%
Note: The Intake and 12 Month Assessment data sets are not directly comparable. The intake comprises of 198 adult service participant records reporting on system use in the past 12 months. The 12 Month Assessment reports systems use in last 3 months by the same 198 individuals, thus the total is estimated based on this figure for 12 months.			

As the system gets better data from the HMIS, we will have increasingly better and more refined information to compare the cost of providing housing with support compared with emergency and institutional responses.

A Systems Approach to Ending Homelessness

In Medicine Hat, as in most communities, housing first was initially conceptualized as a programmatic intervention that aimed at rapidly rehousing individuals and supporting them to maintain housing stability. We have since learned that it is much more.

The shift to housing first in Medicine Hat has been more fundamental than introducing specific programs. We have looked to housing first as a call to approaching homelessness differently in our community. Rather than simply introducing new programs, we have restructured our entire system's approach to homelessness following housing first as a philosophy.

This means that all key players in our Homeless-Serving System follow the same vision, and are committed to working together towards realising it. The transformation of Medicine Hat's approach to homelessness has required a reorientation towards ending homelessness and housing first using a system planning approach.

System planning is a method of organizing and delivering services, housing, and programs that coordinate diverse resources to ensure efforts align with ending homelessness goals. Rather than relying on an organization-by-organization or program-by-program approach, system planning aims to develop a framework for the delivery of initiatives in a purposeful and strategic manner for a collective group of stakeholders.

While system planning is an internationally recognized best practice critical to ending homelessness, it remains elusive in practice. Based on a review of promising approaches to system planning, several key elements to system planning have been identified as necessary to its successful implementation.[xxx]

System Planning Elements[xxxi]
1. Systems-focused Plan to End Homelessness Community plan follows a systems approach and the housing first philosophy to end homelessness.
2. Backbone Organization Backbone organization is in place leading the Homeless-Serving System to meet Plan targets. Key roles include: 1. Planning Lead, 2. System Planner, 3. Information System Manager, 4. Funder, 5. Evaluator, 6. Innovator, 7. Community Facilitator, 8. Researcher & Knowledge Leader, 9. Advocate.
3. Community Engagement A transparent process is established to identify system gaps and priorities for planning and investment that incorporates input from diverse stakeholders, including service participants**.**
4. Defined Structure Agreed-upon program types are established across the Homeless-Serving System using common definitions and clearly articulated relationships among components.
5. Standards of Care Agreed-upon standards, policies, and protocols are in place to guide program and system functioning, including referral processes, eligibility criteria, service quality, program participant engagement, privacy, safety, etc.
6. Performance Management Performance expectations at the program and system levels are articulated; these are aligned and monitored to drive Plan targets.
7. Coordinated Intake & Assessment Common processes are established that ensure appropriate program matching, consistent prioritization, and streamlined flow of program participants across the Homeless-Serving System.
8. Homeless Management Information System (HMIS) Shared information system is implemented that aligns data collection, reporting, coordinated intake, assessment, referrals and service coordination in the Homeless-Serving System.
9. Technical Assistance Capacity building support is available to service providers and mainstream system partners in key areas including system planning, HMIS, program and system performance management, and other Standards of Care aspects.
10. Embedded Research Commitment to evidence-based decision-making and planning is built into the backbone organization and community's approach to system planning.
11. Systems Integration A focus on integrating the Homeless-Serving System with key public systems and services, including justice, child intervention, health, and poverty reduction is evident.

Medicine Hat has been at the forefront of the shift to system planning in the ending homelessness movement. Over the past four years, MHCHS and community partners have implemented critical measures to shift towards a systems approach, as outlined below.

Elements of System Planning	Medicine Hat's Progress
1. Plan to End Homelessness	Re-focused Plan to End Homelessness (2014) follows a clearly articulated system planning approach.
2. Backbone Organization	MHCHS leads the implementation of the Plan and system planning activities. Considerable capacity has been amassed internally to undertake the role of the backbone organization locally (see next page).
3. Community Engagement	MHCHS works with the Community Council on Homelessness (CCH), made up of 22 community stakeholders. The CCH has begun to shift its role towards system planning; this includes playing an active role in the priority-setting process for community investments.
4. System Structure	The 2014 Plan clearly articulates the Homeless-Serving System structure, reflecting practice at the community-level.
5. Standards of Care	MHCHS and its funded agencies have implemented common Policies and Procedures in to guide practice at the program and system level; MHCHS monitors these on an ongoing basis in alignment with provincial and federal requirements.
6. Coordinated Intake & Assessment	The Housing Assessment and Triage process has been implemented; together with the SPDAT, these initiatives ensure consistent intake and referrals into programs to match program participant needs.
7. Performance Management	MHCHS has developed a rigorous performance management and quality assurance system to monitor progress across the Homeless-Serving System. These include common system and program benchmarks that align with the community Plan, as well as funder requirements.
8. Homeless Management Information System	Efforts to Outcomes, Medicine Hat's HMIS, has been in place since 2009 in provincially funded programs; plans to expand implementation are underway.
9. Technical Assistance	MHCHS has developed a fulsome technical assistance and capacity building programme for Homeless-Serving agencies focused on building housing first case management capacity, supporting HMIS uptake, and introducing system planning at the agency and program level.
10. Embedded Research	HMIS data analysis is embedded in decision-making on an ongoing basis. MHCHS and the CCH have supported the development of a poverty reduction plan locally, and are building a comprehensive research strategy, which includes a focus on youth homelessness.
11. Systems Integration	MHCHS has begun work on developing protocols to work with health, police, justice on shared priorities. On an operational level, case managers collaborate with partners to further program participant outcomes. The re-focused Plan places priority on systems integration through Strategy 3: Systems Integration & Prevention.

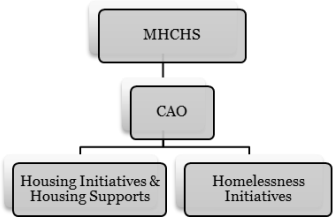
The Medicine Hat Community Housing Society

The Medicine Hat Community Housing Society (MHCHS or 'the Society') is a management body established by Ministerial Order under the Alberta Housing Act, a charitable organization under the Societies Act, and the Community Based Organization/Community Entity for Medicine Hat established to coordinate initiatives in the community dedicated to ending homelessness.

MHCHS has two (2) mutually supporting core business functions:

1. **Housing Initiatives & Housing Supports**
   MHCHS has been established as a "Management Body" (MB) by Ministerial Order; a MB is established for the purpose of administering social housing programs for the government under the Alberta Housing Act.

2. **Homelessness Initiatives**
   MHCHS has been established as the Community Based Organization (CBO) and Community Entity (CE) for Medicine Hat, charged with leading and implementing the local Plan to End Homelessness. A CBO (provincial) and CE (federal) is established for the purposes of administering funding from these respective jurisdictions, targeted to initiatives aimed at ending homelessness. The responsibility of the homelessness initiatives falls under the scope of the Homeless & Housing Development Department (see Organization chart below).



Organizational Structure

The MHCHS Board of Directors is a governance board comprised of 11 members as described in the Ministerial Order. The Board governs in accordance with the Society Bylaws and provides policy and planning direction to the Chief Administrative Officer (CAO). A number of standing and working committees, which include valuable community allies with similar goals and objectives, support the work of the MHCHS. Advocacy is also a primary function of the Board.

The CAO is responsible for conducting and overseeing all aspects of the business of the Society and reports directly to the Board of Directors. A staff of 37 employees (35 full time and 2 part-time) are tasked with delivering the services of the MHCHS.

The primary statutes affecting MHCHS are the Alberta Housing Act, the Residential Tenancies Act, and the Freedom of Information and Protection of Privacy Act. Under the Alberta Housing Act, there are also a number of Regulations which impact the Society.

The Lead Organization

Moving to system planning, housing first, and ending homelessness requires a different type of leadership at the community level. In Medicine Hat, the MHCHS has taken on the role of the lead organization leading the implementation of the plan to end homelessness and system planning activities.

In its unique capacity as both the Management Body for social housing and the Community Based Organization who oversees homeless investments on behalf of the federal and provincial governments, the MHCHS has been able to effectively leverage its role and resources in implementation.

Over the past four years, the MHCHS has grown in its role as a steward of public funds and system planner at the community level to meet the following key roles of a lead organization:

1. **Planning Lead**: Leads the implementation of the Plan to end homelessness, including annual strategic reviews and business planning; monitor and report on progress of the Plan

2. **System Planner**: Designs, implements, and coordinates the Medicine Hat Homeless-Serving System;

3. **Information System Manager**: Implements and operates ETO as the local Homeless Management Information System;

4. **Funder**: Manages diverse funding streams to meet community priorities, compliance, monitoring, evaluation, and reporting requirements to funders;

5. **Evaluator**: Ensures comprehensive program monitoring and quality assurance processes are in place; implements and supports uptake of Standards of Care for programs within the system;

6. **Innovator**: Implemented housing first in a smaller center with innovative adaptation for youth and women fleeing violence; leverages social housing portfolio and private sector partners; early adopter of system planning using the housing first approach;

7. **Community Facilitator**: Consults and engages with diverse stakeholders to support plan implementation; targets capacity building initiatives, including comprehensive training and technical assistance for the Homeless-Serving sector;

8. **Researcher & Knowledge Leader**: Ensures research supports the implementation of local plans and share best practices at provincial and national levels; focuses on knowledge mobilization to support agencies, peers and public policy makers in the execution of their roles;

9. **Advocate**: Advances policy and practice issues and acts as champion for ending homelessness in the local community, provincially, nationally and internationally.

Through implementation of these activities, the MHCHS has become a nimble decision-maker that uses data and available information to effectively coordinate the Homeless-Serving System. The MHCHS has the capacity to draw on HMIS data to monitor emerging trends in program participant needs, and program outcomes to trouble-shoot and adjust its approach in real-time. This enables more effective use of resources and better outcomes for program participants.

As a first community to end homelessness, it is imperative that Medicine Hat shares its learnings to support the ending homelessness movement nationally and internationally. To date, the MHCHS has undertaken some knowledge mobilization activities to transfer local success and best practices. Moving forward, its capacity to engage in dialogue with other community lead organization stakeholders, researchers, and policy makers should be a priority focus.

Without success across Canada, Medicine's Hat's end to homelessness will not be sustainable for the long term.

II. CBO DECISION MAKING PROCESS

The community engagement process for the development of this Service Delivery Plan was different than what was implemented in previous years; it was much more community based and inclusive of stakeholders. In 2012, MHCHS began planting the seed in the community and at the Community Council on Homelessness (CCH) table that an update to the existing Plan to End Homelessness in Medicine Hat was needed based on the tremendous progress the community had made. To ensure the implementation of the Plan builds on the expertise of diverse partners and shifts to address changing conditions, MHCHS works closely with the Community Council on Homelessness, which is currently made up of 22 stakeholders that represent a broad cross-section of interests and expertise locally.

In the fall of 2013, with the support of the Community Council on Homelessness, MHCHS initiated a strategic review process to determine a framework for the Plan's update. MHCHS prioritized a “Made in Medicine Hat” approach that included the purposeful engagement of diverse stakeholders in the update process, including partner agencies, government, mainstream systems, and service participants. An external consultant was hired to work alongside community to refocus the Plan. This included a full review and evaluation of the existing programs, service delivery models, and systems planning undertaken by the CBO. Not only did the CBO want to know the status of our outcomes as a community based on the data, but we also invited areas for improvement at the systems planning level as well. To achieve this, the consultant was provided full access to the data, processes, the community, and the service participants.

The MHCHS has a reputation for our highly regarded consultative approaches and processes around housing and homelessness. This extends beyond our community into other jurisdictions, both provincially and nationally.

At Home in Medicine Hat. Our Plan to End Homelessness was approved by the CCH and the MHCHS Board in March 2014. The Service Delivery Plan and the Federal Community Plan are engendered in the Plan.

The Request for Proposals (RFP) Process

The 2014-2015 RFP process also experienced some changes from previous years. Concerns were raised from our community partners at the program delivery level in 2012-2013 about the

need to write full proposals through an RFP process. The community partners expressed that the amount of resources required to respond the RFPs was taking away from the good work that was occurring in the community. The CBO committed to looking at streamlining processes, meanwhile messaging the rationale for implementing an RFP process. In 2013-2014, the CBO was able to begin the movement from a full RFP release to something more responsive to community need, while maintaining the balance of fiscal stewardship. In the 2013-2014 Request for Proposals Homelessness Initiatives, the CBO outlined the Program Timeline requirements:

> "Commencing April 1, 2013 and ending March 31, 2014. Funding agreements may be extended beyond one year based on continued OSSI funding to the CBO, satisfactory service delivery by the service provider and a demonstrated need for the continuation of the program delivery at the current operating level as evidenced by both an internal agency program evaluation, and a CBO program evaluation."

The MHCHS decided to exercise the option to extend funding agreements based on:

a) continued OSSI funding from the Province, *and*
b) confirmation of satisfactory service delivery by the service provider, *and*
c) a demonstrated need for the continuation of the program delivery at the current operating level.

Points "b" and "c" above were required to be evidenced by both:

a. an internal agency program evaluation, *and*
b. a CBO program evaluation.

If a service provider (agency) chose to not submit a program evaluation and/or demonstrate the need for the service, it would result in funding agreements not being extended to service providers.

All service providers provided evaluations on their existing service delivery. The internal evaluations coupled with the CBOs program evaluation secured funding for the existing providers. The CBO submitted the recommendations for continued funding to the CCH, which were approved on March 27, 2014 and are awaiting final MHCHS Board approval.

During the funding recommendation process, the proponents – many who hold seats at the CCH table – are excluded as voting members on the issue, and are note counted as contributing to quorum. In the event that quorum is not reached at an in-person meeting, an email vote is conducted, with proponents excluded from the process.

The CCH Terms of Reference outline the conflict of interest policy:

> **"CONFLICT OF INTEREST**

Conflict of interest shall be determined as any interest that might be construed as real, potential or apparent. All Council members shall disclose any association with an applicant organization who may, directly or indirectly, benefit from a decision of the Council.

Members may not vote on any issue where a conflict of interest is identified."

The community announcement of successful proponents will occur in April, 2014 once they are approved by the MHCHS Board, and will form part of the marketing strategy around the Plan. We are eager to share with the community what great housing first programs are in operation in this community.

Based on the past allocation to community, there are currently minimal funds that remain to be allocated out to community. These funds have been earmarked for emerging community needs, and at the time of writing the SDP, changes to the market rental situation in Medicine Hat have transpired into an imminent concern at the program and community level. The changes will see an unprecedented hike in the rental rates that will impact our existing service participants' housing stability. Our priority is to ensure the existing programs have adequate funding to be responsive to this need.

III. COMMUNITY ACCOMPLISHMENTS & CHALLENGES

Our Accomplishments:

1. Delivering on Our Commitments
    a. Refocusing Our Plan to End Homelessness
    b. Full Implementation of a Systems Planning Approach
    c. Hiring Additional Staff
    d. Continued Investments in Community Capacity Building
    e. Youth Homelessness Research
    f. Community Commitment to Development of Residential Treatment Facility
2. Evidence-Based & Data Driven Adjustments to Service Delivery
3. Support From Mayor and City Council
4. Remembering the Why.

Increasing Our Capacity:

1. Building Local Leadership
2. Balancing Want versus Need

Opportunities to Increase Capacity:

1. Telling the Story (versus selling the story)
2. Sharing Our Success
3. Transitioning to Sustainability

Barriers and Factors Impacting Implementation of the Plans (Provincial 10 Year and the local Plan)

1. Recognition that Housing and/or Availability of Adequate Rent Supplements are Required, Urgent, and Will Determine the Success of the Plans.
2. Lack of Investment in the Recognized Need for Permanent Supportive Housing Options Across the 7 Cities
3. Inadequate Benefit Amounts Provided by Income Support Programs

Moving Towards Coordinated Community Strategy
See Strategies Below.

Shelter Visioning Process.
See Strategy 2.3 below.

IV. CBO PRIORITIES

1. Priorities for the 2014-2015 fiscal year: End Homelessness
2. Priorities past 2015: Sustaining and End to Homelessness

Based on the learnings to date, best practices research, and community input, the following key strategic directions will guide us to realize our vision:

1. The full-scale implementation of the **system planning** approach in the Medicine Hat Homeless-Serving System.

2. Ensuring adequate and appropriate **programs and housing** opportunities are in place to meet priority population needs to end homelessness in Medicine Hat by March 2015.

3. Introducing system integration and targeted **prevention** measures to stop the flow into homelessness and maintain an end to homelessness beyond 2015.

4. Using **data and research** to improve and refine our approach.

5. Stepping up as a **leader** to support the ending homelessness movement in Alberta, Canada, and internationally.

Strategy 1 - System Planning

Considerable progress on implementing a system planning approach to end homelessness has been made to date. Yet, work remains to be done. We need to reach beyond funded programs to connect all homeless-serving agencies into common processes. The systems approach needs to be embedded at the agency and program level to guide decision-making and implementation activities through and through.

We will build on current success and further connect into public systems, including hospitals and jails. The range of services available that support prevention can be leveraged further, particularly in light of Medicine Hat's Poverty Reduction Plan.

We will work to clearly articulate the Medicine Hat Homeless-Serving System with our community partners. This will include developing a clear system structure, along with program and system-specific outcomes and targets that align with provincial and federal expectations.

1. Maintain focus on long-term chronic and episodically homeless.

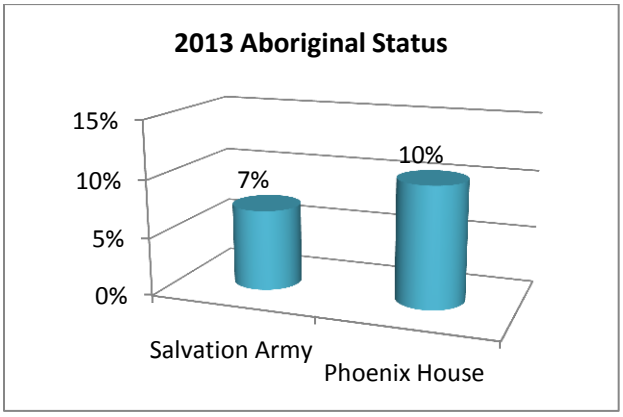
We know that our success at reducing shelter numbers is the result of the systematic focus on the chronic and episodically homeless. We will continue to maintain this focus at the system planning and service provision level.

The ongoing analysis of HMIS data together with the use of the SPDAT will assist us in ensuring programs are targeting appropriately and meeting housing stability targets for our most vulnerable. By 2015, we aim to re-house 290 homeless; of these, 240 will be chronically or episodically homeless. To achieve maximum impact, we will particularly focus efforts on long term shelter stayers and rough sleepers with the appropriate service needs to access our housing first and Permanent Supportive Housing programs. This will drive our prioritization process to ensure alignment with the system level goals of reducing shelter stays as well.

2. Apply priority populations lens to meet the needs of youth, women, families, seniors and Aboriginal people.

From our work, we have further learned about the importance of accounting for sub-populations with particular needs. Their distinct needs must be accounted for in our response, particularly for those who are most vulnerable. Our response, including housing first programming, has aimed to tailor interventions for families, particularly women with children who are fleeing violence. Women are also likelier than men to live in poverty, making the attainment of housing even more difficult.

We are also keenly aware that Aboriginal People are over represented in our shelter population, making up 4.6% percent of the general population but 7-10% percent of the population in our two main shelters. Moving forward, we will strive to ensure the culturally-specific needs of this group are met through tailored approaches.



We also know that young people experiencing homelessness and housing instability require particular attention. MHCHS and community stakeholders are working with Dr. Yale Belanger from the University of Lethbridge to determine the extent of youth homelessness in Medicine Hat. This will provide us with a better understanding about local needs and solutions moving forward.

As our homeless population and general population continue to age, planning for appropriate responses to a growing senior's component will be critical. This will impact our program and housing design, creating demand for accessibility features in particular.

Moving forward, our service planning and delivery will use a priority populations lens to ensure unique needs are met. Based on local needs, we will develop program and policy response to to this end and support the work of our government partners is this arena, particularly by aligning with the *Alberta Plan to End Youth Homelessness* launched by Human Services in 2014.

3. Enhance access across the Homeless-Serving System.

The creation of a single point of entry to the Homeless-Serving System is critical in systematic efforts to end homelessness. Our Housing Assessment and Triage has made a critical contribution to streamlining program participants into appropriate programs and housing quickly and consistently. Yet, only a limited number of programs are currently using this process, which leaves the rest of our system decentralized in some respects. Further, service participants report ongoing barriers accessing the right supports, at the right time and having clarity around eligibility and program rules.

Without aligning key providers in the system to the single access point and HMIS, our ability to manage the flow of program participants is limited, and so is our capacity to fully engage in system planning. To this end, we will pursue the expansion of our Housing Assessment and Triage across the Homeless-Serving System in tandem with HMIS implementation (see Strategy 4 - Data & Research). We will develop clear and transparent referral processes and ensure consistency in their application with service participants, providers, and system partners.

4. Maximize the impact of current program investments.

During the research phase to develop the re-focused Plan, we analysed current program capacity and performance. An estimated 40% Intensive Case Management program capacity was underutilized while Rapid Rehousing programs remained in very high demand at 95% capacity. This was due to a recent program restructuring in our system causing a temporary slow-down in rehousing. We are working with service providers to address any lax program capacity to alleviate areas of demand; this requires a new way of delivering services that is nimble and responsive to quickly shifting demands in the target population. Both the MHCHS and its funded agencies will need to continue to push towards working differently and nimbly moving forward to meet shifting demand.

We also have to re-consider our current investments in light of the re-focused Plan. While our current HPS funded portfolio has made important contributions in the effort to end homelessness, there is a need to ensure that investments are congruent with the re-focused Plan and the federal shift to housing first. MHCHS will work with community partners, Human Services and HPS to ensure funded programs are aligned with both the Plan and government priority investment areas in 2014.

Our currently funded HPS programs will be re-evaluated to ensure resources are maximized to meet community priority needs as three-year contracts conclude in 2014 and competitions for these funds ensue. This will be the case for Human Services investments through our annual performance management processes as well.

5. Enhance service quality and performance in the Homeless-Serving System.

Considerable efforts have been made at the program level to increase fidelity to housing first through investment in training and monitoring. We recognise that the new Plan calls for a reconsideration of our approach to capacity building and performance management. To this end, the MHCHS will work with partner agencies and the CCH to enhance program monitoring and contract management processes to support service quality, adherence to Policies and Procedures, housing first program fidelity, while meeting legal and financial monitoring commitments to funders.

The MHCHS will continue to work with its local and provincial partners to implement capacity building and training initiatives to improve service quality in priority areas including: safety planning, using data in service planning, serving high acuity program participants, and delivering Permanent Supportive Housing. We will explore measures that increase staff retention and ability to deliver quality services.

6. Advance the engagement of community partners in system planning.

We recognize that system planning is not the work of one organization. To be successful, the systems approach must permeate every aspect of our Homeless-Serving System. By engaging diverse voices in decision making that advances our system planning work, we will enhance outcomes for our community. We will enhance outcomes for our community by engaging diverse voices in decision making that will advance our system planning work.

To this end, the MHCHS will work with Homeless-Serving agencies to enhance the work of the Program Planning Committee that works with the MHCHS to implement a systems approach to service planning and delivery. The role of the Community Council on Homelessness (CCH) will also continue to shift from program design towards system planning.

Further, the development of a formalized program participant engagement process, including a program participant satisfaction survey, to ensure consumer voice in system planning will be developed. The MHCHS will also undertake an assessment of its internal capacity to deliver system planning functions and ensure resources are in place to lead the re-focused Plan.

7. Engage community funders to align performance monitoring and reporting.

Our community has limited resources to meet service demands; we have to ensure processes are in place that reduce duplication of efforts and drive common community goals. In 2014, we will convene a Funders Table to share information with funding partners, including FCSS, the United Way and the Community Foundation, on common priorities and identify areas where we can leverage one another's resources and where duplication can be avoided. Agency capacity building, as well as aligned funding and reporting processes are potential areas for exploration. Common policy priorities and clarity on the role of various partners in homelessness, broader prevention, and poverty reduction efforts can also be considered.

Strategy 2 - Housing & Supports

The development of our Homeless-Serving System since 2009 has resulted in the introduction of a slate of programs based on the Housing First approach. Besides building service capacity to deliver these services, our community has also introduced the Housing Assessment and Triage process that provides a single point of entry into our Homeless-Serving System. This ensures that program participants are assessed using the same process and are appropriately referred into programs that best meet their needs. We are also able to track program participant progress through our system using the HMIS to ensure best outcomes.

Nevertheless, our current program and housing capacity are unable to meet the needs of all homeless program participants at this time. Despite considerable investments from our provincial and federal partners, several service gaps remain which must be addressed in order to end homelessness by 2015. Further work is also needed to ensure current capacity is maximized and targeted towards priority populations.

1. Enhance Housing First programs and Permanent Supportive Housing capacity.

In order to accelerate progress to the 2015 deadline, a number of measures would need to be put in place. These include temporarily ramping up housing first programs to bring capacity for rehousing of chronic and episodic homeless to 240 annually in Intensive Case Management programs. Similarly, increasing Rapid Rehousing capacity by about 50% (about 50 additional program participants housed per year) would expedite shelter closures and an end to homelessness in 2015. This would address the 850 unique shelter users in the system currently, of which 35% are chronically homeless and 40% are episodically homeless.

This strategy leverages the strong relationships we have built with our private sector partners, and enables accelerated results by taking advantage of existing stock in the rental market while PSH units are coming on stream for those with the highest level of needs.

An estimated cost of $1.3M is needed to enable this expansion in 2014/15; we are anticipating that by March 2015, this added capacity will be in place. If so, the ability of our programs to house every homeless shelter user will be realized by the end of 2016 fiscal. The impact of the additional capacity on shelter use should make a significant reduction in the length of stay as more than 290 homeless would be housed by March 2015.

To address the lack of PSH for the most vulnerable homeless, we estimate that a total of 50 units will be needed over the next 3 years, likely using a combination of acquisitions and new construction. A capital investment of $7.5M is estimated at $150,000/door.

Once the goal of ending homelessness is achieved, the program funding used for this temporary ramp up can be reallocated along with a repurposing of emergency shelter funds from unused capacity towards the new PSH units with an estimated operational cost for supports of $750,000 annually and about $640,000 to prevention services targeting those at imminent risk for homelessness, approximately 1,700 - 1,800 Medicine Hatters.

We recognize that this ramp up will require significant effort in our community and the commitment of our provincial and federal partners to fund operations of both Intensive Case Management, Rapid Rehousing and PSH expansion.

In sum, the cost of ending homelessness in our city is:

- One-time capital investment of $7.5M in PSH shared between government and community at a 70/30 split; an ongoing cost of operating these units of $1.7M is estimated at full capacity.
- An additional investment of $1.3M annually until the end of 2016 fiscal in Intensive Case Management and Rapid Rehousing to enable quick ramp up and reallocation towards Permanent Supportive Housing (PSH) operations and Prevention services long term.

If these measures are undertaken from a programmatic perspective, along with the strategies outlined in the remainder of this plan, Medicine Hat will truly have developed a system that is not only achieving an end to homelessness, but is able to sustain it in the long run.

It is critical that we invest in success strategically. An end to homelessness in Medicine Hat is not only possible, it is achievable with relatively minor additional funding. A total of $7.5M in capital and $5.1M additional program funding from 2014-2016. In other words, $12.6M is what we need to meet our goal between now and the end of 2016 fiscal.

While we recognize the need to address homelessness across the province and Canada, we also know that being the first city to end homelessness would reaffirm the promise, the movement and housing first for all of us. It would also cement Alberta's place as at the forefront of innovation in social policy internationally.

	2014/15			2015/16			2016/17			2014-2016 Totals	
	Housed	Total Cost	New Investment Cost	Housed	Total Cost	New Investment Cost	Housed	Total Cost	New Investment Cost	Total Cost	New Investment Cost
ICM	220	$ 2,230,000	$ 1,115,000	220	$ 2,230,000	$ 1,115,000	170	$ 1,723,182	$ 506,818	$ 6,183,182	$ 2,736,818
Rapid Rehousing	50	$ 679,500	$ 226,500	50	$ 679,500	$ 226,500	50	$ 679,500	$ 226,500	$ 2,038,500	$ 679,500
PSH Operations	15	$ 225,000	$ 225,000	50 (35 new)	$ 750,000	$ 750,000	50*	$ 750,000	$ 750,000	$ 1,725,000	$ 1,725,000
PSH Capital ($150K/door)		$ 2,250,000	$ 2,250,000		$ 5,250,000	$ 5,250,000		$ -	$ -	$ 7,500,000	$ 7,500,000
		$ 5,384,500	**$ 3,816,500**		**$ 8,909,500**	**$ 7,341,500**		**$ 3,152,682**	**$ 1,483,318**	**$ 17,446,682**	**$ 12,641,318**

* PSH service participants who maintain housing.

Beyond 2017	**Housed/Served**	**Ongoing Cost**
ICM	60	$ 608,182
Rapid Rehousing	30	$ 407,700
PSH Operations	50	$ 750,000
Prevention	TBD	$ 636,800
Total		**$ 2,402,682**

The Mental Health Commission's national study *At Home/Chez Soi*[xxxii] of housing first interventions estimates that on average, $9,250 per person per year is saved comparing clients who received housing and supports compared to those who did not. This includes costs saved from reducing sheltering, health and justice system usage, including ER and EMS. Assuming this average cost-savings, we estimate that by the end of 2016, over $8M will have been saved from the proposed investment. In other words, the cost of the additional program investments ($5.1M) needed for operations would be entirely covered by the savings generated, with room to spare.

Estimated Cost-Savings 2014-2016 Fiscal		
	Total Operations Cost	**Total Cost Savings**
ICM	$ 6,183,182	$ 5,642,500
Rapid Rehousing	$ 2,038,500	$ 1,387,500
PSH Operations	$ 1,725,000	$ 1,063,750
	$ 9,946,682	**$ 8,093,750**

2. Increase capacity for the development and operation of Permanent Supportive Housing.

Permanent Supportive Housing (PSH) is long-term housing without a length of stay limit for homeless persons experiencing complex barriers to housing stability. PSH is targeted at program participants who demonstrate deep disabilities and an inability to live independently

without an ongoing subsidy and supports. The program strives to move the program participant to increasing independence, however does not impose a time limit on participants. While PSH can be delivered in scattered-site and place-based, congregate models, we strongly believe that the latter is best suited and most efficient for the population we are seeing in our community.

A notable number of participants currently enrolled in our Rapid Rehousing and Intensive Case Management programs require long term supports beyond the scope of current interventions. Due to their complex needs, which may include a combination of physical limitations, mental illness, cognitive impairments, and substance abuse, these participants need PSH options. There are also additional potential PSH participants currently residing in shelters or transitional housing who could benefit from this service in our community.

Though some of these program participants are currently served by our Intensive Case Management programs, we know this is an interim measure rather than the long term solution. The Intensive Case Management model using scattered site housing is not the appropriate fit for this population who require a place-based, dedicated housing model with intensive supports onsite.

We know that PSH models for place-based programming should be tailored for chronic populations. Some will require very intensive, and therefore costlier, 24/7 on-site supports and clinical services. Others can succeed with less intense on-site supports complemented by community-based services.

Accounting for the additional capacity needed to meet the needs of an aging, chronically homeless population and potential in-migration of high acuity program participants, we conservatively estimate a total of 50 units of PSH will be needed over the next 3 years.

We have presented this business case to Municipal Affairs and will continue to advance it as our most pressing priority to realize the goal of ending homelessness in Medicine Hat. We will continue to advance this ask to Municipal Affairs to support 15 PSH units in 2014 and the balance of 35 in 2015. Further, work with Human Services to ensure appropriate supports are in place for PSH program participants.

We will also identify additional community organizations that have an interest and capacity to deliver place-based PSH. This includes identifying underutilized facility space that could be re-purposed to support the delivery of PSH (e.g. Salvation Army shelter, short-term supportive housing units, etc.).

Current provider capacity to operate PSH is limited. To support agency capacity to take on this task, we will develop targeted training at the frontline and management level on PSH operations. We will also develop policies and procedures to guide service providers and monitor service quality.

3. Re-vision the role of emergency shelters post-2015.

Working with our Human Services and emergency shelter partners, we have already begun to engage in a process to re-vision the future of shelters in our community. MHCHS will continue to work closely with the Salvation Army to develop a framework that will quickly transition people out of the shelter. Once this framework is mapped out, our community partners and the community at large will be invited to provide input into the process.

We are confident that we can reduce Medicine Hat's Salvation Army emergency shelter stay to 10 days length of stay working with Human Services' Shelter Visioning initiative. This requires the development of expedited rehousing and diversion, along with a range of housing options, including Interim Housing. Interim Housing is geared towards service participants that are in the process of rehousing (this avoids shelter usage), and for those being discharged from institutions into homelessness and that are connected with Housing Assessment and Triage. With less shelter space needed, we have the opportunity to consider the use of facilities for PSH or other community needs.

4. Maximise the use of affordable housing stock in ending homelessness.

We are fortunate to have a range of affordable housing options available in our community. We are further fortunate to have the same organization leading our homelessness plan, MHCHS, to be the main operator of our affordable housing stock. This presents us with the opportunity to maximize the use of both sets of resources to meet community objectives.

To this end, we will undertake a process to review areas where common protocols can be developed to ensure placement of formerly homeless individual in affordable housing in 2014 as appropriate. While we currently do not estimate any additional affordable housing to be needed in Medicine Hat, in the immediate term, we see considerable potential in better using existing units if a portion of these could be re-purposed to PSH or prioritized for formerly homeless individuals.

We will also further streamline access to affordable units and engage in work with provincial partners to develop a centralized housing registry that connects into our homeless supports.

5. Build on the success of our private rental sector partnerships.

Medicine Hat's private rental sector has championed an end to homelessness not only at the political level, but in daily operations. We have had the benefit of working hand-in-hand with our private sector landlords over the past four years. They have become critical partners in our effort: 117 landlords and property management companies have helped 703 adults and children in Medicine Hat have a place to call home. Without the capacity to have quick access to quality rental units, many of our program participants would still be homeless.

We will continue to support the work of our Landlord Roundtable, which meets on a quarterly basis facilitated by the MHCHS. These meetings serve to provide information to/receive input

from community landlords and to problem-solve any areas of concern that arise. We will also introduce education supports for landlords to better equip them to be part of the solution with our agency partners.

Strategy 3 - Systems Integration & Prevention

We know that without partnerships with key public systems, the efforts and innovation undertaken in our Homeless-Serving System will come up short in the long run. Clearly defining the roles of the Homeless-Serving System in relation to its partners in health, corrections, income supports, child intervention, and poverty reduction is critical. Further, ensuring that our work is defined, yet integrated, is necessary to meet program participant needs, while respecting what each partner does best.

We consider systems integration as the next phase in our system planning work. It is not enough to organize our Homeless-Serving System; we need to ensure it works in tandem to meet community goals with our public system partners.

We often hear about the importance of prevention in our work: building the infrastructure necessary for those at risk to remain housed and close the front door into homelessness. Yet prevention work is often elusive in practice as planners and practitioners debate definitions, target populations, how best to maximize limited prevention dollars, and how to measure impact. Our learnings over the past four years have refined our understanding of prevention and its connection to systems integration.

From our perspective, the role of the Homeless-Serving System with respect to prevention must be clear and defined in relation to other systems to ensure we are all doing our part. To this end, we propose the following refined definition of homelessness prevention for our community based on the work of Burt et al. (2005)[xxxiii]:

Prevention Type	**Eviction Prevention**	**Diversion**	**Discharge Planning**	**Universal Prevention**
	Preventing evictions/ housing loss mitigation.	Helping people who approach the shelter system to get back into housing rather than enter shelter.	Preventing homelessness upon release from institutions.	Measures that assure that everyone can afford housing - rent subsidies, affordable housing.
Homeless-Serving System's Role	Lead program development to stabilize those at imminent risk for homelessness using supports and connecting program participants to financial assistance.	Lead program development to divert at the shelter door using the centralized entry system using supports and connecting program participants to financial assistance.	Work in partnership with key public systems (health, corrections, child intervention services) to align homeless programs to needs of at risk populations.	Support broad policy initiatives for increasing affordable housing stock, rent subsidies. Support poverty reduction measures that alleviate needs of at risk population.

Based on this understanding of prevention and system integration, we believe a number of measures can enhance our capacity to prevent homelessness before it starts in our community.

1. Enhance access to appropriate levels of income assistance and rent supports for those at risk and experiencing homelessness.

While significant strides have been made to ensure homeless program participants have access to income supports, further work is necessary at the policy and practice levels to continue service integration and reduce duplication of resources. We will work in partnership with our Alberta Works and AISH colleagues to ensure program participants have access to the necessary income to maintain housing stability.

Through the support of Municipal Affairs, the MHCHS has been able to support more than 40 program participants to graduate from our Intensive Case Management and Rapid Rehousing programs by providing necessary ongoing rental assistance. This frees up program space for those who require it and enables the reintegration of graduates in community. We will continue to deliver this service and advocate for its continued funding provincially. We will monitor long term success and costs to build the business case for sustainable program funding.

We will also advance recommendations to Municipal Affairs for the increase of rent subsidies available to meet local needs. At this time, provincial investment in rent subsidies allows approximately 900 individuals to be supported on average with a subsidy of $300-$400 monthly. We estimate an 1,700-1,800 individuals are at risk for homelessness and can benefit from such supports, thus will advance an ask for an additional $1M to serve an additional 300 Medicine Hatters to eliminate the current social housing waitlist.

2. Explore the addition of a diversion and/or targeted eviction prevention program component to the Homeless-Serving System.

Most individuals and families who seek shelter can successfully navigate out of the Homeless-Serving System, yet some can still benefit from diversion supports. Supports offered through diversion may include assistance with system navigation, minimal advocacy, locating housing prior to discharge, etc.

We estimate that 1,700-1,800 Medicine Hatters are at risk for homelessness and may need support to stay housed. Targeting those at highest risk will be critical to ensure our resources have the greatest impact.

It is often difficult to determine how best to use limited resources to target those at risk of eviction, given that many do not become homeless in the first place. Nevertheless, promising practices in prevention suggest that such measures can complement the targeted work of diversion programs. To this end, we will explore the feasibility of such a program in Medicine Hat and determine best means of implementing and funding it, if appropriate. We will also assess the capacity of our Housing Assessment and Triage to be enhanced with a diversion

program component to assist those who approach the shelter system to get back into stable housing.

We anticipate that, once the initial ramp up of Housing First programs has completed the task of meeting our ending homelessness goals, we can restructure services towards this service in 2016 fiscal.

3. Enhance the Homeless-Serving System's capacity to support an end to discharging into homelessness.

An analysis of the MHCHS Rapid Rehousing program caseloads from 2009-2013 shows that on average, in the 12 months prior to entry in the program, 10% were discharged from correctional facility and 13% were discharged from a health facility. Further, 25% of all housing first program participants reported a history of involvement with foster care.

Clearly, program participants are being discharged from corrections and health, into homelessness. The sheer number of service participants with involvement in the child intervention systems is startling. We cannot simply develop policies that state what systems should do without the backdoor into housing secured. The most comprehensive discharge plan will falter without the appropriate housing and supports available to operationalize it.

We estimate that the proposed ramp up of additional spaces in Intensive Case Management, Rapid Rehousing, and PSH can accommodate some of the flow of homeless discharged into our Homeless-Serving System by 2015. However, we need to work with our mainstream partners to introduce system prevention measures targeting homeless program participants who frequently use corrections, health, child intervention and Homeless-Serving System by ensuring appropriate solutions are in place to prevent homelessness. This may mean that these system partners take on a different role in this work and may require additional resources, particularly for groups who require long term supportive housing and ongoing clinical health care services.

To support systems integration, we will work with our partner systems to develop discharge planning protocols in our community, which includes a placement committee that meets to assess common program participants and develop integrated case plans to support housing stability. The role of this committee will be to develop community-wide policies and protocols that avoid discharge from public systems into homelessness in the first place. This work will also align with the provincial work on discharge planning through the Alberta Discharge Planning Committee and the Interagency Council on Homelessness.

4. Work with the education system to reduce homelessness risk among young people.

Public education can be a key preventative measure to increase housing stability. Basic budgeting and tenant education on rights and responsibilities targeting students can prepare young people to become good tenants down the road.

Such measures should be incorporated in secondary school curricula. Focused teaching on budgeting can also help them avoid financial difficulties. These measures can be a focus in existing life-skills classes, or even in math curricula.

5. Enhance service integration between the Homeless-Serving System and Alberta Health Services to support homeless and at risk populations.

We know that certain program participants have complex medical needs requiring intensive health interventions and are outside the scope and expertise of our Homeless-Serving System. In particular, program participants who have ongoing and acute psychiatric service needs are best served by the health system.

To this end, we will build even stronger working relationships with our colleagues in the health field. Better articulated roles are needed. Further, enhanced access to health supports will be even more critical to meet vulnerable program participants' needs.

We will continue to work with AHS partners to increase access to services for our program participants and promote systems integration at the policy and practice levels. We will continue discussions with AHS to support the clinical in-reach component of service delivery, and other services, as deemed necessary.

A critical medical need in our community is that of addiction treatment. Currently, program participants are unable to access treatment support locally and must travel to larger centres to address these needs. We are encouraged by recent developments that would bring about the development of an addiction treatment facility in Medicine Hat to not only support the needs of our homeless and at risk program participants, but the general community as well. This will allow more integrated supports to be available locally, and ensure program participants are able to access their informal family and friends networks on their path to recovery. We will work with AHS to ensure the Homeless-Serving System and the addiction facility work in an integrated manner to serve those at risk and experiencing homelessness.

6. Explore system integration options between the Family Violence and Homeless-Serving Systems.

Approximately 37% of our Housing First program participants reported a history of family violence. To address this, an Intensive Case Management program delivered by MHWSS specifically works with individuals and families coming out of our women's shelter. We nevertheless recognize that the complexity of these situations require a rethinking of current approaches. This includes recognition of the impact of family violence on both men and women and their children.

Aside from increasing our capacity to serve these populations through staff training (danger assessments, housing placement safety, etc.), we need to do a better job integrating our family violence intervention and prevention approach with the work of our Homeless-Serving System.

In the coming years, we will work with our colleagues locally and provincially to explore the Homeless-Serving System's role in family violence prevention and intervention, and vice versa.

7. Support the development of a Poverty Reduction Strategy that addresses homelessness risk in Medicine Hat.

In 2012, the MHCHS capitalized on an opportunity to participate and invest in a community-based research initiative that aimed to create a greater understanding about how to reduce poverty in Medicine Hat. Two other community partners, the United Way of South Eastern Alberta, and the Community Foundation, also invested in this research and the ensuring report *Moving From Charity to Investment: Reducing the Cost of Poverty in Medicine Hat* (2013).

We recognize that a comprehensive poverty reduction strategy will alleviate housing stress for those at risk and mitigate homelessness in our community. We see the role of our Homeless-Serving System to support the development of a comprehensive slate of preventative supports, which includes other funding partners and all levels of government. We can also leverage employment readiness supports for at risk and formerly homeless Medicine Hatters.

We will continue to support broad prevention measures in our community by lending our voice to advocacy efforts and aligning our work with that our of other system partners. Our focus in such discussions is to ensure measures introduced have a marked impact on homelessness in our community.

Strategy 4 - Data & Research

As the first Canadian community to end homelessness, Medicine Hat is at a critical juncture as it sets out in a bold, new direction. We have made significant efforts over the past four years to improve our data and knowledge. Our community recognizes that research matters; further, that we need the contribution of the research community to realize our goals. Our ability to implement an HMIS quickly and generate real-time data to support system planning has been instrumental to our success.

Our community, province and nation benefits from some of the best and most engaged researchers in the world. Recently, increased coordination among the research community has begun to play a vital role in ending homelessness. Medicine Hat can benefit from and contribute to these efforts by participating in the creation of a research strategy to support our re-focused Plan, as well as engaging in research efforts at the provincial and national levels.

Moving forward, we are committed to enhancing our engagement with the research community in what we hope will be an ongoing conversation that serves as a critical feedback loop into the design and implementation of our Plan. By contributing our locally generated knowledge and data to such efforts, we also hope to make an important contribution to the ongoing advancement of knowledge on homelessness.

1. Expand HMIS implementation across the Homeless-Serving System and support systems integration.

Our HMIS, Efforts to Outcomes (ETO), is a web-based data collection application that is used by programs in Medicine Hat. ETO provides a platform to collect standardized information relative to the experience of individuals and families that have entered the housing first Intensive Case Management and Rapid Rehousing programs.

Currently, our HMIS is only implemented in some provincially funded programs. Unfortunately, this limits our capacity to monitor program participant flow, outcomes, and needs, across the Homeless-Serving System. Further, without sharing information with other systems, particularly health and justice, our ability to curb discharging into homelessness is further hampered.

Despite the limited uptake, the HMIS has nevertheless provided us with unprecedented data on our program participant population, their longitudinal service needs and outcomes, as well as the integration and impact of our programs.

We know we can leverage our HMIS by expanding its use across the Homeless-Serving System and developing information sharing protocols with our public system partners. This will be important to support our system integration work. It is critical that HMIS uptake is expanded into all shelters and Homeless-Serving programs and facilities. Further integration with public systems and social housing via a centralized housing intake will also be important moving forward. We will work with community and public system partners to support this expanded implementation.

2. Enhance the Homeless-Serving System's research and data analysis capacity.

We can enhance the use of data collected at the program and system level to adjust our approach in real-time. At the system level, the MHCHS has already made use of this information in its system planning activities and is beginning to work with research partners to explore the use of the data and contribute to the larger body of knowledge on homelessness.

To ensure HMIS and research knowledge has the most impact and supports system planning, capacity building with our agency and program partners is needed. This requires increasing capacity to interpret data and develop solutions to emerging issues in real-time.

We will work at the system and program level to leverage HMIS data by analyzing information collected to date in system planning and strategy development, priority research areas and performance management. We will continue to provide technical assistance and add capacity to improve reporting and data quality in sector.

3. Develop a Research Strategy in partnership with provincial and national research partners to advance an end to homelessness.

As one of the few communities to have an operational HMIS in place for a considerable period of time (since 2009), Medicine Hat has a wealth of information available and ready to contribute

to the development of the body of knowledge on homelessness in our country. The data set developed locally can be mined by academic partners across disciplines to answer priority research questions that support an end to homelessness.

At the community level, we have outstanding questions that we need research partners to help us answer. While our HMIS data can certainly help focus research efforts on program design, Standards of Care, and performance management, we have additional research needs that require primary data collection to discern the role of migration in homelessness, particularly in relation to Aboriginal people and immigration. We also need to refine our understanding of the at risk population and how best to serve their needs.

On the issue of youth homelessness, the MHCHS and community stakeholders have already begun working with Dr. Yale Belanger from the University of Lethbridge on a scoping study to determine the extent of youth homelessness in Medicine Hat. Based on this research, we will engage in dialogue with system and community partners, to develop solutions moving forward at the program and policy levels.

We will develop a Research Strategy aligned with our Plan's strategic priorities, in partnership with academic institutions, the Alberta Research Consortium, the Canadian Homelessness Research Network (CHRN), and the Canadian Observatory on Homelessness. This will ensure Medicine Hat both contributes and benefits from the advancement of research on homelessness in Canada.

4. Participate in the 2014 Homeless Point-in-Time Count to develop nationally-comparative baseline data on homelessness in Canada.

We have an important opportunity to participate in the first-ever national Point-in-Time (PiT) count in 2014. While the value of PiTs is limited to providing a snapshot of homelessness on a particular night, it nevertheless aligns our efforts to those of other communities across the country, and presents Canada with an important baseline data on homelessness.

Given strong partnerships between the key stakeholders, we are confident in our capacity as a community, to come together in a short time, to participate in this initiative, with the support of the CHRN, who is leading the initiative. The value of this initiative for our community is its capacity to raise awareness about homelessness, locally, and nationally. We will further benefit from the support of a national research team, through the CHRN, that will provide technical assistance and research support. We will also be able to use the count to raise Medicine Hat's profile nationally, as a community that is ending homelessness. By having access to the data collected locally, we will also expand our knowledge about homelessness locally through a new data source.

Strategy 5 - Leadership & Sustainability

Medicine Hat will be the first community to end homelessness in Canada. Despite being a small centre, with limited resources and funding, we will have made an unprecedented accomplishment and demonstrated that when a caring community, engaged governments and administrations, and committed service providers put their minds to a task, they are unstoppable.

Our community has, and will continue, to lead the country in ending homelessness through these efforts; from doing the innovative heavy lifting work that supports our homeless population, to coming together as a Homeless-Serving System to tackle this social issue using common will, real-time data, and research. We managed to keep homelessness top of mind during in challenging political times, and secured unprecedented levels of funding to resolve it. We are, and should be, proud of our accomplishments. Further, we should share and learn from success across Canada.

1. Increase public awareness and engagement in for ending homelessness in Medicine Hat.

At a broader public level, we need to increase awareness about homelessness in our community, not only to keep the issue on the radar, but as a means of getting the word out about critical resources for those at risk. Targeted marketing, regarding available resources that addresses and promotes housing stability, can be critical to ensuring Medicine Hatters have the right information, at the right time.

Increasing awareness, and mobilizing the public to end homelessness are further critical to moving decision-makers on policy and funding measures that address homelessness and affordable housing issues. If these remain top of mind for our community, they will continue to be top of mind for our political representatives. By focusing on enhancing the engagement of our private sector partners, we can also bring innovative ideas, social and financial capital to make our plan a reality.

We will also continue to celebrate our success, and share our accomplishment, with the Medicine Hat community and engage them to be part of the solution through ongoing Project Connect and other public engagement opportunities,

2. Develop and advance policy priorities to support the Medicine Hat Plan to End Homelessness.

Medicine Hat will continue to develop policy solutions that address the root causes of homelessness in partnership with the 7 Cities, national bodies, including the Canadian Observatory on Homelessness and the Canadian Alliance to End Homelessness, as well as academia. We will advance evidence-based recommendations in the areas of discharge

planning, service integration, access to mainstream supports, and funding for homeless services and affordable housing.

We know that, in the long run, additional affordable housing options will decrease the need for homeless services. To this end, we will continue to advance policy changes that increase available affordable housing options and rent supports in our community at the municipal, provincial, and federal levels, including secondary suite legalization.

We will continue to champion an end to homelessness in our community by engaging in innovative public education initiatives to increase awareness, and by maintaining homelessness on the political agenda.

3. Provide leadership to end homelessness in Alberta and Canada.

On a provincial level, Medicine Hat will continue to play a leadership role as a member of the 7 Cities. Our collective work will promote best practices nationally, facilitate implementation learnings in our respective communities, and promote shared policy, research, and capacity building priorities.

MHCHS is honored to have been appointed as one of the Community Based Organization representatives to the Alberta Interagency Council on Homelessness. The Interagency Council on Homelessness is made up of 32 individuals representing various sectors and levels of government with knowledge and expertise in the areas of housing and homelessness. The work of the Council will help to propel the homelessness agenda forward by elevating the conversations, and revealing and addressing the systemic barriers to ending homelessness experienced by communities across the province.

Medicine Hat will continue to play a key leadership role on the Interagency Council on Homelessness, representing smaller centres and Southern Alberta, advancing common policy, research and funding priorities to advance an end to homelessness in Alberta.

Medicine Hat is also a leader in the ending homelessness movement in Canada. It is imperative that we contribute the knowledge base we have developed to support our colleagues, particularly those in smaller communities.

We will elevate Medicine Hat's profile and success nationally and internationally by demonstrating and sharing best practices in ending homelessness. Our community will participate in knowledge-sharing activities including conferences, social media, teleconferencing, etc. to highlight the work underway in our community and to learn from others.

We will also support funders of homeless services locally and nationally; particularly Alberta Human Services and the Homeless Partnering Strategy, to advance the systems approach to ending homelessness and Housing First.

4. Enhance the Homeless-Serving System's role in emergency response planning.

Recent events ensuing the 2013 flood in Calgary and Southern Alberta demonstrate that we are faced with a dramatically shifting landscape that requires constant strategic adjustment, but also serves as testament to the unequivocal spirit of community in Medicine Hat.

Aligning system planning for homeless services with the emergency response planning process will be a priority moving forward. Particularly post-2015, when the end of homelessness has been realized, the role of the Homeless-Serving System will need to be reconceptualised. We believe that our resources can be leveraged to support emergency response systems significantly; our access to trained staff, committed volunteers, the shelter, data, housing and case management infrastructure can make a critical contribution in future times of need for our community.

5. Ensure a sustainable end to homelessness in Medicine Hat beyond 2015.

The MHCHS was tasked with leading the implementation of the Plan to End Homelessness with an end-date of March 2015. We believe we will accomplish this task. We also know that maintaining an end to homelessness requires the same, if not greater, vigilance on the part of our community.

Constant adjustment to our Homeless-Serving System in light of a shifting political and economic landscape requires that strong leadership and system coordination continue beyond 2015. Further, performance management, funding allocation, HMIS operations, research and policy, along with system and program planning will continue to be needed.

Some communities are considering downloading the functions of the backbone organization to other agencies. We will engage in dialogues about the future of the lead organization as a community and develop a sustainability plan for the long-term, recognizing and building on the critical leadership role the MHCHS has played in our community.

To ensure that an end to homelessness is sustainable, and that our system is continuously improving to enhance our capacity to respond to homelessness, the MHCHS will continue to support community partners to engage in system planning as this dialogue unfolds.

Once we meet our goal of ending homelessness, system sustainability will be necessary. We are also faced with the challenge of maintaining success. This Plan has outlined the means of achieving measurable goals that clearly articulate what an end to homelessness means in our community. However, we have also laid out the foundation for what will be necessary to sustain this achievement. Getting there is part of the journey; a sustained end to homelessness will be our next challenge.

[i] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Aboriginal People. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805

[ii] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Immigration and Ethnocultural Diversity. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805

[iii] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Immigration and Ethnocultural Diversity. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805

[iv] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Immigration and Ethnocultural Diversity. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805

[v] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Education. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805

[vi] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Labour. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805.

[vii] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Income. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805.

[viii] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Income. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805.

[ix] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Income. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805.

[x] Lee, C.R., & A. Briggs (2013) Moving From Charity to Investment: Reducing the Cost of Poverty in Medicine Hat Alberta: Vibrant Communities Calgary.

[xi] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Income. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805.

[xii] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Income. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805.

[xiii] Tutty, L., Bradshaw, C., Worthington, C., MacLaurin, B., Waegemakers Schiff, J., Hewson, J., Dooley, D., Kean, S., McLeod, H. (2009) Risks and Assets for Homelessness Prevention: A Literature Review for the Calgary Homeless Foundation. Retrieved from: http://calgaryhomeless.com/what-we-do/research/

[xiii] Tutty, L., Bradshaw, C., Worthington, C., MacLaurin, B., Waegemakers Schiff, J., Hewson, J., Dooley, D. (2011) Preliminary analysis only from phase 2 of the HART research project.

[xiv] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Housing. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805.

[xv] CMHC (2006). Housing in Canada Online dataset. Retrieved from: http://cmhc.beyond2020.com/TableViewer/tableView.aspx?ReportId=3&IF_Language=eng.

[xvi] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Housing. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805.

[xvii] CMHC (2006). Housing in Canada Online dataset. Retrieved from: http://cmhc.beyond2020.com/TableViewer/tableView.aspx?ReportId=3&IF_Language=eng.

[xviii] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Housing. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805.

[xix] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Housing. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805.

[xx] Statistics Canada (2013) NHS Focus on Geography Series - Medicine Hat: Housing. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/FOG.cfm?lang=E&level=3&GeoCode=805.

[xxi] Lee, C.R., & A. Briggs. (2013). Moving From Charity to Investment: Reducing the Cost of Poverty in Medicine Hat Alberta: Vibrant Communities Calgary.

[xxii] CMHC (2011) Recent trends in housing affordability and core housing need. Retrieved from: http://www.cmhc-schl.gc.ca/en/corp/about/cahoob/upload/Chapter_6_EN_dec16_w.pdf

[xxiii] City of Medicine Hat (2012) Medicine Hat Census Report. Retrieved from: http://www.medicinehat.ca/modules/showdocument.aspx?documentid=3348.

[xxiv] Calgary's rate was estimated between 1.3% and 1.5% in 2000 and 2009 respectively; this was averaged to 1.4%.

The 2000 rate was reported in the City of Calgary (2007). Background Research for the 10-Year Plan to End Homelessness in Calgary. Retrieved from: http://www.homelesshub.ca/ResourceFiles/052ca1q0.pdf. This calculation by City of Calgary was based on Perras & Huyder, 2003 Interagency shelter user count for 2002 (A collaboration with the Interagency Committee). Calgary: The Mustard Seed (Calgary) Street Ministry.

The 2009 rate was reported by the Calgary Homeless Foundation in the Calgary Plan to End Homelessness (January 2011) Update. Retrieved online: Housing and Urban Development.

[xxv] CMHC (2013) Rental Market Report Fall 2013- Alberta Highlights. Retrieved from: http://www.cmhc-schl.gc.ca/odpub/esub/64483/64483_2013_B02.pdf.

[xxvi] CMHC (2013) Rental Market Report Fall 2013- Alberta Highlights. Retrieved from: http://www.cmhc-schl.gc.ca/odpub/esub/64483/64483_2013_B02.pdf.

[xxvii] CMHC (2013) Rental Market Report Fall 2013- Alberta Highlights. Retrieved from: http://www.cmhc-schl.gc.ca/odpub/esub/64483/64483_2013_B02.pdf.

[xxviii] Gaetz, Stephen (2012) The real cost of homelessness: Can we save money by doing the right thing? Canadian Homelessness Research Network. Retrieved from: http://www.homelesshub.ca/ResourceFiles/costofhomelessness_paper21092012.pdf.

[xxix] Pomeroy, S. (2005) The Cost of Homelessness: Analysis of Alternate Responses in Four Canadian Cities. Ottawa, ON: National Secretariat on Homelessness.

[xxx] Turner, Alina (2013) System Planning 101. Canadian Alliance to End Homelessness 2013 Conference Presentation. Retrieved from: http://turnerresearchandstrategyinc.com/publications.html.

[xxxi] Turner, Alina (2013) System Planning Elements. Canadian Alliance to End Homelessness 2013 Conference Presentation. Retrieved from: http://turnerresearchandstrategyinc.com/publications.html.

[xxxii] Mental Health Commission of Canada (2012) At Home/Chez Soi Interim Report. Retrieved from: http://www.mentalhealthcommission.ca/English/document/5032/home-interim-report.

[xxxiii] Burt, M., Pearson, C., Montgomery, A., McDonald,W. & Assoc. (2005) Strategies for Preventing Homelessness. U.S. Department of Housing and Urban Development Office of Policy Development and Research. Retrieved from the Urban Institute: http://www.urban.org/UploadedPDF/1000874_preventing_homelessness.pdf.