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Final Report

At Home in Winnipeg: Localizing Housing First as a Culturally Responsive Approach to Understanding and Addressing Urban Indigenous Homelessness

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Prairie Research Centre

Authors and Affiliations

Jino Distasio, Sarah Zell, and Marcie Snyder, The Institute of Urban Studies, University of Winnipeg

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**At Home in Winnipeg:
Localizing Housing First as a
Culturally Responsive Approach to
Understanding and Addressing
Urban Indigenous Homelessness**

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**Jino Distasio, Sarah Zell,
and Marcie Snyder**

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Institute of Urban Studies
University of Winnipeg
599 Portage Avenue, Winnipeg
P: 204 982-1140
F: 204 943-4695
E: ius@uwinnipeg.ca
Mailing Address:
515 Portage Avenue,
Winnipeg, Manitoba,
R3B 2E9

Authors:

Jino Distasio, Sarah Zell, and Marcie Snyder

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THE UNIVERSITY OF
WINNIPEG

Institute of
Urban Studies

At Home in Winnipeg:

*Localizing Housing First as a
Culturally Responsive Approach to
Understanding and Addressing
Urban Indigenous Homelessness*

Acknowledgment and Dedication

Over the last ten years, many have come to understand the role Housing First can play in ending homelessness in Canada. This new perspective on addressing homelessness owes much to an innovative research project known as At Home/Chez Soi (AHCS). From the AHCS study, we learned about how to bring together the right mix of people, housing, and supports to make a difference.

This report is dedicated to the 2,148 people who took part in this landmark study and shared so much of their lives with us. We also mark, with deep sorrow, the passing of many brave individuals whose contributions are immeasurable and form an integral part of the At Home/Chez Soi legacy.

For me personally, I note the loss of Freeman Simard, who helped guide the early part of the project and shared his wisdom with me over many years. He remains with us in spirit but is deeply missed. As well, we mark the passing of Dr. Paula Goering, who was the overall research lead for the AHCS study. Her legacy and pursuit of better health and supports for Canadians will not be forgotten.

In Winnipeg, many organizations came together to ensure those in the study had access to the right supports and services. To all the staff at the Ma Mawi Wi Chi Itata Centre, Aboriginal Health and Wellness, and Mount Carmel Clinic, your contributions to the wellbeing of participants were critical.

On the research and administration side of the project, the partnership between the University of Winnipeg's Institute of Urban Studies and the University of Manitoba's Department of Psychiatry was fundamental in supporting data collection and project operation. Dr. Jitender Sareen's leadership was critical to the success of the Winnipeg Site. Susan Mulligan and Corinne Isaak were instrumental in the early stages of the research design and ongoing efforts to coordinate some 6,000 local interviews. A special thanks as well to Marcia Thomson, who was Winnipeg's key governmental contact and who ensured, at the policy level, that the right messages resonated. Lucille Bruce, a Site Coordinator, and team leads Don Robinson, Betty Edel, Darlene Hall, Paula Hendrickson, and Lukas Maitland were at the frontline of making change happen.

To the past and present members of the Lived Experience Circle (LEC), who continue to meet and share their gifts, I remain deeply moved by your level of resiliency and hope. I will forever cherish my time with the LEC and the gifts you have shared. To my friend Joe, who even tried to teach me some guitar, it has been one hell of a journey. I am grateful we continue to learn from each other.

We owe so many for what was achieved during a project that was simply looking at how we might better support those struggling with finding home. Our journey together did not solve homelessness for all Canadians, but we made important gains and shed light on a pathway that had become darkened.

Jino Distasio, Institute of Urban Studies

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List of Acronyms

AC – Advisory Committee

ACT – Assertive Community Treatment

AHCS – At Home/Chez Soi

ALC – Aboriginal Lens Committee

BUILD – Building Urban Industries for Local Development

CLC – Community Liaison Coordinator

HF – Housing First

HN – High Need

HPS – Homelessness Partnering Strategy

ICM – Intensive Case Management

LEC – Lived Experience Circle

MGR – Manitoba Green Retrofit

MHCC – Mental Health Commission of Canada

MN – Moderate Need

NWG – National Working Group

PI – Principal Investigator

PLT – Project Leadership Team

PWLE – People with lived experience

RCT – Randomized controlled trial

TAU – Treatment as Usual

WRHA – Winnipeg Regional Health Authority

Preface

In the spring of 2008, the Mental Health Commission of Canada (MHCC) began work on the At Home/Chez Soi (AHCS) project, a landmark \$110 million dollar study of homelessness and mental health. Implemented in five Canadian cities, AHCS had an immense impact on the lives of the 2,148 people who participated in the study and on those of us who helped launch and manage the effort. By 2014, findings from AHCS had informed and greatly altered the trajectory of policy and program delivery not only in Canada but globally. More and more cities were implementing what had become a proven Canadian Housing First (HF) approach.

In the decade since the launch of AHCS, the manner in which homelessness is understood, addressed, and ended has fundamentally changed, with many more remaining in stable, long-term housing. The outcomes of the AHCS project are documented in the scholarly literature and are beyond the scope of this project (Aubry et al., 2016; Goering et al., 2011; Goering et al., 2016).

This story is a departure from outcome-based analyses and focuses more on one city's journey to developing and implementing a Housing First approach. In Winnipeg, our method was unique in many ways. In 2008, Housing First was neither known nor understood much beyond what had been emerging in New York City, where in 1993, Dr. Sam Tsemberis launched the Pathways Model to End Homelessness (Tsemberis and Asmussen, 1999; Tsemberis and Eisenberg, 2000). Through the 1990s and into the early 2000s, Winnipeg witnessed a rise in homelessness and poverty, especially in central neighbourhoods and the fringes of downtown. However, Winnipeg was unlike New York both in size and scale and also with regard to how local responses to homelessness were addressed.

What defined HF in Winnipeg, more than any other city in the AHCS project, was its rootedness in the community. In 2008, Winnipeg's community-based organizations interrogated HF and its Western, psychiatric-based approach, questioning whether and how it would apply in a city whose homeless population was more than 70% Indigenous. The early tension and challenges raised among community groups informed the approach adopted by the organizations that would ultimately form the local AHCS Winnipeg Site.

In many ways, Winnipeg's community-based model supported and strengthened local capacity while striving to end homelessness and poverty. The "Winnipeg Way" included many unique adaptations of HF, with a capacity-building emphasis remaining front and centre.

This report focuses on Winnipeg's model and governance structure, one that arose partly out of the city's struggle to understand how an American approach could hold relevance in a Canadian prairie context. The intent is to share how capacity was built and maintained among the various project

partners, including community-based organizations, government representatives, and academics, all of whom worked to support the 540 people who participated in the study in Winnipeg. We also examine how this approach was viewed from a national perspective by including thoughts from members of the Mental Health Commission of Canada and government actors who played a part in selecting Winnipeg as a site for the AHCS project.

1. Introduction and Background

Winnipeg is a mid-sized prairie city. Its roots run deep in the community, with a strong sense of resiliency and hope among the agencies that work tirelessly to support those in need. The manner in which Winnipeg's community responded to increasing levels of homelessness over the last decade forms the basis of the analysis presented in this report. In particular, the objective is to examine the At Home/Chez Soi (AHCS) project and how a number of organizations came together to launch a transformative approach to addressing homelessness for those struggling with mental health issues. Our specific focus is on how local capacity was built and structured to undertake what has been called the largest demonstration project of its kind in the world (Macnaughton et al., 2010). The Winnipeg approach was distinct and involved the inclusion of Indigenous practices to deliver Housing First (HF). This report has a particular focus on how a unique governance model emerged out of partnerships among community-based organizations, government, researchers, and others who collaboratively strengthened local capacity while ending homelessness.

Beginning in 1999, there was increasing pressure in Canada to address mounting poverty and inequality in our cities and communities that was contributing to a rise in homelessness (Hwang, 2001). Toronto's "Tent City" of 1999 was a watershed moment in bringing the reality of the homeless crisis to the attention of the nation and a global audience who wondered how such a propitious country could be struggling (Ranasinghe & Valverde, 2006). Much of the attention was raised by activists and others who pushed for action (Gilbert & Phillips, 2003). However, early responses to Canada's homeless crisis were often rudimentary and sought to put more heads on shelter beds as opposed to addressing root causes or focusing on prevention. During the early 2000s, despite bigger issues simmering on the horizon, including a growing shortage of affordable housing and a shortfall in the services aimed at ending homelessness, Canadian policy emphasized expanding the crisis support system (Frankish et al., 2005; Gaetz, 2010). As well, there was a growing recognition that those struggling with reoccurring periods of homelessness and mental health were progressively being forgotten or deemed "too hard to house" by a system not geared toward addressing the needs of those struggling with co-occurring disorders, such as addiction and mental health (Goering et al., 2011).

In 2006, a report by Senator Michael Kirby called for an overhaul of the mental health system that was failing far too many Canadians (Senate, 2006). The report, entitled *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, would serve as the basis for the establishment of the Mental Health Commission of Canada (MHCC) in 2008. In reality, from the mid-1990s onward, addressing homelessness disproportionately emphasized the notion that we could build our way out of the crisis by creating shelter beds and addressing shortfalls in affordable housing. While

expanding the stock of housing was essential, it would take time before we realized this must occur simultaneous to addressing the health circumstances of individuals.

It is in 2008 where our story begins, when a number of local groups and organizations in Winnipeg first became aware of Senator Kirby's intent to launch a project. The MHCC was beginning to reach out to the five cities that would become the study sites in the At Home/Chez Soi (AHCS) project (Moncton, Montreal, Toronto, Winnipeg, and Vancouver). At the same time, community-based organizations in Winnipeg began to mobilize to better understand what was being proposed by the MHCC, how the city would play a role, and who would be involved. This early relationship-building process and the interrogation of the HF approach were integral to the formation of the Winnipeg team and to the development of its unique local approach and model proposed to the MHCC.

In Canada and Winnipeg, there were a number of factors contributing to the growing desire to address the needs of persons struggling with mental illness and homelessness that the MHCC (2008) cited as reasons for undertaking the study, including:

- ❖ During the early 2000s, there was a heightened sense that Canadian cities had experienced substantive growth in the homeless population (which had been accelerating since the mid-1990s);
- ❖ There was increased awareness of the prevalence of mental illness, substance abuse, and chronic physical health conditions among those persons homeless;
- ❖ There was increasing recognition that different subgroups had varying levels and types of need (e.g., youth, seniors, immigrants, and Indigenous people); and
- ❖ Those chronically homeless (estimated at 15% of the total homeless population) had high levels of need and consumed a large proportion of service and societal costs.

As noted, five cities took part in the MHCC study with each having a unique set of characteristics that offered a cross-section of issues for assessment over the course of the study. The following is a simplified overview of the general distinctions among the cities:

- ❖ **Vancouver:** an emphasis on people with a mental illness who struggle with substance abuse and addictions issues (often in a concentrated area of the Downtown Lower East Side);
- ❖ **Winnipeg:** an urban Indigenous population and a concentrated area of poverty within the inner city;
- ❖ **Toronto:** a growing immigrant population and ethnocultural diversity, including many who were non-English speaking;

- ❖ **Montreal:** distinct mental health services provided to homeless people in Quebec and a unique social housing industry; and
- ❖ **Moncton:** very rapidly growing small city with a shortage of mental health services and a focus on the rural population.

The overall intent of the At Home/Chez Soi project was to “collect policy and program relevant evidence about the service and system interventions to achieve housing stability, improved health, and wellbeing for those who are homeless and mentally ill” (MHCC, 2008). This was to be achieved by testing the effectiveness of Housing First in five Canadian cities, assessing whether it offered better outcomes compared to those persons using existing services and supports.

The following report reflects on and analyzes Winnipeg’s pathway into the AHCS project. It provides background on HF and the Mental Health Commission of Canada, followed by an examination of the Winnipeg Site’s model and philosophy of care. The primary objective of this research is to reflect on the early design and implementation of the Indigenous and capacity-building components of the Winnipeg Site of the AHCS project. We examine the 2008–2014 period, chronicling how the city developed its governance model and plan to address homelessness using the HF model. As noted above, what is unique about Winnipeg is how the HF model was adapted locally. We explore the processes of the early relationship-building and development phase as well as the governance structure necessary to localize and adapt the project, with an emphasis on the Winnipeg Site’s unique capacity-building outcome.

Throughout this report we use the name At Home/Chez Soi (AHCS) to describe the Mental Health Commission of Canada’s research project. This name was selected in 2009 in Toronto at the meeting of project stakeholders, who felt that the project needed a title focused on the concept of home. The name and subsequent logo would define the MHCC’s project over the course of the study and into the present. Its selection represented the view that all Canadians should be “at home” and not in the streets. It also reflected the bilingual importance of the project in connecting the five cities. Locally, each city used At Home/Chez Soi or AHCS to create a sense of unity among the cities.

What is also important to note is that ultimately AHCS was a large, randomized controlled pragmatic field trial (RCT) that enrolled 2,148 people across the five city research sites into a highly scripted study (Goering et al., 2011). Because of its nature as a demonstration research project, site development and HF implementation involved adherence to a rigorous research protocol to ensure HF was delivered consistently among the sites. There is little doubt that the research study context created tensions and challenges (indeed, this is documented elsewhere; e.g., McCullough & Zell, 2016). However, it also offered the opportunity to have Winnipeg play a key role in pushing the limits of how HF could operate within a distinct paradigm. In this research, the objective is to distil how the Winnipeg Site was able to adapt and localize HF to address the community context.

Specifically, we explore the following questions:

1. What processes defined the relationship building phase among a range of stakeholders, including local members of the community, government, the homeless service sector, and specifically the Indigenous community, at the Winnipeg Site who came together to launch the AHCS project?
2. How did this relationship-building process influence the subsequent development of a unique governance and program structure that localized a culturally responsive adaptation of the Housing First model in Winnipeg?
3. At the Winnipeg Site, the approach to governance was underpinned by a shared, community-driven, Indigenous-centered understanding of Housing First. How did this approach contribute to broader capacity building, which in turn contributed to the successful implementation of the demonstration project, and did this impact ongoing sustainability?
4. What Winnipeg experiences can inform broader adaptation of the Housing First in Canada and within Indigenous communities and are there distinct policy implications?

Setting the Context/Research Rationale

The urbanization of Indigenous peoples living in Canada has been increasing for several decades with an estimated 56% of Indigenous people now living in cities. In Winnipeg, which is situated geographically on Treaty No. 1 territory and the homeland of the Red River Métis, approximately 12% of the urban population identifies as Indigenous (Statistics Canada, 2017). Despite an increasing urban presence, Indigenous peoples continue to face a disproportionate burden of socio-economic and health disparities as compared to non-Indigenous populations. Furthermore, Indigenous populations experience higher rates of homelessness. An estimated 1 in 5 urban Indigenous persons in Canada are likely to be homeless on any given night, as compared to 1 in 128 non-Indigenous persons. In Winnipeg, over 70% of the homeless population identifies as Indigenous, and this number is thought to have remained largely unchanged for some time (Maes Nino et al., 2016).

These ongoing disparities are coupled with a cross-section of intertwined health factors, including housing distress, mental and physical health challenges, substance use, poverty, and lower overall life expectancy (Adelson, 2005; King et al., 2009; Smylie 2009). The roots of these disparities are intimately tied to socio-economic and political inequities, which stem from the intergenerational impacts of colonial legislation that actively dispossessed and dislocated Indigenous communities from their families, lands, languages, and culture. Cultural oppression, routine racism, and intergenerational trauma play a contributing role in high rates of homelessness (Patrick, 2014). These inequities are exacerbated by mainstream housing models that have remained rooted in Western ideals. These models

may have intrinsic cultural biases and often do not fully comprehend the worldviews, housing needs, and self-determination of urban-based Indigenous peoples.

Although Indigenous urbanization is by no means a recent phenomenon, adequate housing supports remains a key issue (Distasio et al., 2013; Snyder & Wilson, 2015), and there is an ongoing and pervasive lack of cohesive urban Indigenous policy (Walker, 2008; Walker et al., 2011). For decades, the federal government has largely neglected the housing needs of the urban Indigenous population, focusing more on reserve-based housing (Belanger et al., 2012). Furthermore, issues of urban Indigenous homelessness remain underrepresented in the literature (Wilson & Cardwell, 2010), and research on Indigenous homelessness reveals a lack of practical application. Given these concerns, there is a need for Indigenous-specific responses (Patrick, 2014) that look beyond housing needs alone, to include holistic approaches that reconstruct links between individual, family, community, and nations (Menzies, 2008).

Housing First and At Home/Chez Soi in Winnipeg

This research examines and explores the concept of a localized, Indigenous-focused approach to Housing First. Housing First in itself is a departure from conventional methods of ending homelessness, where housing is often contingent on clients first addressing mental health and/or addictions challenges. Often, such interventions employ an abstinence-based approach that requires adherence, which translates into conditions placed on obtaining or maintaining housing. In contrast, HF is consumer-driven, recovery-oriented approach prioritizing community-based services and support (Tsemberis et al., 2004). Research indicates that providing housing, along with access to health and social supports, reduces homelessness and hospitalization and increases positive outcomes such as social networks and wellbeing (Gaetz et al., 2013; Goering et al., 2011).

Although cities across Canada have adopted variations of the HF approach over the past decade, it was the AHCS research demonstration project that “solidified Housing First as a paradigm-shifting approach to ending homelessness in Canada” (Gaetz et al., 2013, 4). Each of the five cities, as part of the AHCS project, delivered HF programming through both an Assertive Community Treatment (ACT) team and an Intensive Case Management (ICM) service team (Tsemberis & Asmussen, 1999). In addition, each site had the option to develop a “third arm” service team, to investigate innovative adaptations that reflected local context, culture, and needs (Nelson et al., 2013). In Winnipeg, the third arm team was an Indigenous-focused, trauma-informed intervention, which was delivered by an Indigenous agency. It focused on an Indigenous primary healthcare model to provide holistic, culturally based services for Indigenous peoples in Winnipeg. The approach combines “the Medicine Wheel and the universal principles of sharing, caring, kindness, humility, trust, honesty and respect” (Goering et al. 2011, 10). While, Winnipeg’s third arm service team was developed specifically to deliver Indigenous-focused services, it is important to note that the other two Winnipeg AHCS service teams also delivered a specific localized version of HF. Indeed, the entire Site was informed by the local context and infused

local and Indigenous aspects into its model and approach. The fact that the three AHCS HF teams were housed and developed within community-based organizations offered an opportunity for the mainstream HF model to be infused with locally based solutions.

Winnipeg's approach to delivering HF was deeply rooted in partnerships formed and consolidated between Indigenous community members, health practitioners, academic members, and government. Elders, traditional teachers, those with lived experience of mental health and homelessness, and Indigenous community organizations actively collaborated with the research team from inception and through implementation, delivery, and the process of securing sustainable funding post-AHCS. Although not without its challenges, the positive implications of this community-driven model remain noteworthy.

The intention of Winnipeg's AHCS project was to build the capacity of community-based teams to effectively and equitably share knowledge of HF practices within the housing/health service sector and the broader community. When federal funding for the HF programs established through AHCS ended in 2013, the three local service teams that had been developed as part of the research project not only survived but remained relatively unified (Distasio et al., 2014). The success of the "sustainability story" in Winnipeg is due in large part to the strong relationships initiated and forged through the project, and especially to its community-driven approach (McCullough & Zell, 2016). The Winnipeg AHCS approach was community-centred and ensured community involvement, mobilized community assets, and worked to promote equity and wellbeing.

In Winnipeg, addressing the specific needs of the Indigenous community was central to the approach used locally. Despite extensive publication on AHCS, and as HF interventions proliferate across Canada and internationally, little to no research has examined community-driven, cultural approaches to ending Indigenous homelessness. Few resources exist that identify culturally responsive services for Indigenous peoples experiencing homelessness (McCallum & Isaac, 2011). This research addresses this gap by telling the story of how Winnipeg's community came together to inform and adapt the mainstream HF model to holistically reflect the needs and concerns of the Indigenous community.

2. Research Approach, Methods, and Guiding Principles

This is a community-driven project committed deeply to privileging Indigenous knowledge in shared dialogue and action that offers fresh perspectives by combining traditional wisdom with contemporary urban needs. The Principal Investigator (PI) for this study, Jino Distasio, was also the PI for the Winnipeg AHCS project. The first step in undertaking this work was to reconnect with key Indigenous leaders from the initial AHCS project, to seek their support and to ask and reflect upon the most beneficial approach to telling the Winnipeg HF story. As such, we undertook the following:

- ❖ Launched the project with a feast. This involved drawing in the three HF teams, members of the original AHCS Winnipeg Site Aboriginal Lens Committee, the Lived Experience Circle, and other community/government leaders who were close to the original project to workshop and provide guidance and support for the methodology.
- ❖ Engaged in a review of the literature/materials relevant to the initial stages of the AHCS project.
- ❖ Conducted stakeholder interviews to understand the process by which the AHCS Winnipeg Site developed a community-based, Indigenous-focused approach to implementing the project.

Our main objective was to document and describe the process of applying a localized, Indigenous lens to HF. We rely on two primary sources of data to do so. First, we conducted 16 in-depth, semi-structured interviews with a cross-section of stakeholders involved in the early development of the At Home/Chez Soi Winnipeg Site. These included project leaders at the local and national level, program team leaders, and members of the Aboriginal Lens Committee and the Lived Experience Circle (which was comprised of staff and participants in the study). See Table 1 for an overview of the sample. Interviews were conducted in-person or by phone between June and October 2017. They lasted 30–60 minutes and were transcribed verbatim. We used a purposive sampling strategy to identify participants and employed thematic coding to analyze the key issues and themes that emerged. Interview findings will help develop a framework from which to describe the establishment of a localized model of HF.

In addition, we engaged in an in-depth analysis of a wealth of secondary materials. These included both (1) documentation from the early AHCS Winnipeg Site development phase, such as meeting minutes and agendas and correspondence and communications between key stakeholders, as well as (2) transcripts from interviews and focus groups from previous iterations of research on other aspects of Winnipeg's development and sustaining of HF. These materials were reviewed, coded, and analyzed, and these data complement and inform the overall analysis presented in this report.

Table 1: Sample of Interview Respondents

Stakeholder Group	N
National Level – MHCC and Housing First	3
Winnipeg Site Leadership	6
Winnipeg Site Service and Housing Provision	4
Winnipeg Site Research	2
Elders, Aboriginal Lens Committee, Lived Experience Committee	3
Total*	16

**Note there is some overlap in roles, particularly those serving as Site Leadership.*

Ethical Considerations and Research Caveats

We view research as a pathway to reconciliation, and as such actively value the OCAP/S principles of Ownership, Control, Access, and Possession/Stewardship (Schnarch 2004). The principles underpinning our research approach are (USAI):

- ❖ Utility, in that research is practical and benefits the community;
- ❖ Self-voicing, where community is a powerful knowledge holder;
- ❖ Access, where lived experience and community narrative are understood to be valid expressions of authorship and that research is never static or finished; and
- ❖ Inter-relationality, where research is socio-historically situated. (OFIFC 2012)

We remained cautious not to pathologize mental health concerns and homelessness. Despite glaring inequities that persist for many urban Indigenous peoples, we use this research as an opportunity to uncover successes and opportunities that arise within a localized, Indigenous-focused HF framework. Furthermore, it is not our intention to conflate First Nations, Métis, and Inuit peoples, but for the purposes of this project, we seek to demonstrate how we came together as Indigenous and non-Indigenous communities, the impacts of these relationships, and how this approach may serve as a model for communities addressing homelessness through programmatic interventions.

3. A National Perspective on Winnipeg's Approach to Housing First

In 2009, the federal government allocated \$110 million to the Mental Health Commission of Canada (MHCC) to conduct the AHCS project, a multi-city evaluation that would measure the effectiveness of the Housing First model in the Canadian context. The intention of this project was to provide policy-relevant evidence about how a complex housing intervention worked on the ground. The MHCC initiative was also designed to provide a more comprehensive understanding of *local successes and challenges*. As mentioned, beyond the conventional ACT and ICM service teams, each AHCS site had the option of developing a third arm, the purpose of which was to investigate innovative adaptations and strategies that reflected local context, culture, and needs (Goering et al., 2011; Nelson et al., 2013). In Toronto, the third arm intervention was founded on an anti-racist/anti-oppressive philosophy to address discrimination (Stergiopoulos et al., 2012); in Vancouver, it was based on the delivery of congregate housing; in Montreal, personalized employment supports for interested participants; and in Moncton, the needs of rural communities were evaluated (Goering et al., 2014). In Winnipeg, the third arm emerged as a community-based Indigenous peer-support model and trauma-informed housing intervention. Indigenous leadership and perspectives were central to adapting the HF model to the local context. This approach addressed the need for culturally safe services and supportive housing (Distasio et al., 2014).

Overall, AHCS demonstrated that HF could be successfully implemented in different Canadian contexts while adapting to meet the local needs of diverse populations. The purpose of AHCS, from a national perspective, was to better understand “what works, at what cost, for whom, and in which environments” (Goering et al., 2014, 11). In the case of Winnipeg, the Indigenous perspective was crucial, given that an estimated 70% of the homeless population in Winnipeg identifies as Indigenous (Maes Nino et al., 2016). To understand pathways into homelessness for Indigenous people, it is necessary to understand that it occurs within the context of colonial and cultural trauma, compounded by income inequality and racism in a housing market already suffering from a shortage of affordable housing.

Since the conclusion of the AHCS project in 2013, the HF approach has had a significant effect on how homelessness is addressed and understood, and there is a growing interest in how HF can be adapted to other community contexts (Gaetz et al., 2013). In this section, we analyze findings from key informant interviews conducted with national representatives involved in the AHCS project to understand how the Winnipeg Site—informed by an Indigenous-led approach—was perceived from the national level. It includes reflections on how the AHCS national team translated the national project to the local level and on the importance of relationship building and the inclusion of Indigenous voices and community priorities at the outset.

Translating a National Project to the Local Level

Most participants spoke about the large-scale nature of the AHCS project, given the time that it spanned, as well its implementation across five urban areas. Reflecting on the implementation of the MHCC project at the local level, one participant explained:

I mean anytime you attempt to, in a very, very short time period, take \$119 million and you've got five years, not only to introduce the intervention, but to build intervention teams and build a capacity that doesn't exist in the community, plus, get all the researchers together, create a research protocol, create programs, implement, troubleshoot, and then try to sustain and you do that successfully within five years ... I mean, it is quite remarkable. Imperfect, but remarkable.

Indeed, the AHCS was the largest-scale randomized controlled trial of its kind that had never been undertaken (Macnaughton et al., 2010). As a research demonstration project, it meant that it was unfolding in real time. One interviewee spoke to this as being “a tremendous challenge because you have to react as it's occurring, and there is a lot at stake. Not really time to reflect when moving on a project of this scale in real time.” This respondent described the Winnipeg project as a ship being “built ... as we sailed it.” While each site adapted its local site coordination, teams, and programs as needed, ultimate responsibility rested with the MHCC, funded by and accountable to the federal government.

Translating a large-scale, nationally delivered project to the local level was not without its challenges. There were multiple and diverse viewpoints about this process. From the national perspective it was suggested that “we needed to be running the same Housing First program that everybody else in the country was running, you know, in terms of its principles and practices.” At the local level, community members “felt like ... listen we know what we're doing ... Who are these outsiders coming to tell us how to run our homeless services?” Consequently, early issues arose regarding how to take a “national research protocol and tailor it and modify it and adapt it” to reflect the local Winnipeg context as well as the concerns of Indigenous stakeholders.

National-level interviewees indicated that from their perspective, the introduction of the project in Winnipeg was met with “resistance” and “mixed reviews” from both Indigenous and non-Indigenous community stakeholders. Stakeholders felt they knew best what the community needed, as well as how to address local housing challenges. One respondent suggested that the project was initially received negatively in Winnipeg:

There were some pretty testy points about who was [MHCC] to do this? Who was the Commission to think the Indigenous community was interested? Who was ... the Commission, to say people needed housing in this way? Um, on and on and on and on. So, it was a, very much a trust building process, trust-built, totally.

As the quote indicates, the process of site development and HF delivery in Winnipeg would come to be built on trust and communication. The community had to come together to balance tensions between

expectations and project deliverables that had already been defined at the national level and the need to shape processes to meet local needs. In response, Winnipeg stakeholders sought to create a community-based, Indigenous-led approach. Another interview participant reflected on this community-based approach to resolving national–local level tensions:

The core Winnipeg planning team ... worked with the research team, they had a core commitment to making sure [AHCS] was really community driven... I think that was a tricky thing to do because there was a lot of centrally, nationally driven, core components that needed to be the same at all the sites, there were some research structures that were the same, so they had to navigate those kinds of things.

While the collaborative process was at times difficult and involved complex partnerships with multiple stakeholders, it was suggested that Winnipeg’s cross-sector governance structure “broke down silos... [bringing together] people who don’t traditionally work together.” Ultimately, an iterative and collaborative trust and relationship building process led to Winnipeg’s community-driven approach.

Interview participants at the national level recognized that Winnipeg stakeholders realized the importance of taking the time to build relationships was a key and necessary means of negotiating these tensions. This feeling resonated many times during the early stages of the project, when MHCC staff and other national-level staff came to Winnipeg to give presentations on HF and expressed their interest in the inclusion of Winnipeg as a study site. Community-based and Indigenous organizations interrogated the MHCC, its proposal to include Winnipeg as a research site, as well as HF itself, with the ultimate goal of ensuring there was comfort in the approach and that the right relationships were being established (McCullough et al., 2012; McCullough & Zell, 2016).

The emphasis on relationship building and time invested in partnership development at the front end was noted by many to be one of Winnipeg’s strongest contributions to localizing the HF approach. In the early stage of the Winnipeg project, many community meetings were held to share ideas and to bring in experts from the MHCC and elsewhere to explain and discuss HF, which in 2008 had very little meaning in the local community. “I think that the community piece in Winnipeg was very strong,” said one respondent. “I always attributed that to the fact that it was kind of a small enough community that everyone, you know, all the stakeholders, could easily be brought around the table and address an issue. And I think that people learned quickly that that was definitely to their advantage.”

When meeting with those coming into the city to share thoughts and ideas on how HF could more effectively end homelessness, Winnipeg was able to leverage local capacity and trust among the players brought around the local table. One respondent reflected that one thing that made Winnipeg unique among the AHCS Sites was “the way that people took the [Housing First] principles and made them local, you know, in terms of hiring people with lived experience, hiring elders, the flexibility of having healing practices and other cultural practices that were meaningful to the clients.” Another person spoke to the

importance of bringing those with lived experience around the table, and to how the Winnipeg approach could serve as an example for adapting HF:

Other places can really learn from thinking about how you ensure there's strong voice of people with lived experience at all levels of planning. One of the lessons is that Winnipeg took the time to do that community consultation. I think that it's very easy to underestimate exactly how much time that will take and how complex it potentially can be... I think, too, demonstrating that using a community development approach positions the project really well, going forward.

Meeting national objectives while consulting with community and reflecting local needs took time, which the local team had to balance with pressure to adhere to structured timelines and deliverables. Although relationship building was recognized to be an important component of the proposal development and implementation processes (McCullough et al., 2012; McCullough & Zell, 2016), one interview participant noted that “there was some discomfort or uncertainty [from the national level] around Winnipeg’s approach because it was so community-driven and, frankly, took longer.” This being the case, this same interviewee pointed to this approach as a key factor shaping the successful implementation of HF in the local context:

My reflection from the national level ... if I ever have the chance to be involved with a project like this or when I give advice to other people on undertaking projects like this, that's one of the pieces—to take the time at the front end, don't rush that, and that was in part my observations from Winnipeg's approach.

This early relationship building process took place among all actors involved in the proposal and site development, including between Indigenous and non-Indigenous stakeholders. This at times meant negotiating multiple worldviews, working collaboratively, and integrating a capacity building focus. The challenge in undertaking a collaborative approach was that the time invested in the front end, at the local level, increased tensions related to delays in the establishment of the various service and housing teams and the recruitment of study participants.

Indigenous Community Priorities

Indigenous community knowledge and leadership were crucial to shaping non-Indigenous understandings of Indigenous homelessness in Winnipeg. One national representative noted that he came to understand that experiences of Indigenous homelessness were not just about being without a house, but also about experiencing a sense of homelessness that entailed displacement from traditional lands, compounded by the impacts of racism and discrimination in an already challenging housing market.

Although the principles of the HF model are meant to honour client choice in a bottom-up approach, this large-scale project did not necessarily reflect Indigenous community priorities. One interview participant noted, “The main barrier in Winnipeg was the fact that [Housing First] was a

Western...intervention. It was not an Indigenous intervention... I think that the emphasis on choice was very, very helpful in helping people who were running some of the Indigenous programs in Winnipeg feel more comfortable with the fact that this is not a kind of program that has a kind of cookbook approach that's going to introduce Western practice or philosophy."

It was suggested that a community-driven governance structure helped to reconcile some of these differences. This comment emphasized that needing to take time and come together in dialogue was crucial:

I would never say it was 100% reconciled, but I think what helped is we found a way to engage ... not as a project, and not as research, but an approach... So it took a long time, but I think as we started to have more meetings... the more good conversations started to happen. That helped a lot... But it was a process.

Another interview participant similarly stated that:

Too often, research projects in particular are just imposed or it's brought to the Indigenous community and said, "We're done, this is it, do you support it?" So I feel like, in the early days there was some bumpiness and lots of conversations that needed to happen with the Winnipeg community and with the [Indigenous] community in Winnipeg around what exactly is the project, what exactly are we asking people to engage in.

It is important to recall that, at the time the MHCC was considering Winnipeg as a potential AHCS research site, and Winnipeg community-based organizations were considering whether to buy in to the project, HF was still a relatively new and untested approach in Canada, and there was little evidence supporting its adoption. The level of mistrust among community organizations that had been asked to simply "swallow, hook, line and sinker," an approach that was not proven to be effective in Canada, nor among Indigenous populations, was critical. One interviewee spoke to the importance of Indigenous service teams and leadership in shaping a local approach to AHCS:

The program in Winnipeg ended up very different in lots of ways from anywhere else because of the way in which... [Indigenous] agencies utilize[d] [Indigenous] types of interventions There were core components that needed to exist from a Housing First perspective, but lots of adaptations. So, in terms of [connecting] people socially, [approaching] health and wellness using the medicine wheel, the involvement of elders ... were supported in that context.

A community-driven approach shaped the formation of the AHCS project and HF approach in Winnipeg. "One of the first things you noticed about going to Winnipeg," one national-level respondent noted, was that "there was always a prayer or a welcoming ritual... It was always, it was beautiful that way, just a lot of respect for local culture." That being the case, it was suggested that even though the project was built from the ground up in terms of being community based, there remained a need for:

More [Indigenous] agencies coming to the table to participate in the dialogue... Just more voices at all levels, right? Service providers, consumers, people with lived experience informing the perspective and building the program from the very beginning. So again, that was done, but I would love to see there be even more.

Although not without some challenges and conflicting viewpoints, Winnipeg stakeholders took the time to develop relationships and build trust, bringing the AHCS project to life in a manner that sought to be respectful of the local context and history. As one interview participant stated, “This was totally about capacity building ... [Winnipeg] went through a much more deliberate community development approach.” Another pointed to how “Winnipeg ... took what was essentially a nationally conceived project with the same set parameters, and I feel that Winnipeg tried to take that and make it a community owned project.” What emerges as clear is that relationship-building, and making time for it, is key to translating a larger-scale or standardized model or approach to the local level.

In addition, Indigenous voices and leadership were key to delivering the HF program in a way that was relevant to the local community in Winnipeg. Although the AHCS project was initially delivered as a Western approach, imposed by federal representatives, community members worked together to make it locally responsive and culturally appropriate. One interview participant noted how the HF program was different in Winnipeg, in that Indigenous agencies delivered housing and support interventions (see also McCullough & Zell, 2016). This helped ensure that community wellbeing and the context of Indigenous homelessness were understood and respected. Respondents also spoke to the necessity of Indigenous-directed services within the AHCS project, as well as to the importance of putting governance structures in place that “incorporate community-based knowledge.” This demonstrates not only the importance of local ownership, but also the importance of bringing different worldviews and knowledge bases to the HF model as it plays out on the ground.

This national overview captures a glimpse into the complexities and difficulties of implementing an unproven mental health intervention in a local community that had much apprehension about Western ways of addressing homelessness. When HF was explained to the community as a success emanating out of New York City, the early challenge was to create an environment of trust among the local groups and organizations that HF lessons from elsewhere could be transferable to Winnipeg. When trust was built during the relationship-building phase, respect was earned, and with respect came better relationships among the local, national, and even international members of the MHCC and the local Winnipeg Site.

4. Pathways Walked Together: Staging At Home/Chez Soi Winnipeg

Between 2008 and 2014, the Winnipeg Site mobilized, established, delivered, and ultimately sustained Housing First in a manner unique among the AHCS cities and HF approaches generally. We illustrate this pathway as consisting of seven steps introduced below and expanded in the following sections.

It is important to reiterate that this AHCS was a randomized controlled trial (RCT) investigating the effectiveness of HF in Canada (Distasio et al., 2014; Goering et al., 2011). The scale of the project and the fact that it was launched in a top-down manner, with the Mental Health Commission of Canada establishing the parameters of the study and cities selected, contributed to the tension experienced among the local groups and organizations. Much of this tension stemmed from the uncertainty about what HF was and who would be charged in Winnipeg with undertaking the implementation of research and service delivery, as well as from a need to define the relationships among local services groups, researchers, and the national team. This early phase of the project was particularly important in setting a context and approach that was distinctive among the AHCS cities. In Winnipeg, there was an inherent need not only to bring various partners together, but even more so to ensure there was a level of comfort and trust among the local group and those from the MHCC.

To explore the design of the Winnipeg approach, the following seven steps offer an overview of the path from the early stages of coalition building to the ultimate struggle to sustain Winnipeg's team as the MHCC funding ended at the conclusion of the study.

- 1. Pre-project Relationship Building Phase:** In 2008, Winnipeg engaged in an early relationship building and nurturing phase. This was critical for shaping the development of the local model and in achieving longer-term sustainability. During this phase, the local community became aware of HF principles and practices (through workshops and discussions). At the same time, the MHCC staff and other national or non-Indigenous actors became aware of the existing local Indigenous leadership and social enterprise expertise in Winnipeg. This step was part of a nearly yearlong effort to build trust and bring together the people, both Indigenous and non-Indigenous, who ultimately interrogated and challenged the New York HF model. In many ways, Winnipeg collectively struggled to adopt a HF approach, questioning whether it was an appropriate fit for the Indigenous population and the city. While much of this tension was resolved, it set a foundation for creating the Winnipeg model that sought to ensure a local lens guided the approach.
- 2. Leadership and Governance Planning Phase:** Creating the right model for service delivery with a strong leadership core was a key early step. This included having community members and others co-share the management of the Winnipeg project. In many ways, this was difficult to achieve, given the scope and scale of the project. While Winnipeg's approach was unique in its structure and achieving consensus, leadership remained tricky, especially in the negotiation of relations among the various local stakeholders and between local stakeholders

and the national AHCS team. A key learning from this phase is that having the right model to equalize power is essential to ensure the voices of varied stakeholders are heard and considered. In Winnipeg, this included working with departments and units within government who were barriers to housing and supports for participants in the study. For example, the inclusion of Manitoba Housing and Employment Income Assistance at the leadership table was critical in changing attitudes about providing supports to persons deemed “too difficult to support” by systems that had otherwise excluded them.

- 3. Localizing Phase:** Above all else, it was essential to ensure the local community and the service teams created approaches informed by local experience. The Winnipeg model used a cultural lens approach to ensure Indigenous values guided the project’s structure. This included much reflection on HF principles through ongoing stakeholder engagement to ensure local experiences and voices were included. Challenges in the adopting the AHCS model also included understanding: how academic research/analysis was to occur, how continued education was to be offered, how Winnipeg would contribute to various national and local teachings, how the HF model would be adapted locally, and how local capacity would anchor and sustain the model. Localizing and adapting the HF approach was fundamental for success. Our view is that HF provides the scaffolding upon which localized structures and actions are graphed to sustain an environment necessary to end homelessness. In addition, we contend that this process should involve a comprehensive local analysis of many factors, including housing market conditions, community capacity, governmental relations, and landlord engagement.
- 4. Housing First Team(s) Development:** To launch and manage HF requires a collective and inclusive framework in order to create program structures, a process that includes hiring and training staff for service delivery, housing, and research/monitoring. For Winnipeg, this phase focussed on identifying local capacity with a history of addressing community need. This included collaborating with three local service organizations that collectively brought a century of experience working within Winnipeg’s inner city. In addition, the AHCS Winnipeg Site was unique in the inclusion of a social enterprise lens that helped grow local expertise and capacity through the creation and launching of Housing Plus and Manitoba Green Retrofit (MGR). MGR’s growth over the study remains one of the only examples of how a HF intervention successfully launched a social enterprise. In addition, it important to note that forming local partnerships and collaborating with other local businesses to deliver supports and services was key to having the diversity necessary for success.

The two main HF models and organizations involved in the AHCS Winnipeg Site are described in the text below (especially Tables 4 and 5). HF principles and philosophy guided service team structures and supported operationalization (see also: <http://housingfirsttoolkit.ca/>). However, given that AHCS was a research demonstration project, it is important to mention that research

monitoring and evaluation was unique. For example, the research team was large and required significant experience working within the community to leverage partnerships in the recruitment and monitoring stages of the project. The Winnipeg Site was also unique within the AHCS project in the creation of the Community Liaison Coordinator (CLC) position. The objective of the CLC was to offer participants randomized into the “Treatment as Usual” (TAU) arm of the study a contact who was a peer and able to draw on life experience and knowledge of the Indigenous community. Ultimately, this role evolved into two positions as the study entered the final phase.

5. **Delivery Phase:** The Winnipeg Site functioned because of strong community partnerships consolidated and forged through intensive site development and implementation plans. The teams had tremendous experience engaging and providing services in the local community. The local governance model was supportive of a collaborative approach to delivery of services and monitoring of the project. This was important in creating balance between the service delivery component and the research team charged with assessing progress. Ultimately, bringing the right groups, who understood the community, around the leadership table was central to ongoing success. For Winnipeg, the emphasis remained on creating capacity in HF by harnessing local expertise.
6. **Monitoring Phase:** The AHCS project was a research demonstration project that required all five city sites to assess and achieve HF program fidelity using a consistent approach. Within the local context, understanding the importance and challenges of research and monitoring and working with an often top-down national model was difficult to negotiate at times. For the local site, the challenge was to recruit over 500 participants into the study. To do this required local buy-in from the service teams and the close to 50 agencies that helped support the recruitment phase. Overall, Winnipeg worked hard to create a strong community-based network that helped get the word out on recruitment and follow-up, which was a departure from the approach of other cities in the project. There was agreement about the importance of the research and findings in supporting AHCS, and ultimately in sustaining the HF approach in policy.
7. **Sustaining Phase:** A key component and objective of AHCS was to support broader efforts to sustain funding and multi-level government involvement post-AHCS. As the project entered the final months of the study, there was tremendous angst among service teams, researchers, and most importantly participants, who feared the project’s end would result in support and service disruption. This final stage was particularly challenging, as separating the “research project” from the reality of sustaining people in housing was immensely stressful. For Winnipeg, this meant that the lives of upwards of 300 people would be affected in some manner if a service or funding interruption occurred. It was critical for all stakeholders to be involved in government relations geared toward sustaining funding. The fact that AHCS was a research project with a

defined timeline and end date made this particularly difficult. It is most important to note the Winnipeg Site and the national team delivered a strong and repeated message to government, policymakers, and the public on the importance of maintaining services. The message incorporated evidence from the study to influence policy, and ultimately the Winnipeg teams were sustained and the Federal Government made a massive investment in HF nationally through the Homelessness Partnering Strategy (HPS).

The seven steps described above serve as a chronological framework for the establishment of HF in Winnipeg. While they orient the process through which the local site came to understand and deliver HF, it is important to note that the Winnipeg Site built on and benefitted from organizations and local knowledge holders with decades of experience dealing with homelessness and poverty in the community. Each organization and person who contributed to the project brought a unique gift, with the culmination being a largely successful project that was able to adapt an American model to fit a Canadian prairie city. This fit was never perfect and there was much tension but, ultimately, Winnipeg proved that HF can be delivered within a population that is primarily Indigenous and in a manner that tries to be sensitive to community needs.

The Winnipeg Site: An Introduction to the Participants

Over the course of 18 months, the Winnipeg Site worked hard to recruit over 500 persons into the study. Recruitment was possible through connections with community-based organizations. It was the intent of the research team to ensure that participants were drawn from a range of locations and providers. Over this time, the work of the research team and others resulted in referrals from close to 50 different organizations. Each recruited participant was randomized into either the HF intervention arm of the study or the “Treatment as Usual” (TAU) group; the randomization process is explained in Goering et al. (2011). Participants were assessed as either High Need (HN) or Moderate Need (MN) and, if randomized to receive HF, assigned to one of the Site’s three HF programs. In addition to the persons who were randomized into one of the three teams, the Winnipeg Site also coordinated interactions with an additional 240 persons who were assigned to the TAU group. For the purposes of the RCT, this group was the comparison group. The reason for the inclusion of a comparison group in the study was to be able to assess whether HF was more effective than the current standard of care in improving housing stability for persons transitioning from homelessness.

Persons being recruited to the study faced a 50% chance of receiving HF or being randomized to the TAU group. Those receiving HF would be outfitted with a fully furnished apartment, while those in the TAU group would receive a small honorarium and meet with the research team for a regular follow-up at three-month intervals. The ethics of this methodology were debated extensively by the national and local teams, and created much tension during the development phase in Winnipeg. Ultimately, the conclusion remained that the inclusion of the TAU group was important to assess the effectiveness of

HF, the main outcome of the study (Silva et al., 2011). Tables 2 and 3 offer a snapshot of the general characteristics of the study participants.

Table 2: AHCS Winnipeg Site Demographic Characteristics of Participants at Baseline

	Total Sample N = 513	High Need N = 199	Moderate Need N = 314
	%	%	%
Age Groups			
34 or younger	37	41	35
35–54	57	57	57
55 or older	6	2	8
Gender			
Male	64	59	67
Female	36	41	33
Other	<1	0	<1
Country of Birth			
Canada	97	95	98
Other	3	5	2
Ethnic Status*			
Aboriginal	71	68	72
Other ethnocultural	5	5	5
Marital Status			
Single, never married	70	72	69
Married or common-law	5	5	5
Other	25	23	26
Parent Status			
Any children	47	47	47
Education			
Less than high school	69	74	67
High school	12	12	12
Any post-secondary	19	14	21
Prior Military Service (for Canada or an ally)	5	5	5
Prior month income less than \$300	47	45	49
Prior Employment (worked continuously at least 1 year in the past)	52	44	57
Currently unemployed	91	93	89

Note: All information was reported by participants except where noted.

**Many values will not reflect proportions in the general homeless population due to deliberate oversampling of some groups in some sites.*

As shown in Tables 2 and 3, more than half of the Winnipeg Site sample was middle-aged, and most became homeless in their late 20s and early 30s. While males are more visibly numerous, the Site strove for a higher sample of women (36% of the sample). The majority of the sample (71%) reported they were of Aboriginal descent. About half (47%) reported having children (though only 5% reported they were married or living common-law), though very few children were living with participants at the time of recruitment. There are many indications that participants faced multiple challenges that contributed to their circumstances. For example, 91% of the sample was unemployed at the time of study entry, and 47% reported a prior monthly income of less than \$300. Among study participants, 69% were absolutely homeless and 31% precariously housed prior to study entry. The majority of the sample was drawn from inner-city locations. The longest single pas period of homelessness reported by participants averaged 33 months. The typical total time participants has been homeless in their lifetimes prior to the AHCS study was nearly 5 years. For more information on the recruitment process and participants see Goering et al. (2011) and Distasio et al. (2014).

Table 3: Homelessness History of AHCS Winnipeg Site Participants at Baseline

	Total Sample N = 513	High Need N = 199	Moderate Need N = 314
	%	%	%
Homeless status at enrolment			
Absolutely homeless*	69	71	68
Precariously housed*	31	28	32
First time homeless			
The year prior to the study	22	16	26
2008 or earlier	78	84	74
Longest average period of homelessness in months (lowest and highest rounded to next month)	33 (1–324)	38 (1–324)	31 (1–324)
Total average time homeless in lifetime in months (lowest and highest rounded to nearest month)	60 (1–420)	61 (1–420)	59 (1–324)
Average age first homeless (lowest and highest rounded to nearest month)	29 (1–68)	27 (1–65)	31 (7–68)

Note: All information was reported by participants except where noted.

**See <http://bmjopen.bmj.com/content/1/2/e000323.full> for definitions of absolutely homeless and precariously housed.*

The Winnipeg Site Housing First Teams

The following section provides an overview of the service teams in Winnipeg and the care models used locally. The intent of this section is not to provide a program review but more to acknowledge some of the unique characteristics of the Winnipeg Site that drew from the Indigenous community and other partners' contributions. It is through these local adaptations that Winnipeg was able to better localize the HF model to a create a community driven approach that was thought to resonate with participants (Distasio et al., 2014).

In the AHCS Winnipeg Site, HF services were delivered by three community-based organizations, shown in Figure 1: the Ma Mawi Wi Chi Itata Centre (which housed and delivered the Wi Che Win HF program), the Aboriginal Health and Wellness Centre (which housed and delivered the Ni Apin HF program), and the Mount Carmel Clinic (which housed and delivered the Wiisocotatiwin program). Each organization had deep roots in Winnipeg's inner city and a long history of serving the needs of both Indigenous and non-Indigenous persons who struggled with homelessness and mental health.

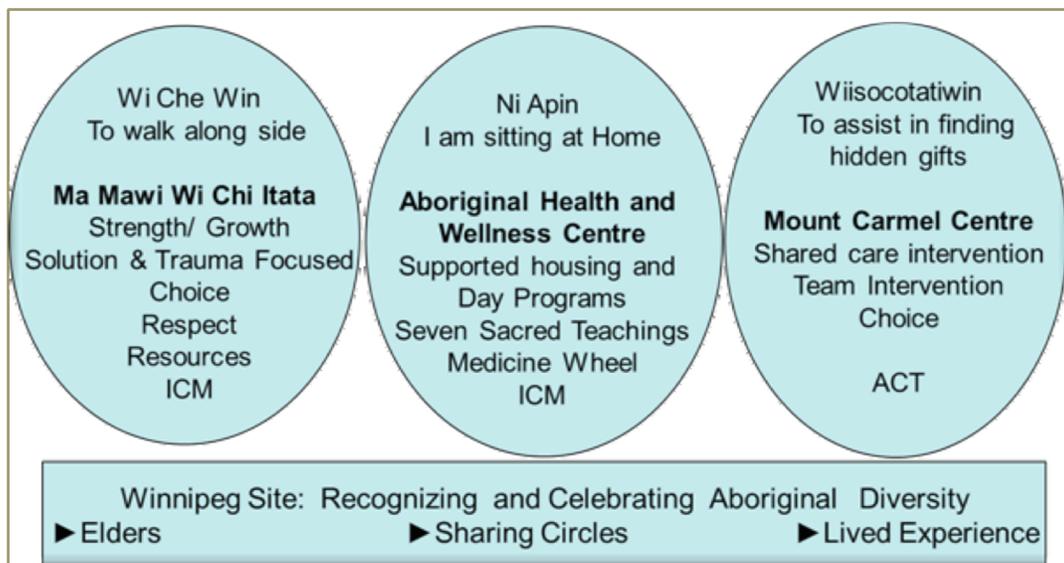


Figure 1: Winnipeg Service Team Overview Developed During AHCS

It is important to reemphasize that AHCS was a pragmatic RCT. As such, the three HF teams were required to adhere to a consistent approach (though there was room to localize aspects), and all had to achieve fidelity with the HF model. The teams delivered HF using either an Intensive Case Management (ICM) or an Assertive Community Treatment (ACT) model. Intensive Case Management is a care standard with focused support for persons with moderate mental health issues while the Assertive

Community Treatment model offers enhanced care to persons with severe mental health issues (see Table 4). For a more detailed discussion of each model and the manner in which participants were randomized into either group see (Goering et al., 2011).

Table 4: At Home/Chez Soi Housing First Model Overview

Housing First Model	
<ul style="list-style-type: none"> • Recovery-oriented culture • Based on consumer choice for all services • Only requirements: income paid directly as rent; visited at a minimum once a week for pre-determined periods of follow-up supports • Rent supplements for clients in private market: participants paid 30% or less of their income or the shelter portion of welfare • Treatment and support services voluntary – clinicians/providers based off-site • Legal rights to tenancy (no head leases) • No conditions on housing readiness • Program facilitated access to housing stock • Apartments were independent living settings primarily in scattered sites • Services individualized, including cultural adaptations • Reduce the negative consequences of substance use • Availability of furniture and possibly maintenance services • Tenancy not tied to engagement in treatment 	
ACT - High Need	ICM - Moderate Need
<ul style="list-style-type: none"> • Recovery-oriented ACT team • Client/staff ratio of 10:1 or less and included a psychiatrist and nurse • Program staff closely involved in hospital admissions and discharges • Teams met daily and included at least one peer specialist as staff • Seven days a week, 24-hour crisis coverage • Weekly home visits 	<ul style="list-style-type: none"> • Intensive case management for a minimum of one year once housed • Client/staff ratio of 20:1 or less • Integrated efforts across multiple workers and agencies • Workers accompanied clients to appointments • Centralized assignment and monthly case conferences • Seven days a week, 12 hours per day coverage

Source: MHCC (2008)

Table 5 offers an overview of each service team, listing the community organization in which it was housed, the care model used, and the maximum caseload. The Winnipeg-specific “third arm” model was called Ni Apin. It was delivered by Aboriginal Health and Wellness, was closely aligned with ICM principles, and was able to achieve good program fidelity (Nelson et al., 2014). The Ni Apin program was the Winnipeg Site’s experimental arm of the AHCS project, which allowed local community adaptations of the HF approach. One unique component of Ni Apin’s approach was a day program with an active drop-in centre that brought participants together. The program also experimented with co-housing and other inclusions that helped localize the approach.

Table 5: Winnipeg Service Team Indigenous Naming

Organization	HF Model	Maximum Case Load	Indigenous Name	Translation
Ma Mawi Wi Chi Itata	ICM	100	Wi Che Win	To walk along side
Aboriginal Health and Wellness Centre	ICM – Third Arm	100	Ni Apin	I am sitting at Home
Mount Carmel Clinic	ACT	100	Wiisocotatiwin	To find hidden gifts

The three Winnipeg teams formed the basis from which services and supports were directed to the 300 persons in the study receiving treatment. The Winnipeg Site also coordinated interactions with an additional 240 persons assigned to the TAU group. As noted, a unique component of the Winnipeg research model was the inclusion of the Community Liaison Coordinator (CLC). The spirit of this position was to offer those individuals randomized to treatment as usual with a person they could connect with throughout the study. This position was heavily scrutinized during the early stages of the project as there was thought it may interfere with the RCT framework. However, the research and leadership team was adamant that this position would be vital in offering a respectful means to connect this group with a person with whom they could share thoughts and ask questions. This outweighed any potential for influencing research results.

Overall, the level of engagement of the Indigenous community was part of all aspects of the project, including project coordination, service delivery, research, and advisory committees. This included those receiving support and housing and those in the TAU group who had access to the CLC and interviewers.

As such, Indigenous values were infused throughout service, program and research for staff and participants. The Winnipeg AHCS sought to be inclusive with a focus on being holistic, relationship-based, strengths-based, and on ensuring participants and staff had access to cultural supports and services.

In addition, Elders and Traditional Teachers were accessible to staff (service and research) and participants and often guided ceremonies, sharing circles and one-on-ones. Perhaps this inclusion was a counterbalance to the top-down structure of the MHCC, allowing the Winnipeg teams to “localize” their approaches both in name and in practice to create comfort in delivering services that had the strongest fit within the local context.

The successful delivery of HF in Winnipeg required the leveraging of expertise from the three teams that provided services and supports to the 300 people referred to the study and assigned to one of the teams based on level of need. Each team had a unique structure that offered a set of services and supports drawing on their decades of community based experiences. The following highlights some of the unique aspects of each team and provides more detail on how the Winnipeg Site was structured and the approach used to launch and deliver HF. This is followed by an examination of the Winnipeg governance model.

Walking Together: The Wi Che Win Model

The Wi Che Win program was the ICM model for Winnipeg and was based on leveraging community strengths to support those in need. The model’s spirit is best described by an interviewee who shared: “The name means walk with me. So that’s our philosophy, when they come through our doors, we have to start walking with them, wherever they’re going, and start where they are, and walk with them to their new neighbourhoods, their new homes. Even if they go to jail, we’ll walk with them. That’s our philosophy.” The Wi Che Win program established the following program principles:

- ❖ **Strengths-based** – founded on the belief that all individuals have strengths and resilience to survive the streets, which can be built on and enhanced and used to create a plan tailored to the individual’s life circumstances.
- ❖ **Client choice** – determines who is significant in their family network, including family and friends, and determines who should be enlisted to support the participant.
- ❖ **Respect** for the individual, their family, and their culture.
- ❖ **Respect knowledge** of the individual/family. The individual and their family know their own person and family history/dynamics better than anyone else.
- ❖ **Individuals need resources, information, and support** to implement their plans. Workers, through intensive involvement (home visits, accompanying the person to resources, etc.), know what resources and information can be made available to facilitate solutions.
- ❖ **Solution-focused** – solutions to deal with living situations as they arise, utilizing the principles of harm reduction, with recognition that relapse will be a part of the challenge.
- ❖ **Knowledge and skills transfer is ongoing** – workers will do *with*, not *for* or *to* participants, to provide opportunities to grow in capacity and learn to problem solve. (Winnipeg Site Proposal, 2009)

In addition to the guiding principles noted above, the Wi Che Win model also included service coordinators and case managers with extensive experience working in the community. Key to the program was the support and guidance of Elders and traditional and cultural teachers who were available to participants, as expressed in the following quote: “These individuals served as spiritual guides and teachers, helping participants understand their traditional roles and relationships with others, and supporting individuals to achieve greater balance through understanding” (Winnipeg Site Proposal, 2009).

What was also special about the Wi Che Win model was the involvement of the Ma Mawi Wi Chi Itata Centre, which has more than 30 years of experience working within the Manitoba Indigenous community, primarily serving Indigenous community members. For the purposes of the AHCS project, they also worked with and supported non-Indigenous participants. All persons in the Wi Che Win program had access to the same services and supports, with many non-Indigenous persons taking part in traditional ceremonies and teachings. This aspect of the model was best summed up by a participant in the study who offered this view:

Being a non-Aboriginal in an Aboriginal agency was an enlightening experience. They showed me ways of knowing and being that I didn't know existed. They mentored me, took me to sweat lodges, and introduced me to a spirituality unlike any I've been exposed to.

The Winnipeg Third Arm Model: Ni Apin

Ni Apin was Winnipeg's experimental model and provided supports to Indigenous community members. The Ni Apin approach was “holistic, cultural-based, pragmatic and specially designed for urban Aboriginal persons who are seeking assistance in re-integrating into the community and establishing a healthy, well-balanced life in an urban environment” (Winnipeg Site Proposal, 2009).

The model aligned closely with the ICM level of supports but included many unique modifications. The intent was to combine both contemporary and traditional philosophies of the Medicine Wheel and to ensure that values, traditions and beliefs embraced traditional approaches to healing. The Ni Apin program was developed based in the universal principles of sharing, caring, kindness, humility, trust, honesty and respect. These principles make up the Seven Sacred Teachings and all of these principles exist within the Medicine Wheel or the Circle of Life.

Another central part of the program was to ensure opportunities for contact with Elders and Traditional Healers, “The Elder is a positive role model for all community members and is a catalyst for change. Through the Elder's sharing of life's experiences, the participants learn about the gifts of wisdom, peace, respect, courage, honesty, humility, sharing, and caring” (Winnipeg Site Proposal, 2009).

The Ni Apin model also offered Indigenous-based supports that included having a Cultural Resource Specialist to support the spiritual component of wellbeing. This position was intended to work with

participants and staff in “developing and delivering cultural and spiritual programming, such as Sharing and Teaching Circles to meet the constituent’s interest and knowledge in order to provide them with options to address their spiritual wellbeing.” Ni Apin focused significant attention on cultural programs, and its entire approach to programming was:

Grounded in the understanding of the impacts of colonization and residential school, and counters these impacts through cultural revitalization by restoring a sense of belonging, restoring the wisdom of traditional teachings, practices, and medicines and providing opportunities to practice new ways of thinking, behaving, and living with others who also committed to balanced health. (Winnipeg Site Proposal, 2009)

As previously mentioned, a unique aspect of the Ni Apin model was the inclusion of the drop-in program that brought people together in an open and respectful manner. The drop-in was located in the Aboriginal Centre of Winnipeg, which is highly recognizable in the city and centrally located. The drop-in operated daily and offered a range of programs addressing issues such as food security, offered sharing and teaching circles, and simply provided a place for participants to gather and share.

In addition, the Aboriginal Centre of Winnipeg became an important location for the Winnipeg Site generally and hosted meetings, events and gatherings throughout AHCS. For the research team, the centre was also key for interviews and referrals and became an important meeting space for the research team.

Finding Gifts: The Wiisocotatiwin Model

The care model used by the Mount Carmel Clinic’s ACT team required additional resources and supports for persons randomized with higher needs (see Table 4). This included having a psychiatrist and additional staff to ensure that the client-to-staff ratio aligned with the HF model and included the right set of supports.

The ACT model also had both Indigenous and non-Indigenous participants. What was unique within the Winnipeg AHCS ACT model was its Indigenous-focused approach, which included a role for Elders who provided guidance and support. This included “having traditional ceremonies and teachings to assist program participants and staff to understand the world through an Aboriginal lens as it is related to healing. The role of Elders was important for creating a traditional foundation for strength and change” (Winnipeg Site Proposal, 2009).

For the Wiisocotatiwin approach, services and supports were set up to enable individuals to regain knowledge of history, traditions, and culture, and to provide opportunities to build a greater sense of self. The types of traditional supports included:

- ❖ Opportunities to participate in sharing circles;

- ❖ Opportunities to attend community events and celebrations, ceremonies, medicine picking, and naming ceremonies to obtain their spirit names; and,
- ❖ Opportunities to learn about the impact of colonization, residential schools, and history on self. (Winnipeg Site Proposal, 2009)

It is important to note that there was a strong emphasis on bringing in the right staff among all the teams. The type of person needed to support a HF team required skills and knowledge about many of the struggles and challenges facing those in the study. One ACT team member shared that it's "just amazing to be able to recognize the gifts of the team, and to honour those, and to encourage them to use them in that good way."

Mount Carmel Clinic had decades of experience working in Winnipeg's inner city. The delivery of the ACT model by Mount Carmel provided a good fit that brought together a strong medical services background with an emerging strength in community-based approaches that offered both Indigenous and non-Indigenous persons the ability to succeed.

Overall, Winnipeg's three service teams provided AHCS participants with a set of services that both aligned with HF principles and achieved strong program fidelity. This was critical for Winnipeg to adhere to the rigors of the RCT and the requirements of the MHCC in delivering HF consistently with the other city study sites. However, in addition to achieving these objectives, each of the three teams was also able to address more fundamentally the need to connect participants with offerings that closely aligned with Indigenous approaches and values. This combined effort localized HF in a manner that persons could better identify with and achieve their own sense of recovery grounded in a community-driven model.

5. At Home/Chez Soi Project Governance Model

The following section examines the overall MHCC model and the Winnipeg model. The AHCS national governance model was comprehensive in nature and integrated the sites through the inclusion of a National Working Group to ensure strong collaboration throughout the research demonstration project (Figure 2). This was deemed critical to the project's ability to ensure program fidelity was aligned among the sites and that all sites adhered to HF principles (Goering et al., 2016).

Over the course of the study, very little turnover ensured strong continuity within the projects' leadership structure, which remained consistent both nationally and among the sites. At the national level, MCCC staff and its board of directors managed the project's massive \$110 million dollar budget and reported progress to Health Canada as required. The AHCS project had a dual national leadership structure that separated the research from the project's more administrative functions. This included National Project Lead Dr. Jayne Barker, who launched AHCS and remained with the MHCC from 2008 to 2011, when Cameron Keller assumed the role until the end of the study. This position focused more on the administrative nature of the project. The National AHCS co-leader was Dr. Paula Goering, who was the National Research Lead until the completion of the project. Dr. Goering's leadership was the foundation for AHCS and central to the development of the project's research framework.

The National Working Group (NWG) acted as the central connection between the MHCC and the local sites. The NWG was comprised of Site PIs and Site Coordinators, along with MHCC staff and researchers. This group workshopped many ideas, addressed problems, and structured much of the analysis for reports and publications. In addition, the NWG was the centre point for the ongoing discussion with government on sustainability post-AHCS. Overall, the total number of persons involved in the leadership side of the AHCS project numbered over 50, and included 6 Site Coordinators and 40 Investigators.

As the project evolved, there arose more need for specialized sub-groups to provide support. This included a number of communities of practice that were tasked with specific issues such as housing, critical incidents, research and publication, and others areas. These smaller working groups were more informal but offered access points for hot button issues and served as a means to have a range of site staff take part in national calls and meetings.

The MHCC national team was central to the functioning of the project and acted as the administrative arm of the study, coordinating finances, education, and training along with governmental relations (among other roles). The MHCC team was key to the success of the project's ability to link data and findings among the sites and to share evidence from the project (on a local, national, and global scale).

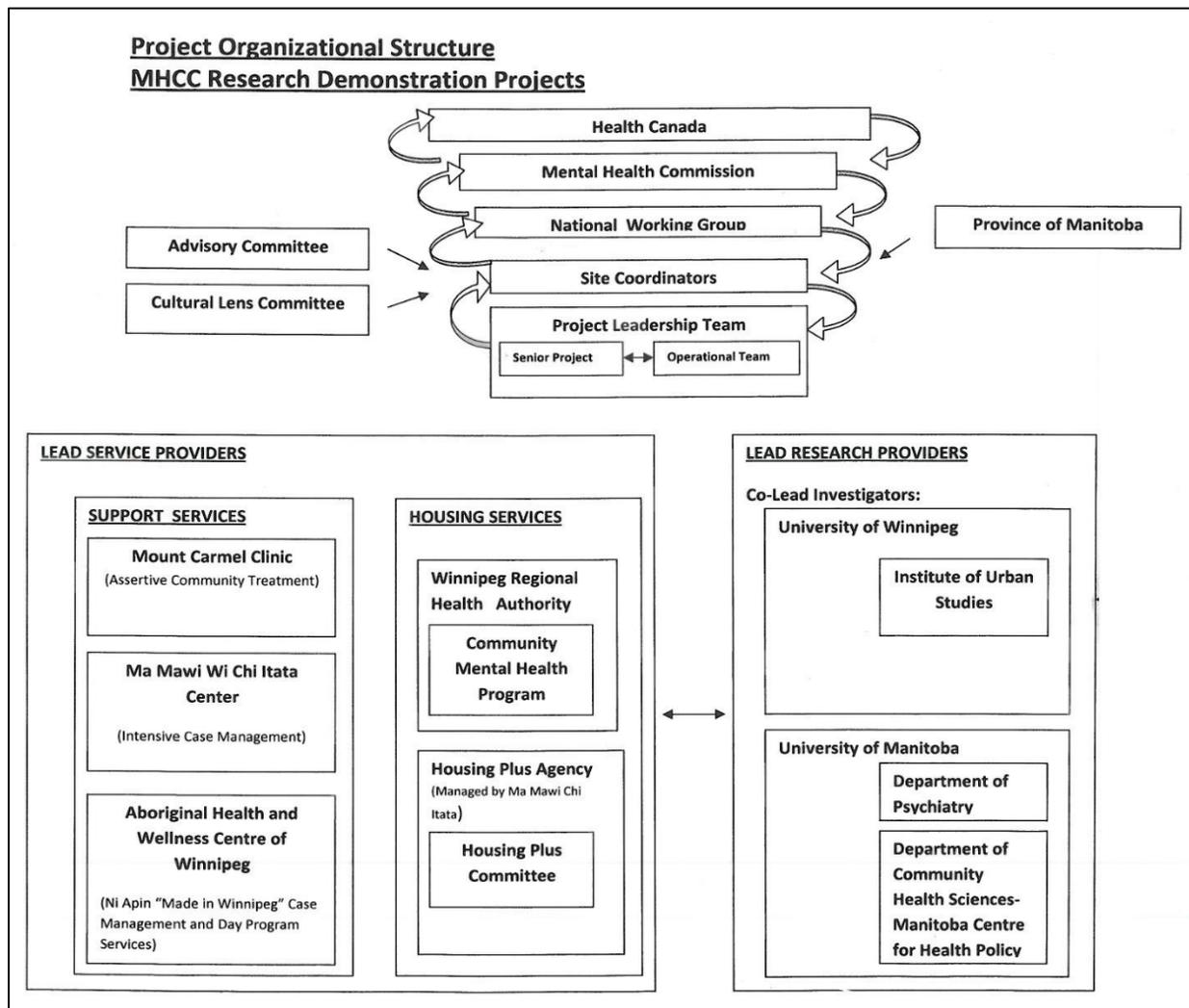


Figure 2: MHCC National and Winnipeg Model

As the project evolved, a key component that is not noted on Figure 2 was the National Consumer Panel (an MHCC group), which helped ensure that people with lived experience (PWLE) had a meaningful voice in the project (Nelson et al., 2016). Throughout the course of the AHCS project, the inclusion of PWLE was essential. In Winnipeg, the Lived Experience Circle (LEC), which embraced peers in a meaningful manner and is discussed in more detail below, remains one of the most important and ongoing legacies of the local project.

Overall, the AHCS project was a well-structured research demonstration project thanks in part to the MHCC leaders, who successfully guided implementation and ongoing efforts. The model was successful

in delivering support and managing a complex project that extended across the country, from Moncton in the east to Vancouver in the west. There were challenges related to setting such a large-scale project within the context of a mid-sized prairie city, and there was some initial friction in Winnipeg, where a history of strong community ownership of addressing issues related to poverty and homelessness had driven much of the program and service delivery for decades. In Winnipeg the approach was to try to reconcile the gap between a large, national-level project and the needs and demands of Winnipeg by creating a local model that better reflected the needs of the community. The tension and ongoing struggle of doing so was perhaps interpreted by some in a negative light, but those close to the project reflect that it was this tension and questioning that helped ensure Winnipeg's approach was better aligned with the local community and its needs.

The Winnipeg Model

Each site developed a local governance model that generally consisted of a Site Coordinator, a Principal Investigator, collaborators and service/research team members (Aubry et al., n.d.). Each site was responsible for their own mechanisms for how they would structure and deliver HF in the community and how they would manage operations. In Winnipeg the governance model included a number of local adaptations that helped ensure stronger community ownership and partnership (Figure 2). The Winnipeg AHCS project is an example of a successful, culturally safe partnership among universities, local Aboriginal organizations, and government, engaged together in the development and ongoing operations of the Winnipeg Site project from its inception.

The following section examines elements of the Winnipeg model that contributed to the delivery of services, housing, research and other partnerships. This was accomplished by reviewing site documentation and drawing from individual interviews with eight members of the original team and four focus groups conducted with service team staff, housing delivery staff, the Aboriginal Lens Committee and research and government representatives as well as members of the Lived Experience Circle. What this sections attempts to describe is the approach used in Winnipeg and those elements of the model that set the city apart from others in AHCS.

From the initial proposal of Winnipeg as a potential site within AHCS project, the inclusion of Indigenous persons and organizations was front and centre. This helped balance the interests of the top-down research model of the MHCC with the need to have more of a bottom-up ownership approach among the local stakeholders. Balancing these approaches presented one of the most challenging aspects of the establishment and ongoing governance of the Winnipeg Site. This was raised in almost every interview, with one person stating that community organizations “were ticked off about the research, research being done in the Indigenous community and not done in an Indigenous way.”

A second interviewee also captured this sentiment and shared:

There was a lot of concern about this project coming into Winnipeg. There was a lot of concern about what it may miss. Concerns about bringing in a mainstream project and working with the First Nations communities, and how that was going to play out. You know, in terms of trying to fit kind of a cookie cutter program into the community. Something that really didn't belong to us... but bringing in a program and saying, this is how, you know, we would like you to work with the First Nation community.

A third interviewee reflected on the early inclusion of Indigenous views within the scale of a national project: "I think that the program is so large that there's some disconnect there between what we are trying to do and who's hearing that. I think [high-level leadership] certainly sees the benefit of it [including us in the process]; however, the critical piece of that is if anyone is hearing us, I don't know. We don't see any results of that."

To counterbalance the need for stronger community awareness and ownership, the Winnipeg model sought to build an approach that tried to give voice to the local groups while balancing the complexities of ensuring the research integrity of the study. Often, as is noted below, this meant Winnipeg would continually try to shift the approach to be more inclusive by adapting the local model through committees and other means that tried to offer access points for a broader set of views.

This resulted in creating a local governance structure rooted in understanding how the local groups worked together and using their knowledge of the local population who were homeless. As one interviewee stated, "Well, I think that the good part is that so many different factions can actually work together, but I think that's because we all, although we're working together, we all have our own focus, and we're not in each other's face." Another respondent reflected: "There's organizations that have natural partnerships here and we've worked together for many years so a lot of that came into play and because we collaborate and we work together on filling in the gaps, a lot of us are working with some of the same people."

The Project Leadership Team

The above comments speak to the scale of the project and having multiple organizations contribute to the delivery of HF and to the concerns about how Winnipeg connected with the national project. Essentially, each of the three HF teams (and the organizations in which they were housed) provided services, including housing provision, in an independent manner. However, where the Winnipeg Site came together was with the Project Leadership Team (PLT). The PLT was the local body that coordinated and managed site issues and interactions with the National Working Group and the MHCC generally. It was chaired by the Site Coordinators.

The PLT emphasized a consensus-based model that provided a strong voice to all members at the table. For Winnipeg, the early adoption of a dual Site Coordinator model provided a sense of balance and inclusion. Site coordination was shared between Marcia Thompson, a governmental representative (with strong background and connections with the Province), and Lucille Bruce, a respected Indigenous community leader. The PLT met frequently at the outset of the project and more toward the end as agendas shifted to issues related to sustainability. The PLT was described by a member as being the centre of decision-making:

Our Project Leadership Team had representatives from Service, Housing, Housing Plus, Research, myself, others, who actually try to, I guess on one level make the day-to-day decisions, but more importantly probably, make sure we're all on the same page and working in the same way. So things like working with landlords, tenant issues of people who haven't been successful in housing, looking at the Housing Plus process, and in fact, actually developing an I.T. system to support that. All those kinds of things have been managed by the Project Team, which is really central to the implementation.

As the MHCC entered into the final year of the research project, all cities became acutely aware of the need to work on sustainability planning. This was particularly challenging, given there were two scenarios considered: one in which funding would continue and programs be extended, or a second in which there would be disruption in the funding of service teams. The possibility of the latter raised anxiety levels of participants in the study, of workers employed to provide supports, and of the local leadership team who potentially faced having to cut people adrift without supports (including housing subsidies).

Overall, the structure of the PLT served the Winnipeg Site well and offered an important layer (and buffer) between the activities occurring in Winnipeg and national-level issues and structures. Some members of the PLT were also members of the aforementioned National Working Group. This offered an important means by which to share information and assess progress while also working out issues.

The Winnipeg Advisory Committee

Like most of the AHCS city sites, the Winnipeg Site also included a larger Advisory Committee (AC), which consisted of close to 20 key stakeholders who brought tremendous experience working in the community and with those most vulnerable. The Winnipeg AC worked to promote partnerships among the groups working to end homelessness in Winnipeg and offered advice on the long-term sustainability of HF in Manitoba. The terms of reference for the local AC were to ensure that the Winnipeg Site offered a holistic approach that was transparent and culturally appropriate in both research and service provision while addressing the needs of the Indigenous community. The AC met more frequently during the initial phases of the project and helped support knowledge dissemination about what HF was and how the AHCS project would unfold in a community that was increasingly sensitive to solutions being imposed by national organizations. A member of the Winnipeg Site stated, "I'm really hopeful that they

can help with dissemination... On an individual level they could go back to their own agencies, their own governments, their own whatever, and share some of this information. Having an Advisory Committee made up of representatives from various external institutions helps spread awareness.”

The Winnipeg Advisory Committee played an important role in the early stages of the project but became less engaged as recruitment proceeded and meetings became less frequent. However, there is little doubt of the importance of such a group in having helped share information and expertise about establishing three HF teams in a community that had no previous experience with HF.

The Aboriginal Lens Committee

For Winnipeg, the Aboriginal Lens Committee (ALC) and the Lived Experience Circle (LEC) represent two local inclusions that set Winnipeg apart from the other AHCS cities. The ALC provided a cultural lens that informed research, supports, and services. The ALC was a council of Indigenous leaders and Elders who met frequently during the early stages of the project. The purpose of the ALC was to uphold the integrity of Indigenous knowledge, wisdom, experience, and ways of being as valid and necessary components of a holistic view of the individual and the community. This was essential in helping complement research and service delivery as well as overall project governance. The members of the ALC also had opportunities to engage with members of the National MHCC team through training and education events, meetings, and conferences.

While the spirit of the ALC was true in striving for strong Indigenous inclusion, their role was not well defined within the overall governance structure of both the national and local projects. Members of the ALC understood there were challenges faced by the Winnipeg leadership team in creating a localized governance model within a broader national project. Furthermore, the ALC realized early that in this top-down national study, the inclusion of local voices would be constrained. “We were brought in at the beginning... [because it was] thought there needed to be a council of Elders or others who had experience working with the community, to bring that cultural piece.,” one ALC member stated. A second member commented:

Within our circle we are knowledgeable about the importance of it [traditional knowledge]. Our past experience shows the success of having this circle of people with different wisdom and gifts in different areas of teachings and knowledge. When we get together it's quite magical, and the teachings are quite magical and it is what is really needed in our community.

The ALC played an important role in helping the project understand local Indigenous values. The idea of using a “lens” committee was to help understand and support the local Indigenous community struggling with homelessness. The contributions of the ALC are difficult to measure but were essential in sharing wisdom and thoughts. For example, one member’s view on collecting information about participants in the study was:

Well, we're concerned about the sanctity of people's stories, life stories. And how will those be used as learning tools for other people and how will those people who shared their life stories be respected and honoured? And those parts that are both sacred and shouldn't ever be repeated. And there are certain ceremonies too that shouldn't be recorded or shouldn't be even mentioned.

This was an important statement that provided guidance to the project team entrusted with the stories and teachings from participants in the study. This is a prime example of the kind of challenge faced by the research team, which had to balance the need to collect very sensitive information about personal struggles and trauma with the imperative to conduct the research in a manner that was respectful. For the majority of the interviews, the Winnipeg Site used a two-person team approach. This allowed one interviewer to focus on the questions and a second person to focus on the wellbeing of the participant. A member of the research team who served in this capacity shared that the second person was:

Not doing the lead interview, but being there. And my presence was just always to support the participant. And they could feel my warmth and they felt very comfortable in that setting. So I was, after leaving or going a little way from the interview, actual formal interview part, I would start meeting with the people on the street, or wherever I met them, in a shopping mall or on a river-trail, whatever. And I am able to recognize those who are in need. And I usually strike up a conversation and if they, I know when they weren't ready to talk so I would just leave them and then come at it from a different angle.

The ALC was established and held their first meeting in late 2009, a few months after the start of recruitment. During the course of the project, the ALC met over a dozen times, and individual members also attended various events and conferences. The role of the council and the view of its members were generally viewed positively, though some felt that the ALC could have done more or should have been included from the very beginning.

The Lived Experience Circle

During the study period, the National Consumer Panel (an MHCC group) served as an important national connection for peers in the AHCS project. The NCP helped create a positive environment for persons with lived experience (PWLE).

In Winnipeg, over the course of the project, it was observed that many were experiencing added trauma and stress related to the study. This included participants in the study, staff within agencies, and members of the research team. Within six months of the start of recruitment in Winnipeg, a small group formed that initially called itself the Local Lived Experience Circle (later retitled the Lived Experience Circle; Hatch 2014). The LEC formed with a focus on celebrating peer inclusion and experience. The initial mission of the LEC was:

To provide a culturally safe, confidential, and supportive space guided by Indigenous Traditional and Sacred Teachings and Ways, for people who are involved with the At Home/Chez Soi project,

to come together, to share their voices and perspectives, and to participate in creating a common voice with meaningful inclusion of people with lived mental health and homelessness.

Generally, the LEC uses sharing and healing Circles, and follows the seven sacred teachings of Love, Respect, Courage, Honesty, Wisdom, Humility, and Truth (Hatch 2014). Figure 3 shows the original conceptual model for the group.

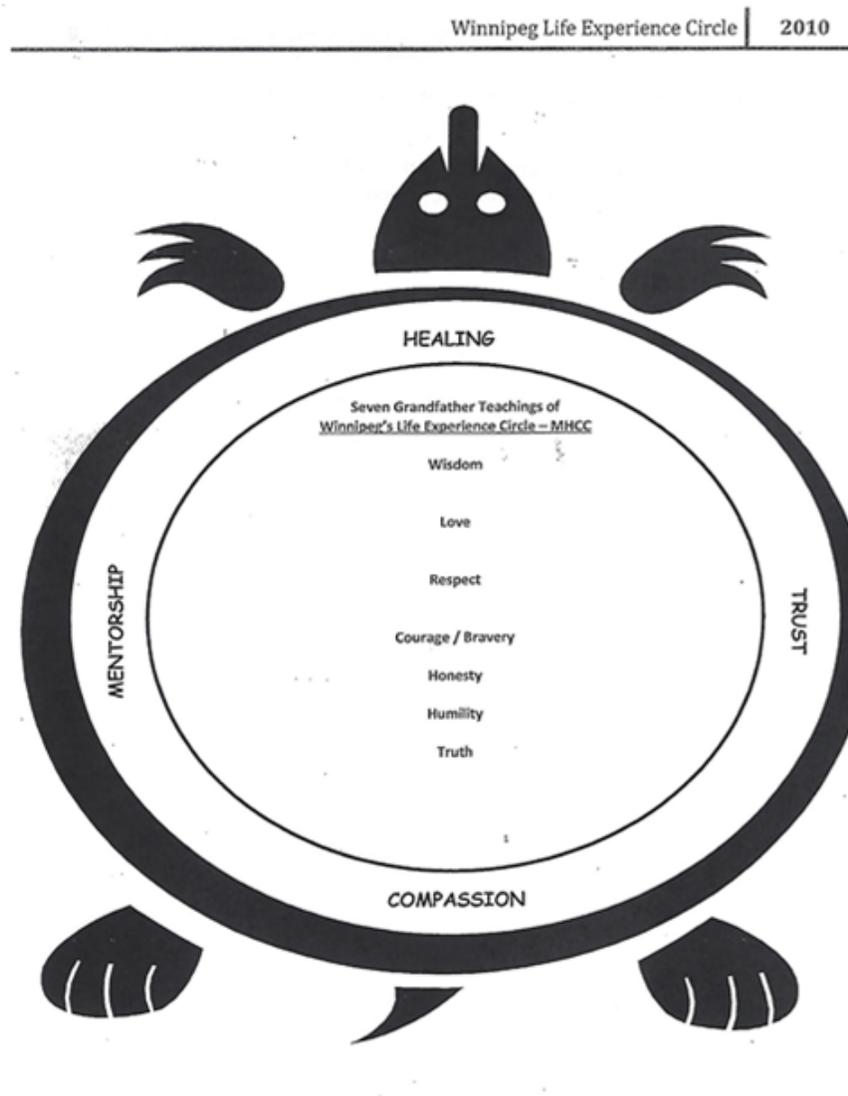


Figure 3: Conceptual Model for the Original LEC from 2010

The LEC played a critical role in the AHCS project and has meet monthly for the past eight years. The group has consisted of peers from the study, and many of the original members are still active. The LEC

became more than a group offering a safe space for sharing. Over time, their role has expanded to include advocacy, and researchers, community organizations, and government meet with and consult the LEC on issues that benefit from the wisdom and expertise of a lived experience perspective. Members of the LEC have traveled to national conferences and events and are often called upon to share views and perspectives on the development of programs and policy related to poverty and homelessness. The development and lasting impact of the LEC is one of the most important outcomes of peer involvement in the MHCC national project.

Strengthened Capacity through Local Engagement

The final aspect of the local model was the capacity-building framework that set the foundation for Winnipeg to provide housing and related services to participants. The housing framework emphasised social enterprise and local partnerships that developed solutions by the community for the community. This section provides a review of the Housing Plus Model and the role Manitoba Green Retrofit (MGR) played as a social enterprise launched through the local Winnipeg Site.

To understand the role of building capacity through a social innovation lens, it is important to revisit the social context for the Winnipeg Site. In the mid-2000, poverty and a difficult rental market presented significant challenges for the local team to address (Distasio et al., 2015). This difficult market condition was part of a systemic set of factors related to a widening gap in social inequality in Winnipeg (Distasio & Zell forthcoming). Housing was in short supply, and what was readily available tended to be overly concentrated in Winnipeg's impoverished inner city. The state of Winnipeg's inner city was mixed and while gains had been made, many struggled to remain housed and above poverty lines (McCracken et al., 2013). The bulk of the available housing stock used by AHCS Winnipeg were comprised of old apartments and converted homes. In addition to quality concerns, the local vacancy rate during the course of AHCS hit an all-time low of under 1%. This volatile market hampered the ability of local teams to access a range of choices when trying to secure "quality, affordable" housing. Figure 4 shows vacancy rates during the study period in Winnipeg in comparison to the other study site cities and Canada as a whole. Winnipeg had the lowest vacancy rates among the cities and was well below the Canadian average. This put significant pressure on the local team to develop a plan that could not only find and secure units for potentially 300 persons over the recruitment period of 18 months (along with additional need associated with rehousing), but also ensure those units were reasonably acceptable in quality and affordability.

To remedy the situation facing Winnipeg's AHCS team, a local plan provided a novel approach to housing and related services, such as move-in and move-out, furniture acquisition, housing inspections, etc. To secure housing while also creating capacity among local organizations, a partnership model was developed that brought together the Winnipeg Regional Health Authority (WRHA), the Ma Mawi Wi Chi Itata Centre, and the social enterprise Building Urban Industries for Local Development (BUILD). What

ensued was the creation of a model that brought a number of groups together to leverage existing knowledge to address issues related to finding decent and affordable housing in Winnipeg.

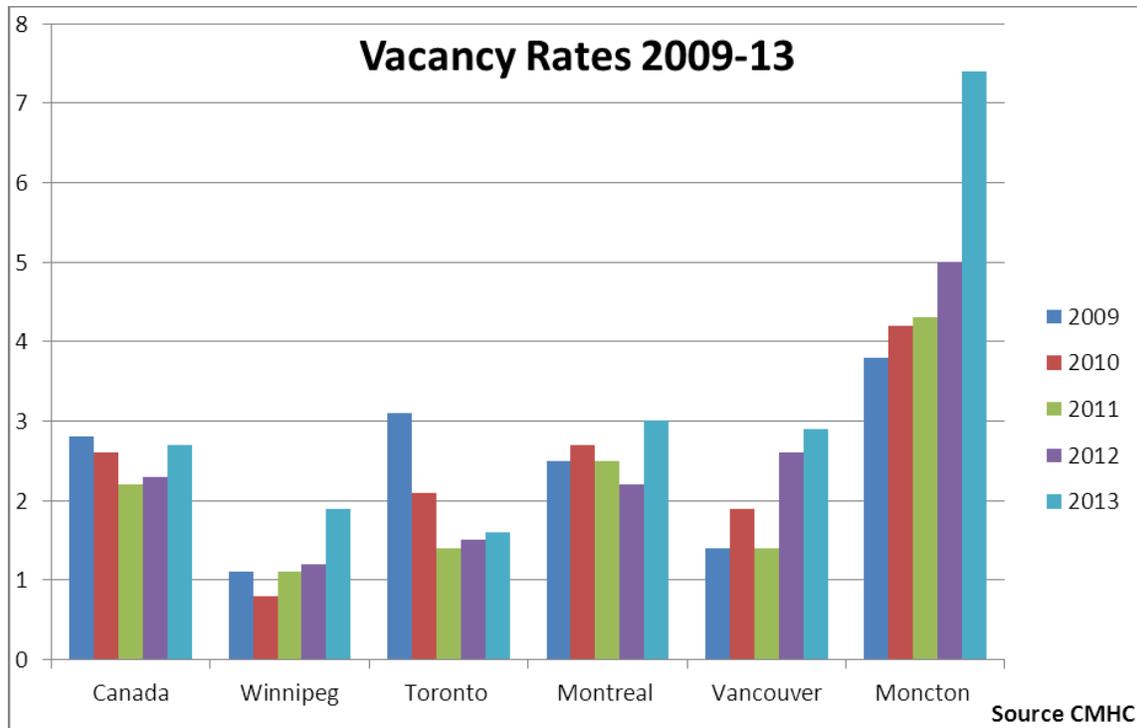


Figure 4: Vacancy Rates in AHCS Cities

Ultimately, the idea was simple: combine the expertise of the WRHA’s housing unit, which had been providing and securing housing for persons with mental illness for some time, with BUILD and the Ma Mawi Wi Chi Itata Centre’s community knowledge. BUILD was a powerhouse of a social enterprise that had been training local inner-city residents in the building trades, and the Ma Mawi Wi Chi Itata Centre expanded its role and mandate to offer a centralized approach to housing services for AHCS with an eye on job skill development.

The outcome was the creation of Housing Plus. It was the guiding agency for housing-related issues, and it had staff seconded from the WRHA and the Ma Mawi Wi Chi Itata Centre. MGR became a spinoff social enterprise created out of the expertise of BUILD (for more info, see <http://www.mgrinc.ca/>).

The social enterprise lens was important in the AHCS Winnipeg Site’s approach. It was geared toward the development of skills and expertise of community members. During the study period, there were well over 250 social enterprises operating and generating jobs, skills, and opportunities in Manitoba (O’Connor et al., 2012). Organizations like BUILD had developed a strong reputation in the community

and were approached to support the AHCS project with skills related to move-in and move-out logistics, addressing and remediating bed bugs, undertaking repairs, damage reporting, and other key support services. MGR became a key part of the housing delivery model in Winnipeg.

The provision of housing was central to all the study cities in the AHCS project. However, the manner in which housing units were secured, offered, and furnished was the responsibility of each site. In Winnipeg, Housing Plus was the one-stop shop for fully furnishing and outfitting each apartment as well as for developing an inventory of units from which the teams could select (Figure 5).



Figure 5: Furniture Assembly Area at Housing Plus Warehouse in Winnipeg

There are two aspects of housing delivery that are important to document. The first relates to how housing units were secured by the Winnipeg Site, and the second is the manner in which the service teams and participants accessed housing and supports provided by Housing Plus. The following provides a very simplified overview of the processes.

Securing housing within Winnipeg's tight rental market was very challenging. The inclusion of the WRHA and their experience in working with property managers to secure units was critical for success. The Winnipeg Site also developed a more coordinated approach that included weekly meetings to talk about housing issues and to work together to secure and distribute units and address other related challenges. Housing Plus also worked with the Province of Manitoba to access some public housing units for the

project. Winnipeg used a number of strategies to secure housing. These included creating a small inventory of units that the service team could show participants. The HF service teams and Housing Plus also worked more on a one-to-one basis with participants, finding individual units as needed (through ads and contacts).

The manner in which participants accessed housing and services is an important part of a HF approach, which strives to provide rapid housing. Key steps taken include:

1. The first step in the housing journey began at the point of a person being randomized into the study and assigned to one of the three HF teams.
2. Following assignment to one of the teams, a case worker would determine housing needs and assess what was available in the local inventory or seek other options based on factors such as type of unit, location, and neighbourhood.
3. It was also important to determine a participant's level of housing subsidy. A key aspect of the local approach was to help persons secure housing at a level above what they would normally access using only local assistance rates (which at the time of the study were \$285 per month).
4. Once a unit was determined to be a good fit, the housing team would help finalize the lease and pay the damage deposits (the lease would be in the name of the participant).
5. Each person would then have an opportunity to visit the Housing Plus warehouse and select items for the apartment. While much of the furniture was bulk purchased, there were a number of options from which to choose.
6. For move-in preparation, Housing Plus and MGR would coordinate all matters related to furniture assembly, move-in inspections, the move itself, and outfitting the apartment. (Figure 6)
7. Once the person was occupying the suite, housing services would remain in place to help address other housing-related issues that might arise. For example, Housing Plus would help when a person lost their key (they had a key inventory) or help address issues related to complaints or damages to a unit.
8. In the event a person required rehousing, the housing team would coordinate the move-out and address any issues related to damages incurred in the unit. This included completing repairs and moving the occupant's possessions. In cases where a person would be away for an extended period of time (e.g., for treatment, incarceration, or because they left the city) a decision would be made as to whether to place possessions in storage.

Some key local adaptations allowed the Winnipeg Site to work with local furniture distributors and suppliers to outfit each unit. This required the local team to secure a suitable space in which to display

options and house an inventory. The Housing Plus Warehouse became the hub for MGR staff and the rest of the housing team, and helped ensure the smooth transition of persons randomized into the study and needing housing.



Figure 6: MGR Providing Move-in Support During Winter

6. Conclusion

The AHCS Winnipeg Site offers important lessons for localizing HF using an Indigenous lens and examples of efforts that both leverage and strengthen community capacity. An Indigenous-centered and capacity-building approach was taken early in the proposal and site development processes, through engaging the Winnipeg community in discussion and relationship-building that enhanced the level of trust among all the partners needed to undertake this massive study. This early approach both interrogated HF and the role of the MHCC, and also, and perhaps more importantly, honoured local knowledge holders and their role in impacting the shape of the project.

The Winnipeg model tried to reflect who the population it was aimed at supporting. Indigenous community members represented 70% of the 513 participants in the study, and there was a strong sense among the local leadership as well as the service team and Housing Plus staff, who were on the frontlines delivering supports and services, that people needed to see themselves in the programs and supports to reflect a sense of belonging and better ensure success.

In the early stages of the project, the inclusion of committees such as the Advisory Committee and Aboriginal Lens Committee offered important voices that guided implementation. There is no doubt that this was a key part of the model adopted in Winnipeg, but one that could have been more effectively engaged. One of the biggest challenges was reconciling the fact that AHCS was a large research project with a need and demand in Winnipeg for a community-driven model. This tension was never fully resolved, but it proved to be an important mechanism that helped guide the project and which resulted in the questioning and adaptation of the HF model.

In addition, the Lived Experience Circle, which continues to meet monthly as of July 2018, sets Winnipeg apart from other AHCS sites. The emergence, creation, and expansion of this group is one of the most tangible outcomes of a capacity-driven approach that continues to see PWLE growing and sharing, nearly a decade after AHCS and HF were first implemented.

On the research end of the project, having both a Community Liaison Coordinator as well as a second person attend interviews were local adaptations that were based in relationship-building and which provided a layer of comfort in a complex research project that was often intimidating. The rigorous structure of a randomized controlled trial and the types of questions asked were unsettling for some, and the intention behind the approach and modifications was to humanize the project as much as possible. It was often difficult to balance these two perspectives, but the Winnipeg Site governance structure was designed such that there were familiar and transparent access points, venues, and opportunities for voices from the community and across the Site to be heard. The Winnipeg Site leadership table met regularly, and that table and the fact there were Site Co-Coordinators enhanced

the ability to share and discuss how the project was proceeding and to learn from each other on making improvements.

Finally, a capacity-building and social enterprise lens offers a hopeful example for future HF efforts. Locally, Housing Plus, BUILD, and MGR proved without a doubt that leveraging and building strength in the housing sector by harnessing local expertise is possible. This is one of the most unique and important elements of the capacity-driven approach used in AHCS Winnipeg.

Ultimately, the AHCS Winnipeg Site's approach of embracing and mobilizing local stakeholders was key to the success of its development, implementation, and sustainability. Leadership took many forms but the governance structure provided an important example of how a strong, localized model can guide the implementation of HF. While Winnipeg's model may not suit other jurisdictions, it is important to look inward and set any HF approach within a local context that works for all the communities involved in the implementation and delivery. As we outline in this report, no model is perfect or without wrinkles or tension. This tension, and the debate and discussion around it, is an important aspect of the localization process, and one that must ultimately focus on the wellbeing of those persons being served.

Perhaps it is fitting to close by restating that the goal of a HF team is to assist persons experiencing homelessness become stably housed, while making available a set of individualized supports to help this process along. Orienting all efforts around community members helps ground teams to focus on ending homelessness, one person at a time, using HF as one tool within a broader set of community strengths. Ultimately, ending homelessness is not about HF or models, its about making sure enough people care to take on the challenge and offer hope that there is a way home for all.

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