3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue - SUPPORT

Date Received	Time Created	Subject	Position	Content	Full Name	Contact Info	Neighbourhood	Attachment
07/14/2022	14:46	PH4 - 3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue	Support	Please see the attached letters in support of this rezoning from the staff of Women Transforming Cities. In addition, please see the attached letter regarding Women Transforming Cities' recommendations for maintaining a safe public hearing process by addressing discriminatory language.	Ash Peplow Ball	s.22(1) Personal and Confidential	Unknown	Appendix A
07/14/2022	15:27	PH4 - 3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue	Support	I am in strong support of this rezoning. I'm proud that Vancouver is "a city of reconciliation" but in order to claim that name we must take actions that materially benefits Indigenous people in every decision the city makes. As part of my work with Women Transforming Cities, I research Municipalities' commitments to reconciliation. Many Council member have spoken passionately about reconciliation. Approving this project is a tangible way to take action. In their report to Council, city staff rightly note that 'Indigenous residents are consistently and significantly over-represented' amongst the population who will be served by this building. The project will also include 'culturally relevant healing and wellness services,' which will further Vancouver's goal of being a city of reconciliation. Furthermore, this project is aligned with addressing the Calls for Justice of the national inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG). The inquiry identifies poverty, insecure housing, homelessness, and barriers to services as a contributing factor to violence against Indigenous women, girls, and two-spirit people. If this Council is serious about addressing gendered anti-Indigenous violence, you can demonstrate it by approving more safe and affordable housing and culturally appropriate services''starting with this fully-funded project. Given these goals and context, the location makes perfect sense because it is on the stolen ancestral territories of the S'wx_w'7mesh (Squamish), S'l''lw'ta'/Selilwitulh (Tsleil-Waututh) and x'm''k''y''m (Musqueam) Nations.	Clara Prager		Unknown	No web attachments.
07/14/2022	16:29	PH4 - 3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue	Support	I am strongly in support of the rezoning at the aforementioned address. This council was elected to, among other things, relieve the current housing crisis and its consequences. Approving the application to rezone will accomplish just that.	Aaron Leonard Prager		Mount Pleasant	No web attachments.
07/14/2022	16:31	PH4 - 3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue	Support	I am strongly in support of the application for rezoning at the aforementioned address. This council was elected to, among other things, help relieve the current housing crisis and its consequences. Approving this application will accomplish just that.	Aaron Leonard Prager		Mount Pleasant	No web attachments.

3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue - SUPPORT

07/15/2022	09:27	PH4 - 3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue	Support	Hello Council, we have now heard from over 200 speakers to this issue which safe to say by witnessed by a caller was Rallying the TROUPS to go against this in protest after consultation with BC Housing. this site is pristine and mental health survivors DESERVE this piece of luxurious land just like those who live in KITS and call it home. I am in TOTAL SUPPORT of MPA building this like fir and 7th ave and changing lives for the better. I am a healthcare professional and published writer and entrepreneur thanks to MPA, i couldn't have helped save lives without a HOME. Please don't listen to all that negative hate speech about the disabled, i don't know any more nicer more innocent people than that group. please don't focus on the children as vulnerable we are not harming children violent or pedophiles, this is a real crisis we are NOW in with people continually dying at the hands of drugs and suicide because gregor didn't do what he promised, please greens step up. listen to adriane as she has been most engaged in this and understands having a home to the vulnerable. I respect you, i have been homeless twice now, when i was 29 it wasn't bad as i was so cute and healthy rich people took me in and then at 54 different story, face on cold hard cement and freezing in summer. I have considered MAID because of all the intolerable STIGMA in this world, especially rich and spoiled Vancouver and it absolutely broke my heart listening repetitiously being called down by these Kits people, and mothers, one even crying (give me a break!)...they are crying over money, over lost income on an already expensive house, depreciating because of social housing in their neighbourhood which is by the way OUR neighbourhood. let's build it and move forward in helping the homeless, no community or neighbourhood should be so special as to not have a part of DTES in their back yard!....please read my speech as i spent much time and thought and lived experience on it....it is easy reading. please listen to the vulnerable like me who need reliable sources of homes and not private where you can easily be evicted. This is again not about the children or the VPD. we are not pedophiles or criminals but I am a healthcare professional, who saves lives and only because of capable MPA. with thanks and gratitude s.22(1) RCT CCT BSC (mental health advocate entrepreneur and philanthropist)	s.22(1)	s.22(1) Personal and Confidential	Fairview	Appendix B
07/15/2022	15:20	PH4 - 3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue	Support	I strongly support this application. I am a resident of Kitsilano (renter) and frequently ride by the site on the greenway and go to Delamont Park with my 3 year old son. I encourage more of these types of developments both in the kitsilano neigbourhood and throughout the city. We need more of these supportive/social housing projects as a society.	Cameron White		Kitsilano	No web attachments.
07/15/2022	18:59	PH4 - 3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue	Support	I am dismayed with how many are opposed to this project, but also encouraged that so many have taken an interest in matters that involve best practices in housing this population. I sure hope their support does not wane once a project is no longer proposed in their own neighbourhood/they are no longer directly impacted.	Sarah Pereira (nee Burnell)		Kensington-Cedar Cottage	No web attachments.
07/16/2022	07:14	PH4 - 3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue	Support	I wish to clarify some strong conclusions that Dr Julian Somers has made regarding scattered vs congregate housing. The work that we did together in the Vancouver At Home project did not find significant differences in residential stability among participants who were randomly assigned scattered site housing vs congregate housing at the Bosman Hotel. In fact there were more favourable secondary outcomes among those in congregate housing. While many benefits of HF (which is a harm reduction model) have been demonstrated, I am not aware of definitive evidence demonstrating that scattered models are superior to congregate models. As well, we have to be careful when extending research findings from studies of HF to recovery oriented housing, which can look quite different from contemporary HF models in practice. I would offer that the Vancouver At Home study included participants with severe mental health conditions and/or addiction. The individuals in our city who are vulnerably housed and homeless are heterogenous and the supports they require are highly variable. Many have disabilities. It is important that the supports and programming are in place for the individuals who are housed there to facilitate living with dignity and to reduce stigma and trauma that they experience on a daily basis.	Dr. Anita Palepu		West End	Appendix C

3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue - SUPPORT

07/17/2022	17:35	PH4 - 3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue	Support	I've spent the weekend reading the Ernst Young review of BC Housing cover to cover for the 2nd time (for which I've awarded myself a medal!). I have issues with the review - I think it is seriously flawed and much ado about not much - which I will be relaying to the Province, and the journalists who reported on it separately. The bottomline for City Council is that the review's focus is on internal processes and not the development or operation of social housing projects. What it says about BC Hsg.'s project development is largely positive. Similarly, what it says about BC Hsg.'s project operations is largely positive. The challenges BC Housing faces, and the report addresses (or tries to) are due to its rapid growth (doubling in size in 5 years in response to the affordable housing crisis) combined with the impacts of the Covid pandemic. There is nothing in the EY review that justifies Council rejecting the social/supportive housing project proposed for 8th and Arbutus. BC Housing, and it's non-profit partners have proven track records and I have no doubt that the 8th and Arbutus will be a successful addition to Vancouver's affordable housing.	Cameron Gray	s.22(1) Personal and Confidential	West End	No web attachments.
07/19/2022	09:41	PH4 - 3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue	Support	Hi, I would hope that Council disregards all opposition comments to the Kitsilano proposal as they did for the East Vancouver proposal at 33rd and Knight. They are the exact same concerns so if you're going to disregard/ignore the concerns of East Vancouver residents, you need to disregard/ignore the concerns of Westside residents. I think we can all agree that the eastside has more than its fair share of social housing and its the westside's turn. I vividly recall Mayor Kennedy Stewart saying that all postal codes need to help our most vulnerable residents. So its time to actually act on that. You can't continually treat different sides of the city differently. We all pay taxes and we all care about the neighbourhoods we live in.	Wendy White		Hastings-Sunrise	No web attachments.
07/19/2022	17:49	PH4 - 3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue	Support	I understand that a project is financially supported by all levels of government. This project must proceed.	Karen Dar Woon		Downtown	No web attachments.
07/21/2022	13:56	PH4 - 3. CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue	Support	Coast Mental Health operates over 50 sites across the lower mainland, several are as large as the proposed site. This is a very common scale of housing in Vancouver, though not common in the neighbourhood. t has been proven to be able to support very vulnerable citizens and provide a dignified may of moving forward in their lives. I do hope council supports the project as housing is so critical.	Darrell Burnham		Mount Pleasant	Appendix D

WOMEN TRANSFORMING CITIES.org

APPENDIX A

PO Box 21575, Little Italy
Vancouver, BC
V5L 5G2 Canada
info@womentransformingcities.org

June 29, 2022

Re: CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue

To Vancouver Mayor and Council,

My name is Clara Prager and I'm a project lead with Women Transforming Cities (WTC). As a grassroots, intersectional feminist organization in Vancouver, WTC strongly supports the rezoning at West 8th and Arbutus to provide 129 units of social housing. **Vancouver is facing multiple deadly crises and this project will save lives.**

WTC has conducted extensive engagement with community organisations and equity-deserving residents across the city for our Hot Pink Paper Campaign, an initiative designed to centre the voices of those most often excluded in the upcoming election (see the attached letter from my colleague, Mahtab Laghaei for more information). Throughout this process, we heard repeatedly that housing security is the top issue facing Vancouverites.

People are dying from homelessness in what has been called "the most liveable city". Councillors, you have a responsibility to save people's lives by approving this initiative. That may sound stark, but it's what we've heard from months of community engagement from some of your most at-risk constituents.

Opponents may say that this is not the right location because it's near a park and a school. The way we've designed our city means that *all* housing is near Parks and Schools. Let me remind you that you approved a nearly identical project a few weeks ago, at Knight and King Edward, that was also near a school and daycare. There is a similar project in Marpole across from a sports field regularly used by young children. Housing should be near parks and schools because those are things residents need to live a good life! If we don't build housing near parks, where will we build it? It would be inhumane to relegate low income housing to parts of the city that don't have greenspace.

Opponents may say that this is not the right mix of tenants. May I remind you that the project was initially slated to be 100% shelter rate and was reduced to only half that in order to accommodate some groups' concerns. All of these homes are crucial to solving the housing crisis. But it's the ones with supports that will make the biggest difference to the people who are suffering the most. I'm asking you not to further reduce the number of shelter rate units because we need *all* of these homes to address the scale of the homelessness crisis.

Opponents may say that this housing is not family oriented. But I would say that *all* housing is family oriented. The tenants who will live here have families! Stable housing will allow them to

reconnect with their loved ones. It may even allow parents to regain custody of their children. It will mean that people with complex health conditions will be around long enough to be present at family events, because through stable housing they'll be able to access healthcare. Each room includes a kitchen where tenants can cook a meal for their family. It includes amenity spaces where they can invite their family over and proudly show them their beautiful new home. Again: all housing is family oriented because access to housing saves lives and keeps families together.

Opponents may say that this isn't the right model, or that it's warehousing people, and will somehow harm them. Noone is forcing anyone to live here. I'd suggest that future tenants can decide for themselves whether being housed here is preferable for them and that we give them some agency and not preemptively make that decision on their behalf. If somehow we find the building empty, then we can certainly find other people who would love these studio apartments.

Opponents may say that there aren't enough supports. I was very impressed hearing from staff and the applicants about how they approach providing supports for tenants. They are professionals. They have decades of experience. I trust them to do their jobs and ask that you do too. This project *does* have significant supports that will enable people to have a better quality of life. A vote against the rezoning would be a vote to deny these supports to people who need them. Voting to reduce the number of units is a vote to reduce the number of people who have access to these supports.

Opponents may say that this housing will harm women. But I'd point out that the housing crisis disproportionately impacts women, especially racialized women, and especially women with disabilities. Furthermore, this project is aligned with addressing the Calls for Justice of the national inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG). The inquiry identifies poverty, insecure housing, homelessness, and barriers to services as a contributing factor to violence against Indigenous women, girls, and two-spirit people.

Yesterday, I spoke to a journalist about why Women Transforming Cities supports this project. I told him that the timing of this hearing is poignant: **It's currently the one year anniversary of the heat dome that killed hundreds of people in this province, including many Vancouverites.** Many of those deaths could have been prevented if people had access to safe housing - like the air conditioned units in this building will provide. **One year later, Councillors, you have an opportunity to take a tangible action to prevent that loss of life from occuring again.**

Please do the right thing. Please bring 129 safe, fully funded homes, with life-saving support services, to this city. Your constituent's lives depend on it.

Sincerely,

Clara Prager
Project Lead, Women Transforming Cities

WOMEN TRANSFORMING CITIES.org

APPENDIX A

PO Box 21575, Little Italy
Vancouver, BC
V5L 5G2 Canada
info@womentransformingcities.org

Dear Vancouver City Council,

While a public hearing can be a productive way to hear about the challenges and successes of an application for land use, they often devolve into the demonization of the future tenants, especially when the project is being planned as social or supportive housing.

With the upcoming public hearing for 8th and Arbutus this month, Women Transforming Cities is asking you to improve the process that exists right now.

The City of New Westminster focused on creating a less harmful space by using 'point of order' from all councilors when constituents spoke about the potential future tenants, especially when stigmatizing, racist, and oppressive language was being used. The comments were redirected back to land use as a reminder that all comments about land use and land use alone were welcome.

Comments and discussion about race, ethnicity, mental health status, criminal history, or addiction, need to be quashed.

We ask you to do the same.

We want folks who experience oppression in our communities to have a real voice in decision making. It's the role of council to make this possible at council meetings. Sitting through meetings where one feels demonized and stigmatized by perception of who they might be is silencing.

This is a way to make Vancouver better for equity-deserving genders by having better, less harmful, more inclusive public hearing processes.

Thank you,
The staff team at Women Transforming Cities International Society

APPENDIX A

WOMEN TRANSFORMING CITIES.org

PO Box 21575, Little Italy
Vancouver, BC
V5L 5G2 Canada
info@womentransformingcities.org

June 29, 2022

Re: CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue

To Vancouver Mayor and Council,

My name is Mahtab and I'm a campaign lead for Women Transforming Cities (WTC). WTC supports this project wholeheartedly. We continue to live in a housing crisis, which jeopardises the lives of so many residents every single day. **An emergency such as this one must prompt acute action.** This project is a tangible opportunity for Council to take action on the urgent need for affordable and supportive housing in the City—an issue every single Councillor has said is a priority area of action for them.

During Vancouver's municipal election, we run the "Hot Pink Paper Campaign" to determine what the priority issues are for groups that are made-marginalised because of their identity and ensure their concerns are centred during the election. This involves hearing from as many residents as we can. We attended community events, visited family places, and spoke with individuals and community organisations. **We heard from people who are traditionally omitted from participating civic processes, especially in public hearings such as this one, due to barriers such as time, employment, and care work.** This extensive engagement laid bare just how crucial affordable and supportive housing projects such as this one are.

As part of our engagement process we asked, "*do people feel like they belong in Vancouver? And if not, what is preventing them from feeling like they belong?*"

Unsurprisingly, housing was the top concern for most residents:

- 80% of residents indicated housing as an issue that is most important to them in the October Vancouver municipal election.
- 86% of respondents selected housing & rent affordability as a reason they believe Vancouver is not a city where they belong.
- For Indigenous participants, trans women, and gender non-conforming participants, 100% of indicated housing and rent affordability as the reason they do not feel like they belong in Vancouver.
- When respondents were asked about how they felt about other issues such as safety, mobility, and employment, they told us that housing was at the core and addressing housing would help address those other issues.

Women Transforming Cities does not believe that this is what residents deserve; this is not an acceptable reality from the same city that has identified housing as one of the key themes from the Missing Murdered Indigenous Women and Girls (MMIWG) Calls for Justice review and the Red Women Rising Recommendations Review. **Approving this project is a tangible way to take action on reconciliation and gender equity—to expand affordable and quality housing for as many people as we can.** That starts with ensuring that 129 people can be housed at 7th and Arbutus.

We cannot continue to talk about housing independently from other crises facing our residents. Indigenous organisations, youth, seniors, family places, and other women's organisations told us that they are seeing food insecurity grow in the last few months like never before, and more low-income service users are having to choose between paying rent, and feeding themselves and their families. **Vancouver remains the city with the most services–food programs, recovery centres, and cultural centres. When residents are pushed out of the city due to unaffordability, they lose access to these critical services.** These points were shared by Indigenous youth groups and seniors advocacy groups alike–it is increasingly telling that even organisations who are not specifically working on the issue of housing, stated it as their #1 concern for people who use their services.

While there are those who oppose this project, there are so many others who have, and continue to, express that they need housing now. Housing will make them feel safer. **Housing will make them feel like they belong in this city.** Housing will enable them to stay in this city and keep them close to their family, friends, and the services that they rely on.

This is why WTC urges you to approve these homes and the services that go alongside them.

Sincerely,

Mahtab Laghaei
Campaign and Research Lead
Women Transforming Cities

APPENDIX B

Here is my speech which was too long to say in 5 minutes but thorough as i listened to 224 speakers.

first i have an important question before i begin of mayor stewart.
is this school across the site christian, St augustine ?
“yes”
oh just wanted to confirm so parents with kids going there including workers there are christian?
“yes”
ok because with callers 0-224 it has NOT sounded very christian so far,…to be clear i am christian & vulnerable.….

Also before i begin I speak FOR the vulnerable, which for various obvious reasons are very underrepresented here with this topic, can i please get 10 minutes to say all i need to say in their defence and if not can i please field questions at the end by council so i can be an example and thorough representation of the vulnerable this housing is for, making this thusly somewhat imbalanced process a little more “equal”, one lady had 20 minutes overall whom represented the school?

Ok I will begin…… I am caller 225.

Hi My name is s.22(1) and i am vulnerable.

after listening to 224 callers and their hate stigma and bullying, I think the clear solution first off you can have MPA screen out drug users from the site and house just those with mental and low income and have this as a stipulation being so close to a school. We need this housing , not all mental do drugs!!. use VAT tool like adriane asked about. and MPA can also enforce no drug use outside of building (and as adriane suggested have insite free drugs inside so no drug dealing). fir and 7 th ave is a great example of success. VAT: Vacancy assessment tool.

I would also implore MPA to please make 80-90 one bedroom with allow pets and just for mental without drug use and or no drugs use outside in perimeter. We want to avoid this looking like another SRO in 60 years.

Thank you mayor, and counCIL for your time and consideration.

especially your time. (but this application should be a non issue in chambers).
I voted green party and voted for Kennedy Stewart. I am a voter. Yes i voted for Gregor too.

I STRONGLY STRONGLY SUPPORT THIS APPLICATION & THE APPLICANT MPA & BC HOUSING & THE CITY.

ps EBY knows what he talks about and will be the next premier Of BC.

Adriane I just wish to say you are a super star as you show up for work everyday and WORK, you set an example of service, you put your heart and mind into things, thank you.

why are we here today and so invested with our time and resources: why ask the cOMMUNITY?……why is this one so special?…**..ONE WORD: stigma. RICH KITS.**

also about liability from that lawyer, it doesn't have to be a "perfect system", just that you did try to avoid negligence, so NO LIABILITY CITY.

I Speak TODAY for the Vulnerable:
People are in the gallery clapping and complaining but they have never been homeless.

WHO AM I? …I am brave along with anyone who has slept on the street**.** WE ARE SURVIVORS, not demons or criminals like the kits gallery has made out.

I have put my face on cold hard cement when I was homeless. Have you? This building is better than a cold hard cement sidewalk as a home.

I am a professional international cardiac tech with pre med from UBC and i have bipolar and I put people like you kits residents on treadmills to see if you have a heart attack, my job is to prevent this happening, this is me and my job and i am vulnerable and I have been homeless twice, most recently this past summer because of an illegal lockout, i live on 10k /year for 20 years now. I must emphasize I am not a threat nor a criminal. Just low income and disabled.

I represent the voiceless, the vulnerable, while half the KITS neighbourhood living on 80-120 k/year signed up to speak , i represent thousands who cannot get to their computer, too busy surviving on the streets or in a drug induced state. **I represent thousands , thousands.**
And I have patiently waited to be speaker 245 too, listening to all this stigma and hate speech from parents beforehand, drilled into my sensitive head (and others listening) and furthering cementing stigma which we work so hard to Undo.

We work hard like the gays and indigenous to undo stereotypes and hate.
The Stigma/HATE out there is still huge, we must be strength in numbers like westend was for gays.

MPA SCREENS PEOPLE and no one with criminal records of children will be allowed, i can almost guarantee it.

I live in a private building on s.22(1), 18 years now, near VGH, my landlord is SYLTON management, an asian owner hiring pacific asset management company whom has been trying to evict me the past 10 years because of my mental disability, not my fibrOMYALGIA but because of my bipolar, which bipolar means i am just a little up and a little down. Mike the maintenance guy threatened my life recently and the landlord purposely killed my beloved rescue cat of 14 years last summer with an illegal lockout still going to RTB this september. This PEOPLE is "criminal" and no he doesn't suffer mentally.

remember, i gave gregor robertson his platform for homelessness in 2008. He did nothing. we must move on it now, we need at least 10- 20 of these buildings in around vancouver especially as DTES experiences gentrification.

Most importantly, I speak for all homelesss and vulnerable. They are not able to speak to you today and wait 2-4 weeks to speak and be open like myself who has nothing to lose.
this housing works and so does bc housing and MPA is stellar, the best non profit in Vancouver to help the homeless.

I have now created and redesigned a bra with world patents and am a billionaire in the waiting. this is thanks to housing and MPA. If you like to invest call me.

you will remember me from all the other callers as I struggle, but I am suCCEsssful and it is simply because MPA has supported me.

I went by the spot on June 30 2022 and it is pristine and perfect for this type of housing and what these people, like me , need and DESERVE. Yes deserve.

I speak for and represent the vulnerable and now the rich, and WE NEED to Produce safe HOMES for these not hard to house but rather “unhealthy” (think cancer) individuals.

It is close to broadway, bus routes, the arbutus greenway and bike paths, perfect.
we are not hard to house, rather people in Vancouver don’t want “ it “ in their own Backyard.
people talk about margaret ford in olympic village, there is a success **on fir and 7th 50-60 units we can look to, a great success, all by MPA.**

SAFETY OF children is a non issue and the traffic will not increases, worse case scenario if it increases we work on the roadway and signals.

IF homelessness was cancer as a health issue we would rally around it, however it is rather deeply stigmatized mental health issues and addictions, so we shun them and JUDGE.

I would like questions to cover further these topics in detail:

my experienced eviction attempts by landlord in private housing in Vancouver.
broadway subway implications to all and how vancouver will change dwarfing this project in comparison.
who is MPA and how have they assisted me.
How ALL this stigma & hate (putdowns) affects me and the vulnerable.

Mary burke (cardiac nurse) is my neighbour in my building speaker number 60.
she knows how my building management has tried to evict me.
AND NO people cannot wait , It needs to happen NOW.

She said “they” don’t get enough supports. We have to stop this language of “US” and “THEY” , it is rather “WE”, “We” must find supports, WE MUST HELP.

WE are all in this together, that is why this is a divisive topic is bc people are saying Us and they…..IT IS WE Council. WE as a city must house these poor people who have nothing.

points: (I Have 6 pages and 14 very important points, you can ask me "what are your 14 points" for instance if i don't get thru them)

First of all **SIZE**, A FACT: 50 % is vulnerable tenants, 50% low income HERE. Not 129 to vulnerable.
50-60 units is sanford and is this size , MPA can do this one. Fir and 7th is similar.
like speaker 84 pointed to sanford being Very successful.

Council,
PLEASE ACCEPT THIS APPLICATION OF **ONLY** 129 UNITS - 50 % vulnerable 50% low income TAKING JUST 5 % Vulnerable PEOPLE (humans) off the streets. And please green light similar ones without so much ridiculous exhausting- time- consuming- stigmatizing debate. Remember it is a "WE" issue. WE MUST DO SOMETHING. THE MONEY IS THERE< BUILD IT< LET IT HAPPEN. 10 years ago was too late, we cannot wait 10 more.

1. Homelessness is an issue…a LIVE ISSUE. Has been for over 30 years.
2. I am vulnerable, i am bipolar, these people are like me, we are not pedophiles nor criminals, The principal of the school was way out of line and has never suffered, he deeply stigmatized MY GROUP. This I know.

MPA SCREENS PEOPLE and no one with criminal records of children will be allowed, i can almost guarantee it.

3. SIZE: this is not an "institutional housing project". It is not a warehouse, SRO, it is a HOME. This SIZE IS REQUIRED. 126 beds or MORE, i would add MPA **should** allow pets in this building (to add to health) and make most one bedrooms.

SIZE OF THE BUILDING: just west of this development are a city block of 3 story low rise, hence, not for long as developers have eyed property within 10 blocks of broadway and going to develop towers everywhere along, we have all seen those recent plans, recently approved by council. Everyone will be renovICTED

and I can hardly wait as a billionaire to buy up a block and put in ALL SOCIAL HOUSING and shelters in areas such as KITS.
note: you can't compare marpole with kits size wise to offer green space- marpole has land space, KITS Simply doesn't, vancouver doesn't, we are now hong kong.

4. Housing is the first step to solving issues, it gives stability first and foremost, then jobs, dignity which then leads to drug abstinence and being clean.
5. Integrated housing does not work, landlords work to evict the mental. (happens a lot)

6. Dr. sommers DOES not know “wholly” what he is talking about, he has never been homeless nor survived it. Bigger buildings can work and integration doesn’t AS people still stigmatize.

7. Proper supports are in place for this housing unit and people are indeed screened.

8. who is the applicant? MPA: MOTIVATION, POWER & ACHIEVEMENT.
This is not about young kids. **MPA IS A STAR NON PROFIT and should be supported.**
MPA is the best Non profit housing society in Vancouver.

9. **this is not about children or schools, this is about saving lives, vulnerable lives**, one day they may need this service as mental health is on the rise along with addictions.

INTEGRATION: (redistributing DTES)

**Simply put DTES must be redistributed throughout vancouver IT”S CITY and no body wants an apparent eyesore or Negative energy around them in their “so called OWN Neighbourhoods” where everyone Own’s the neighbourhoods, well drug use is everyones problem as it doesn't discriminate, along with mental health.
Rich and poor fall victim, young and old, healthy or not.**

Let’s embrace them not shun or judge them. STIGMA is the hardest thing I still deal with and I have never touched drugs, nor a child. As I say I am not a criminal. I work in Healthcare & i suffer mentally.

“integration” is spreading these congregate buildings throughout vancouver. Not relying on private for integration. The REQUIRED supports simply are not out there for so called integration into private.

10.

I gave gregor his platform for homelessness in 2008 as he was an MLA, I told him nearly all these homeless are “disabled”, we met over 4 times when everyone was concerned about cambie business, he said “cheryl you are the ONLY One coming in here and talking about this”, I know i said, he ran with it as his platform to win mayor, then he did and did nothing. we all remember gregor , he built up concrete vancouver without any concern for social housing, if I was mayor I would have put 10-15% social housing in each building, then there would now be no homelessness.

THIS IS CITY LAND, which gregor should have pushed this building thru long ago while in power and had majority, Adriane carr will recall me from decades ago speaking to GREGOR in chambers about DTES.

11. STIGMA prevails.

Will this building be PERFECT< no what is, nothing, it will be a work in progress, we must grab the money and run with the PLAN.

I reiterate 1/2 will be for vulnerable, 1/2 for low income. Not 100% vulnerable tenants, MPA can most certainly handle this size and has a proven track record. I can field any questions about MPA and their impact.

Again saying vulnerable are child abusers is akin to saying low income are too- **ridiculous**, look at jeff epstein for THE RICH who prey on vulnerable children?

The opposers are nothing but spoiled, healthy & make 80 k a year , live in a bubble, and are stigmatizing people. I know them well. They worry about "their housing prices" declining. they are educated like me, but I am not like them.
STIGMA IS DANGEROUS, calling mental disabled people akin to pedophiles is like calling transgender like that. It is simply not true.
this is not science, it is emotional to have a place to live, these people have no families to lean on, abandoned.

speaker number 72 the rep from the school, was wrong, it is not a safety issue, i take big issue with her calling me a criminal bc i have mental health issues, i am a healthcare professional, one of the best in the city as my employer once wrote in a letter. I have saved many many lives not harmed children. I say all this stigma is VERY VERY disturbing & dated & INCORRECT. It is simply hate speech (they should actually be arrested for stating such too). Council you must ignore them and step up and be bigger.

I sympathize with parents but they are outright WRONG ON THIS ISSUE.
As I say I represent the homeless and vulnerable and mentally disabled and i don't even have a parking ticket!.

THis is not about young kids. **MPA IS A STAR NON PROFIT and should be supported.**
"WE" REQUIRE THIS SIZE (at bare minimum).

12. THE SCHOOL ISSUE : DTES has schools and you don't hear any harm or reports from there?

13. IT IS SIMPLY THE PUSHBACK " Not in My back yard" **NIMBY**. said over n over repetitiously.
" I am a professional engineer with four kids and Not in MY BELOVED neighbourhood," one guy said …..really you should hear your self righteous self, claiming kits to be YOURS, all YOURS?

14. TOPIC OF VPD:
VPD does not need to be consulted, just like for a mansion. These people are not concerning citizens requiring monitoring by VPD. This is not a drug house or gang reLated.

in closing, i would like Questions, i know we are all very tired after nearly 250 speakers but this is important "we are the vulnerable whom this is FOR and as humans we are all vulnerable".

moreover,

Dr. Sommers said "congregate housing works". and his quote by councillor swanson was correct.

The speaker in pink in chambers, charlene, who talked about families, is way out of line.
speaker 67. She took over 20 minutes.

in conclusion,

Council,
PLEASE ACCEPT THIS APPLICATION OF **ONLY** 129 UNITS - 50 % vulnerable 50% low income TAKING JUST 5 % Vulnerable PEOPLE (humans) off the streets. And please green light similar ones without so much ridiculous exhausting- time- consuming- stigmatizing debate. Remember it is a “WE” issue. WE MUST DO SOMETHING. THE MONEY IS THERE< BUILD IT< LET IT HAPPEN. 10 years ago was too late, we cannot wait 10 more.

this building will stand as “a jewel” in the community and soon dwarfed by development and will be a reminder that council did get “SOMETHING RIGHT” when people see it , especially functioning so well with its human well respected tenants “like myself”, they will certainly get my next vote.I will see it long overdue from gregor days when it should have been done and Greens stand up to gregor to push thru something this Grand.

I am open to all questions (and yes will go on advisory boards) and you can ask me anything as i am an expert at being vulnerable ,
mental and know MPA well, as well as an expert at homelessness (i have helped keep riverview out of developers hands for over 20 years)…….., thank you for your time and concern today, I am not sure why we are here today and it not given the Immediate green light. like gregor should have done decades ago.

AS I SAY there needs to be about 20 more of these thru Vancouver.
There is no longer any green space in this area, you can blame money laundering in BC for housing skyrocketing, i wish that got as much attention as this building.

People are in the gallery clapping and complaining but they have never been homeless.

SIMPLY PUT HOMES SAVE LIVES. They give Dignity and self respect & purpose and this beats personal issues, look how many people drink now, that is addictions. Yes you are addicted.

No one cares about homeless until they are children?….why is this, all these people are someones children.

it is the parents responsibility to educate their children not protect them from the truth & life’s hard reality.

I would encourage them all putting down the mentally disabled and addicted to spend a weekend cooking at the gospel mission DTES for these vulnerable people, put their christianity to work, st augustine is a christian school afterall, they should lead their children by example.

THANK YOU.
love and peace from the vulnerable, no one is immune.
————————-

(more detail about my "private " "integrated" living scenario as a mental person):

I live in a building on s.22(1), near VGH, my landlord is sylTON management, an asian owner who hired pacific asset management company has been trying to evict me the past 10 years because of my mental disability, not my fibrOMYALGIA but because of my bipolar, which bipolar means i am just a little up and a little down.

THe maintenance guy they hired has actually threatened my life last month, this is what you call a criminal his name is Mike. Does he suffer mental disabilities , no, he is just a bad person. The landlord also purposely killed my rescue cat of 14 years this past summer, for which they are facing a present lawsuit. This is criminal.

This is called life, but this so called integrated housing & one should not have to be presented by this in life or housing. I have already been illegally evicted from a so called integrated private building back in 2004 before i found where i live now for the past 18 years, it was because i was mentally ill & stigmatized, full stop.

The Stigma/HATE out there is still huge, we must be strength in numbers like westend was for gays.

BROADWAY SUBWAY IMPLICATIONS: (the future of vancouver)

broadway subway is causing a lot of evictions in the next decade namely me who live on s.22(1), 4 blocks away, along with mary speaker 60 who opposed this application. 13 stories is a non issue and recently a building 4 times this size was approved for corner of broadway and birch where the old denny's was. There will soon be 15 story buildings put in all along broadway and 10 blocks wide surrounding it.

Who is the ApplICANT, Who is MPA, MPA is "motivation, POWER and ACHIEVEMENT".

You will remember me out of all 225 callers to date too.

IT IS SIMPLY THE PUSHBACK " Not in My back yard" NIMBY.

there should be housing separate for families. It is a numbers game

in conclusion,

Council,
PLEASE ACCEPT THIS APPLICATION OF **ONLY** 129 UNITS - 50 % vulnerable 50% low income TAKING JUST 5 % Vulnerable PEOPLE (humans) off the streets. And please green light similar ones without so much ridiculous exhausting- time- consuming- stigmatizing debate. Remember it is a "WE" issue. WE MUST DO SOMETHING. THE MONEY IS THERE< BUILD IT< LET IT HAPPEN. 10 years ago was too late, we cannot wait 10 more.

APPENDIX C

A Randomized Trial Examining Housing First in Congregate and Scattered Site Formats

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Abstract

Objective

No previous experimental trials have investigated Housing First (HF) in both scattered site (SHF) and congregate (CHF) formats. We hypothesized that CHF and SHF would be associated with a greater percentage of time stably housed as well as superior health and psychosocial outcomes over 24 months compared to treatment as usual (TAU).

Methods

Inclusion criteria were homelessness, mental illness, and high need for support. Participants were randomised to SHF, CHF, or TAU. SHF consisted of market rental apartments with support provided by Assertive Community Treatment (ACT). CHF consisted of a single building with supports equivalent to ACT. TAU included existing services and supports.

Results

Of 800 people screened, 297 were randomly assigned to CHF (107), SHF (90), or TAU (100). The percentage of time in stable housing over 24 months was 26.3% in TAU (reference; 95% confidence interval (CI) = 20.5, 32.0), compared to 74.3% in CHF (95% CI = 69.3, 79.3, p<0.001) and 74.5% in SHF (95% CI = 69.2, 79.7, p<0.001). Secondary outcomes favoured CHF but not SHF compared to TAU.

Conclusion

HF in scattered and congregate formats is capable of achieving housing stability among people experiencing major mental illness and chronic homelessness. Only CHF was associated with improvement on select secondary outcomes.

Registration

Current Controlled Trials: ISRCTN57595077.

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Data Availability: In order to protect participant anonymity, the data used in the following analyses are not publicly available. Data access requests can be made by contacting Karen Fryer at kfryer@sfu.ca.

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Competing interests: The authors have declared that no competing interests exist.

Introduction

Housing First (HF) has been implemented internationally to promote recovery among people leaving homelessness with serious mental illness [1–4]. HF involves the provision of supports to clients in market housing (i.e., scattered among existing rental accommodations) with a strong emphasis on the promotion of client choice regarding the process of recovery, including sobriety and engagement with treatment [5; 6]. Outcomes of HF include robust positive impacts on residential stability [7], service costs [8;9], and client satisfaction [1]. The results of multi-centre randomised controlled trials have reported significant differences in housing stability between scattered site HF and usual care, but found an absence of differences on a wide range of secondary and exploratory outcomes including: quality of life; symptom severity; community integration (psychological and physical components); overall recovery; and community functioning [10;11].

As an alternative to the use of scattered sites, congregate HF (i.e., where all accommodations in a building are reserved for program clients) has been implemented in the US [12; 13], Europe [14], and Australia [15:16]. HF in congregate format has produced effective clinical outcomes and cost savings with clients with histories of homelessness and alcohol dependence [17; 18] and has been hypothesized to offer advantages to participants with complex needs including substance dependence [19]. In some jurisdictions, the co-location of clients in a single site may be seen as preferable based on potential efficiencies and economies of scale. However, little is known about the impact of congregate HF on overall recovery or the relative benefits of congregate HF and scattered site HF for clients with mental illness and co-occurring substance use disorders. No experimental trials have investigated these questions. The current study addresses this gap by examining data from a randomised controlled trial which compared the effectiveness of scattered site HF (SHF) and congregate HF (CHF) versus treatment as usual (TAU) for adults with histories of chronic homelessness, current mental illness, and high levels of need for support in Vancouver BC.

The Vancouver At Home study is part of a five-site Canadian project investigating scattered site interventions for people who are both homeless and mentally ill. The five sites shared a common core of measures, and the related outcomes have been reported (10,11). In addition, each site expanded on the common core in order to address distinct research questions related to homelessness and mental illness. In Vancouver, a unique focus was the inclusion of HF in both congregate and scattered site formats.

Aims of the Study: We hypothesized that both SHF and CHF would generate superior outcomes than TAU over 24 months on housing stability (primary outcome) and on the following secondary outcomes: community functioning; community integration; quality of life; recovery; food security; and psychiatric symptom severity. Participants met criteria for longstanding homelessness, serious mental illness, and a high level of need for support.

Methods

Study design and participants

This study was a non-blinded, parallel three-arm randomised trial [20]. Recruitment was conducted with community-based partners (n = 40) representing homeless shelters, outreach teams, mental health and addiction service providers, hospitals, police and justice system diversion programs. Research ethics board approval was received from Simon Fraser University and the University of British Columbia.

Verbal consent was obtained to conduct eligibility screening. Interviews were conducted by trained researchers. Eligible individuals were: at least 19 years old; met criteria for at least one current mental disorder; were absolutely homeless or precariously housed; had moderate or severe disability defined as a score of 62 or lower on the Multnomah Community Ability Scale (MCAS;[21]), as well as at least one of the following: legal system involvement in the past year, substance dependence in the past month, or two or more hospitalizations for mental illness in any one of the past five years. Homelessness was defined as either absolute homelessness (having no place to sleep or live for more than 7 nights and little likelihood of obtaining accommodation in the coming month) or precarious housing (currently residing in marginal accommodation and having two or more episodes of absolute homelessness as defined above in the past year). Current mental illness was assessed using the Mini International Neuropsychiatric Interview 6.0 (MINI; [22]) for the following: major depressive episode; manic or hypomanic episode; post-traumatic stress disorder; mood disorder with psychotic features; and psychotic disorder. Interviewers assessed participants' mental status (e.g., current substance use or psychiatric symptoms) and rescheduled interviews if indicated. Written informed consent was obtained from all participants, with recruitment extending from October 2009 to June 2011.

Randomisation

Randomisation was performed using a centralized computer generated procedure. Interviewers used laptop computers with secure live connections to upload data and receive randomisation results prior to notifying participants of the outcome. Randomisation results were received by interviewers after baseline interviews were completed, and participants randomised to SHF or CHF were directed immediately to service representatives.

Procedures

Services were modeled on the approach developed by Pathways to Housing (PH), including an emphasis on promoting client choice and adoption of a harm reduction ethos and practices in relation to addiction [6]. Training was delivered to service providers by senior personnel from PH. Two structured fidelity assessments were conducted by an external team [6], comprised of representatives from PH, the study funder, and individuals who had experienced homelessness.

For SHF, an inventory of private market rental apartments was developed in a variety of neighborhoods throughout the city of Vancouver. A maximum of 20% of the units in any building could be allocated to the study and participants were provided with a choice of housing units [6]. A housing portfolio manager was responsible for building and maintaining relationships with landlords. Participants in the SHF condition received support in their homes from an Assertive Community Treatment (ACT) team. The CHF condition had on site 24x7 supports comparable to ACT and was mounted in a single vacant building with the capacity to house at least 100 occupants in independent suites but without full kitchens. The building was located in a mixed residential and commercial neighborhood, adjacent to numerous amenities, and was equipped with facilities to support residents, including: central kitchen and meal area, medical examination room and formulary, and recreational areas (yoga, basketball, road hockey, lounge). Tenants were provided with opportunities to engage in part-time work both within the building (e.g., meal preparation, laundry) and in the community (e.g., graffiti removal service). A reception area and front desk were staffed 24 hours. Tenancy in either of the experimental housing conditions was not contingent on compliance with specific therapeutic objectives (e.g., addiction treatment). Program staff in each intervention condition participated in a series of continuing professional development events in person. Subsidies were provided through the study to ensure that participants paid no more than 30% of their total income on rent. Treatment as Usual (TAU) consisted of existing services and supports available to homeless adults with mental illness living in Vancouver.

A team of field interviewers followed participants. Interviewers received in-depth training and supervision in the administration of measures, which were pre-tested with a sample of participants. Interviews were considered ‘on time’ if they occurred within 2 weeks of the designated due date. Participants received C$35 for the baseline interview and C$20–30 for each subsequent interview. Scales were administered in person at 6-month intervals through 24 months and responses entered immediately on laptop computers. Additional brief interviews every 3-months collected details of residential and vocational time-lines. Interviews conducted at 6-month intervals required between 90 to 180 minutes to complete in most cases. A field research office was open daily throughout the study period, and participants were encouraged to drop-in regardless of their interview schedule. Interviewers obtained periodic updates regarding participants’ routines and typical whereabouts, and collateral contact information was obtained in order to facilitate future follow up. Interviews were conducted in various locations based on randomisation arm and participant preference, including participants’ homes, the field research office, and public settings.

Outcomes

The primary outcome for the trial was housing stability over 24 months, based on the percentage of time stably housed, obtained using the Residential Time-Line Follow-Back Inventory (RTLFB). The RTLFB has demonstrated strong psychometric properties in homeless samples [23]. We administered the scale every 3-months in order to enhance accuracy of recall, and participants’ residence status and type was coded for each day during the recall period. As a result we generated a continuous record of housing status for each participant throughout the trial. We defined stable housing on the basis of holding a lease (i.e., tenancy rights) or living in one’s own residence (room, apartment, house or with family) for an expected duration of at least six months. Participants who were living in other housing conditions (the streets, emergency shelters, crisis units, hospitals, jails, etc.) were considered as unstably housed.

Secondary outcomes and their associated instruments were: severity of disability (Multnomah Community Ability Scale (MCAS) [21]), community integration (Community Integration Scale (CIS) [24]); psychiatric symptom severity (Colorado Symptom Index (modified) (CSI) [25]); overall health (EuroQol 5D (EQ-5D) [26]); food security (USDA Adult Food Security Survey Module [27]); substance use (Global Appraisal of Individual Needs, Substance Problem Scale (GAIN-SPS) [28]); quality of life (Quality of Life Interview, 20-item (QoLI-20) [29]); and recovery (Recovery Assessment Scale, 22-item (RAS-22) [30]). Scales for secondary outcomes were administered at 6-month intervals [20], however comparisons were made based on difference scores between Baseline and study end. Safety and adverse events were monitored throughout the study.

Statistical analysis

The primary outcome analysis involved separate comparisons of SHF and CHF with TAU on an end point analysis of housing stability. Our sample size estimate was based on a moderate effect size for the primary outcome (Cohen’s d = 0.5) with significance levels of 0.05 (two-tailed). With no attrition rate and no adjustment for multiplicity, a sample of 64 participants in each study arm would have sufficient power (80%) (Ref 20; 2). The formula ($n_{new} = n/1\text{-}L$) is used to estimate the adjusted sample (n_{new}) to account for the attrition rate (L). With a multiplicity adjustment (two pairwise comparisons: CHF vs. TAU & SHF vs. TAU) and an attrition rate of 10%, the estimated sample size was 87 in each arm. A recruitment target of 100 participants in each arm was planned anticipating a higher attrition rate.

All analyses were based on an intention-to-treat principle. The primary outcome (percentage of time stably housed) was calculated using total number of days in stable residences over 24 months following randomisation as numerator and total number of days in any type of residence (stable or unstable) during the same time period as denominator. Secondary outcome analyses compared change scores, which were calculated as the difference between 24-month and baseline assessments on each measure. Due to the continuous nature of outcome variables, one-way analysis of variance (ANOVA) was used. Following ANOVA, post-hoc pairwise comparisons (SHF vs. TAU and CHF vs. TAU) were performed to evaluate the intervention effect. Dunnett's method was used to correct for multiple comparisons resulting from the multi-arm study design with a single comparison group [31]. If Levene's test for homogeneity of variance was non-significant ($p \geq 0.05$), the overall p value was based on ANOVA test and adjusted p values for pairwise comparisons (SHF vs. TAU and CHF vs. TAU) were based on Dunnett's test. If Levene's test was significant ($p < 0.05$), the overall p value was based on Welch's ANOVA test and adjusted p values for pairwise comparisons were based on Games-Howell test. As measures of the intervention effect, difference scores (percentage of time stably housed over 24-month for the primary outcome, and change scores between baseline and 24 months relevant scales for secondary outcomes) between specific HF and TAU along with 95% confidence intervals were reported. All reported p values were two sided. Because groups were balanced in terms of baseline characteristics [20], outcome analysis with adjustment of covariates was not performed.

Missing data were observed in this study due to invalid (e.g., 'declined,' 'do not know') or skipped responses to specific items/scales, and participants who died, withdrew or were lost to follow up. Missing data for the primary outcome was low (2%) and higher for secondary outcomes (see S1 Table: Follow up completion rate for secondary outcomes). Last observation was carried forward.

For certain instruments (Food Security, GAIN-SPS, RAS), the response 'Do not know' was considered negative or neutral, as appropriate, and used as a valid response to calculate the total scale score. To replace missing responses to specific items, mean substitution was used to obtain the total scores as long as no more than half of the items were missing. Missing baseline values were replaced by the group specific mean.

Sensitivity analysis was conducted among participants with non-missing outcome data and the same analytic method. IBM SPSS Statistics (Version 22.0) was used to conduct these analyses.

This trial is registered with Current Controlled Trials: ISRCTN57595077 (Vancouver at Home Study: Housing First plus Assertive Community Treatment versus Congregate Housing plus Supports versus treatment as usual). In order to protect participant anonymity, the data used in the following analyses are not publically available. Data access requests can be made by contacting Karen Fryer at kfryer@sfu.ca.

Results

A participant flow diagram is shown in the Figure (Fig 1, Participant Flow). A total of 800 individuals were screened and 297 met eligibility criteria and were randomised. In most cases, exclusion was due to ineligibility. The first participant was enrolled on October 19, 2009 and the final participant was enrolled on June 29, 2011. The follow up rate (291 out of 297 participants) for the primary outcome variable (percentage of time stably housed) at 24 months was 98% (SHF: 100%, CHF: 100%, TAU: 94%). Missing data were due to participant deaths (n = 3, within five months of randomisation) and failure to locate participants (n = 3). The number of participant deaths over 24 months (n = 17) did not differ significantly between groups (SHF: 7; CHF: 4; TAU: 6; Log-rank p value = 0.482, see S2 Table: Mortality among 'Vancouver At Home' Participants (n = 297) by study arms), but missing data due to follow-up were higher in the TAU arm.

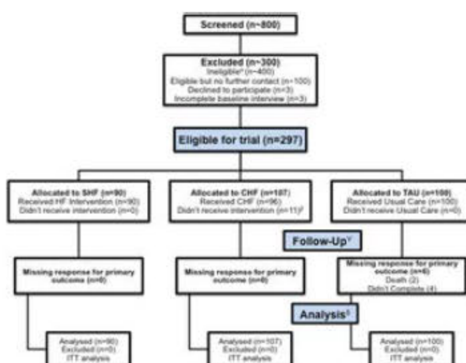

Fig 1. Participant flow through screening, assessment, allocation to study arm, completion of follow-up visits and inclusion in the analysis.
https://doi.org/10.1371/journal.pone.0168745.g001

Participant baseline characteristics by study arm are shown in Table 1. Participants were roughly 40 years old, predominantly male and White, and had not completed high school. Psychiatric status reflected study inclusion criteria, with the majority meeting criteria for a Psychotic Disorder as well as Substance Dependence. On average, participants first experienced homelessness in their mid-twenties, had been homeless for at least 3 years cumulatively, and most reported three or more comorbid physical illnesses.

Variable	CHF (n = 107) N %	SHF (n = 90) N (%)	TAU (n = 100) N (%)
Socio-Demographics			
Age at randomization (years), mean (SD)	40.0 (11.6)	39.5 (10.8)	39.5 (11.2)
Male gender	82 (77)	66 (74)	70 (71)
Ethnicity			
• Aboriginal	21 (20)	11 (12)	12)
• White	60 (56)	53 (59)	57)
• Mixed/Other	26 (24)	26 (29)	31 (31)
Incomplete high school	70 (66)	47 (53)	62 (62)
Single/Never married	76 (72)	63 (70)	75 (77)
Homelessness, median (IQR)			
Lifetime duration of homelessness (months)	36 (12–72)	42 (12–84)	48 (13–108)
Longest duration of homelessness (months)	20 (7–48)	12 (6–40)	12 (6–48)
Age of first homelessness (years)	27 (20–38)	26 (19–35)	24 (18–36)
Absolutely homeless, n (%)	66 (62)	72 (80)	72 (72)
MINI International Neuropsychiatric Interview diagnosis			
Major Depressive Episode	35 (33)	31 (34)	29 (29)
Manic or Hypomanic Episode	25 (23)	23 (26)	20 (20)
Post-Traumatic Stress Disorder	27 (25)	17 (19)	19 (19)
Panic Disorder	20 (19)	15 (17)	24 (24)
Mood Disorder with psychotic feature	20 (19)	17 (19)	19 (19)
Psychotic Disorder	79 (74)	59 (66)	73 (73)
Alcohol dependence	28 (26)	19 (21)	25 (25)
Substance dependence	67 (63)	55 (61)	61 (61)
Suicidality (moderate or high)	34 (32)	28 (31)	31 (31)
Daily drug use	31 (29)	19 (21)	32 (32)
Injection drug use	19 (18)	16 (18)	19 (20)
Comorbid Conditions List (CMC)[1]			
Blood borne infectious diseases[2]	33 (32)	23 (26)	31 (32)
Head injury	66 (62)	62 (69)	63 (63)
Multiple (> 3) physical illness	69 (65)	52 (58)	68 (68)
Secondary/exploratory outcome[3,4]			
Severity of disability (MCAS)	49.90 (6.69)	51.64 (6.52)	50.63 (6.38)
Physical community integration (CIS)	2.10 (1.75)	1.64 (1.47)	1.63 (1.70)
Psychological community integration (CIS)	10.61 (3.68)	11.29 (3.48)	11.10 (3.19)
Psychiatric symptom severity (CSI)	37.12 (12.91)	36.40 (13.34)	40.25 (12.49)
Overall health (EQ5D)	59.48 (23.38)	64.22 (22.65)	62.04 (22.07)
Food security (FS)	4.24 (2.56)	4.29 (2.56)	4.75 (2.41)
Substance use problems (GAIN-SPS)	2.39 (1.64)	2.08 (1.66)	2.29 (1.92)
Quality of life (QOL20)	72.61 (21.69)	76.22 (21.20)	74.72 (21.43)
Recovery (RAS-22)	76.83 (11.26)	80.18 (11.16)	78.85 (10.53)

CI: Confidence Interval; CIS: Community Integration Scale; CHF: Congregate Housing First; EQ5D: EuroQuol 5D; GAIN-SPS: Global Assessment of Individual need-Substance Problem Scale; ITT: Intention-To-Treat; INT: intervention; MCAS: Multnomah Community Ability Scale; QOL20: Quality of Life Index 20 item; RAS-22: Recovery Assessment Scale 22 item; SHF: Scattered Site Housing First; TAU: Treatment As Usual; VAH: Vancouver At Home.

1. Response 'Do not know' was considered as no.
2. Includes HIV, Hepatitis C & Hepatitis B.
3. Missing values were replaced by group mean.
4. Levene's test for homogeneity of variance was non-significant and p value was obtained from One-way ANOVA with equal variance.

doi:10.1371/journal.pone.0168745.t001

Table 1. Characteristics of VAH participants at enrolment visit (randomization).
https://doi.org/10.1371/journal.pone.0168745.t001

Primary outcome

During the 24-month follow-up period, the percentage of time spent in stable housing was significantly higher in both intervention arms compared to TAU (see Table 2). Using the intent to treat sample (n = 297), the intervention effect (mean difference between intervention and TAU condition) was 48.0% (95% Confidence Interval (CI) = 40.0–56.3) for CHF and 48.2% (95%CI = 39.5–56.9) for SHF. Intervention effects using the non-missing sample (n = 291) were 46.4% (95%CI = 37.9–54.8) for CHF and 46.5% (95%CI = 37.7–55.3) for SHF.

	Number of days in stable residence Mean (SD)	Total number of days with housing data[1] Mean (SD)	% of time spent in stable residences Mean (95% CI)	P value for overall comparisons[2]	Intervention effect: difference in % of stable housing (Intervention -TAU) Mean (95% CI)	Adjusted P value for pairwise comparisons
ITT sample (n = 297)[4]						
CHF (n = 107)	509.3 (195.0)	676.1 (116.8)	74.3 (69.3, 79.3)	<0.001	48.0 (40.0, 56.3)	<0.001
SHF (n = 90)	509.0 (188.3)	684.1 (109.2)	74.5 (69.2, 79.7)		48.2 (39.5, 56.9)	<0.001
TAU (n = 100)	181.1 (204.5)	650.6 (164.2)	26.3 (20.5, 32.0)		Reference	Reference
Non-missing sample (n = 291)						
CHF (n = 107)	509.3 (195.0)	676.1 (116.8)	74.3 (69.3, 79.3)	<0.001	46.4 (37.9, 54.8)	<0.001
SHF (n = 90)	509.0 (188.3)	684.1 (109.2)	74.5 (69.2, 79.7)		46.5 (37.7, 55.3)	<0.001
TAU (n = 94)	192.7 (205.6)	650.6 (169.4)	27.9 (22.0, 33.8)		Reference	Reference

CI: Confidence interval; CHF: Congregate Housing First; ITT: Intention-To-Treat; SHF: Scattered Site Housing First; TAU: Treatment As Usual; VAH: Vancouver At Home.

1. Total number of days with housing data didn't differ significantly between groups.
2. Levene's test for homogeneity of variance was non-significant and p value was obtained from One-way ANOVA with equal variance.
3. Dunnet's test was used to adjust for family-wise errors.
4. -Six participants had missing information and were treated as being still homeless for ITT analysis.

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Table 2. Effect of Housing First Intervention on Primary Outcome (percentage of days in stable housing) among VAH participants (n = 297).
https://doi.org/10.1371/journal.pone.0168745.t002

Secondary outcomes

Treatment effects on secondary outcomes are presented in Table 3.

Table 3. Effect of Housing First Intervention on Secondary/exploratory Outcomes among VAH participants (n = 297).
https://doi.org/10.1371/journal.pone.0168745.t003

The mean change in MCAS score (severity of disability) from baseline to 24 months was significantly different between TAU and CHF participants (5.81, 95%CI = 2.69–8.93), but not between TAU and SHF participants (1.66, 95%CI = -1.59–4.92).

Mean change from baseline to 24 months did not differ significantly between SHF and TAU for community integration on physical (0.47, 95%CI = -0.14–1.09) or psychological subscales (-0.34, 95%CI = -1.88–1.20), psychiatric symptom severity (3.82, 95%CI = -0.49–8.12), overall health (-3.34, 95%CI -11.78–5.09), substance use problems (0.38, 95%CI = -0.34–1.10), community functioning (1.66, 95%CI = -1.59–4.92), quality of life (4.51, 95%CI = -3.86–12.89), or recovery (0.05, 95%CI = 3.63–3.74). A difference approaching significance (p = 0.057) was observed for food security and favouring TAU compared to SHF at 24 months (0.99, 95%CI = -0.02–2.01).

Mean change from baseline to 24 months was significantly greater in CHF compared to TAU for psychological community integration (2.53, 95%CI = 1.05–4.01) and recovery (5.58, 95%CI = 1.65–9.50). No differences between CHF and TAU were observed for physical community integration (0.47, 95%CI = -0.14–1.09), psychiatric symptoms (1.68, 95%CI = -2.44–5.80), overall health (1.33, 95%CI = -6.74–9.40), food security (0.99, 95%CI = 0.02–2.01), substance problems (0.24, 95%CI = -0.44–0.93), or quality of life (6.11 (95%CI = -1.91–14.12). The same significant differences favouring CHF were obtained with analyses restricted to non-missing cases (see S3 Table: Sensitivity analysis (non-missing cases) for effect of Housing First Intervention on Secondary Outcomes among VAH participants).

Discussion

HF in both congregate (CHF) and scattered site (SHF) formats achieved markedly superior housing stability compared with TAU over the 24-month follow-up period. Previous studies have reported high rates of housing stability through SHF for people with mental illnesses [32] and CHF for people with alcohol dependence [17]. The current study is the first experimental trial to compare SHF alongside CHF with usual care. Our results demonstrate the nearly equivalent housing stability outcomes associated with both interventions for homeless adults with serious mental illness and comorbid conditions including substance dependence.

We found no evidence of improvement relative to TAU in SHF on any of the secondary outcomes examined. These null findings are consistent with the results of a recent multi-site randomised trial of SHF involving participants selected on the basis of less severe needs [10] as well as an earlier multi-site study reporting that chronically homeless and mentally ill individuals were successfully rehoused yet remained socially isolated with limited improvement in social integration [33]. In contrast, the current trial found that CHF was associated with significant improvement concerning severity of disability, psychological community integration, and recovery. The measures detecting these differences respectively assess subjective experiences of community belonging and participation [23;34;35], subjective appraisal of psychiatric and physical health [36–38], and interviewer assessed level of functioning across multiple domains [21;39]. These secondary outcomes may be interpreted as hypothesis generating and await further research and replication.

Although both SHF and CHF had equivalent complements of service providers, the team supporting SHF provided outreach throughout the city on (at least) a weekly basis. The team supporting CHF worked on site and was able to engage residents as indicated. Additional factors that may have contributed to improvement in CHF were on-site recreational and vocational opportunities, and a supportive peer environment. Qualitative research has found that ongoing substance use and experiences of loneliness and isolation are often reported following the transition to SHF [40–42]. Difficulties transitioning to SHF may explain some of the null findings compared with TAU over 24 months. In contrast, previous research on CHF has identified that shared backgrounds and experiences of residents contributed to a positive sense of community [18].

Analyses of administrative data in the current trial have shown that participants randomised to SHF and CHF interventions had fewer criminal convictions [43] and fewer emergency department visits [44] than those assigned to TAU. Qualitative analyses identified substantial deficiencies in shelter and support services in TAU [42]. Notwithstanding these previous findings, the current results indicate that neither CHF or SHF were sufficient to mediate changes over 24 months in measures of quality of life, overall health, or psychiatric symptom severity, beyond what would be expected from prolonged homelessness with minimal supports. Attention is needed on adaptations to HF that stimulate change in these domains, and on identifying and acting on the factors that predict youth at risk for prolonged homelessness [45–48;49].

At baseline our sample had high prevalence of psychosis (71%) and substance dependence (62%)[20], which are associated with very high mortality risk among the homeless [50;51]. Seventeen participants died during the 24 month follow up, whereas several previous trials of SHF reported no participant deaths over at least 24 months [5;22;52]. We observed no differences in rates of death between study arms, demonstrating that intensive inter-disciplinary interventions were not sufficient to significantly reduce the likelihood of mortality compared to usual care.

Limitations of this research include reliance on self-report. Notwithstanding this limitation, comparison of self-report and administrative data sources within our sample (for justice, health, and social services) revealed high overall levels of agreement [53]. A further limitation is that we are unable to account for potential neighbourhood-level effects in our analyses (i.e., while SHF apartments were dispersed throughout Vancouver, the CHF intervention was necessarily in a single neighbourhood). Our sample of

mentally ill homeless people may not be representative of populations served in other locations. Secondary outcome analyses should be considered exploratory and hypothesis generating. Strengths include an experimental design, well-funded HF with independent fidelity assessments, 24-month follow up, and strong participant retention [20].

Previous research suggests that individuals with active psychosis may respond less favourably to CHF [18]. Further investigation is needed to examine whether individual level characteristics are associated with differing outcomes between CHF and SHF. HF is clearly capable of achieving high levels of housing stability. Nevertheless, recent trials have found that SHF has not resulted in client improvements across a wide range of additional outcomes over 24 months [10;11;54]. Research must now examine adaptations to HF that promote recovery following the advent of housing. The current study contributes to this goal by investigating the relative impact of SHF and CHF compared with TAU for people with serious mental illness, prevalent substance use, and multiple comorbidities.

Supporting Information

S1 CONSORT Checklist.
https://doi.org/10.1371/journal.pone.0168745.s001
(DOC)

S1 Table. Follow up completion rate for secondary outcomes (6-month interval scale)
https://doi.org/10.1371/journal.pone.0168745.s002
(DOCX)

S2 Table. Mortality among 'Vancouver At Home' Participants (n = 297) by Study Arms
https://doi.org/10.1371/journal.pone.0168745.s003
(DOCX)

S3 Table. Sensitivity analysis (non-missing cases) for effect of Housing First Intervention on Secondary Outcomes among VAH participants
https://doi.org/10.1371/journal.pone.0168745.s004
(DOCX)

S1 Protocol.
https://doi.org/10.1371/journal.pone.0168745.s005
(PDF)

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Author Contributions

Conceived and designed the experiments: JMS MP AP.

Performed the experiments: LC SNR KF MP AM AP JMS.

Analyzed the data: AM JMS.

Contributed reagents/materials/analysis tools: SNR.

Wrote the paper: JMS AM MP LC SNR AP KF.

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APPENDIX D

July 21, 2022

Mayor and Council
City of Vancouver

CD-1 Rezoning: 2086-2098 West 7th Avenue, and 2091 West 8th Avenue

I am writing on behalf of Coast Mental Health to support the rezoning application to develop an innovative 13 storey residential building with 129 Social Housing units. Coast as many would know, has been providing specialized supported housing for people with mental illness since 1974, most are in the City of Vancouver and all are in residential neighbourhoods across the City. As you also know, most of our services experienced considerable community pushback and concerns about the risks to the neighbourhood prior to opening. In all cases, those concerns quickly dissipated after the housing opens and the tenants go on to living their lives.

Just last week we celebrated the 11th Anniversary of opening the Dunbar Apartments at 17th and Dunbar. Several tenants spoke at the event about the profound impact on their lives from having safe, affordable housing with appropriate supports https://www.youtube.com/watch?v=kWtbaJbnoN4 . Arthur's story in the Youtube video speaks to the impact. Arthur spoke last week to reaffirm the importance of decent housing.

This is the opportunity Council faces to set the stage for more Arthurs' to enjoy life-changing experiences, to end homelessness for the tenants and allow them to live their lives with dignity. Council has consistently supported these types of programs over the year and I'm sure will find a way to move this desperately needed project forward.

I wanted to specifically address a few concerns that I have read about in the media. The first has to do with the discussion about the learnings from the 4 year At Home/Chez Soi national study on homelessness that was sponsored by the Mental Health Commission of Canada which began in 2009. Coast Mental Health had the privilege of being one of the service providers in the Vancouver study which involved supporting 100 people with complex mental health and addiction problems utilizing a strict Intensive Case Management model. Indeed, MPA Society, the proposed service provider for the proposed site, also was a key participant in the study which demonstrated that rapid access to housing with supports effectively supported the recovery of clients with significant challenges and barriers.

Much has been said about the relative performance of the scattered site clients to those who were housed in the Bosman as part of the congregate model. I can confidently say that the Bosman did not and does not represent congregate housing very well. All of the tenants had very serious and complex challenges, which did frustrate their ability to benefit from some of the services. It is safe to say that the Bosman is an outlier in the world of congregate housing and to compare those outcomes to other congregate housing forms is misplaced. Indeed, even with its challenges, the date indicated that the Bosman did have an overall positive impact on the tenants.

I also want to speak to the size of the project at 129 units. There are many successful projects of this scale throughout the City. I'm pleased to see the design has ample amenity space to engage and support the tenants. The operator, MPA Society, is an experienced and very capable operator. Their operations at 2275 Fir Street which includes a large resource centre serving hundreds of clients and a 70 unit supported housing project operated by Sanford Housing Society. This site serves many more people than the proposed housing complex

and has successfully integrated into the community. So much so that the Community Advisory Committee set up to facilitate its success voted to stop meeting over 5 years ago. MPA has a long and successful attachment in the Kitsilano community and I have every confidence that they will competently manage this project to the betterment of the tenants and the community.

I do appreciate that these are difficult decisions for council, but have confidence that you will, like you have so many times in the past, support this development and make a difference in so many lives.

Best regards,

Coast Mental Health

s.22(1) Personal and Confidential

Darrell J. Burnham,
CEO

Examples:

Figure 1 Pacific Coast Apartments - 96 Units Opened, May 2011

Figure 2 STOREYS - Richmond - 129 Units, including Mental Health Clubhouse, Social Service Centre - Opened 2017

Figure 3 Seymour Place and Coast Mental Health Resource Centre - Yaletown -136 units Opened 2000