

Building for Recovery CMHC Solutions Lab

CHALLENGE BRIEF

Addressing Homelessness and Addiction in Waterloo Region

Porchlight Counselling and Addictions
Overlap Associates

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CELEBRATING 85 YEARS
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PORCHLIGHT
COUNSELLING + ADDICTION SERVICES

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EXECUTIVE SUMMARY

The Building for Recovery initiative aims to shift the dual crises of homelessness and addiction in Waterloo Region by creating a new recovery housing community. Homelessness in the region has surged dramatically, rising from 333 people in 2018 to 2,371 in 2024 (Nielsen, 2021; Koehler, 2024); while substance use and addiction is both a leading cause and consequence of this crisis. National data show that over a quarter of unhoused individuals cite addiction or substance use as the primary reason for losing their housing (Quayum et al., 2021, p.4).

Porchlight Counselling and Addiction Services (Porchlight) currently operates an abstinence-based recovery housing program with only 19 beds, spread across temporary, private-market rented homes. This program only services a fraction of the individuals in the region who are experiencing both homelessness and addiction at any given time. The result is long waitlists for recovery housing and a heightened risk of relapse for those left without stable housing supports.

Building for Recovery proposes to establish a permanent, purpose-built "recovery campus" known as Wanner Village on a 10-acre property owned by Wanner Mennonite Church in Cambridge. Through a phased construction of 2-6 small homes on this site, the project will create up to approximately 60 transitional recovery beds (8-10 residents per home); offering a threefold increase over Porchlight's current capacity. This campus will provide stable, affordable housing in a peaceful, community-supported environment, paired with structured recovery programs and wraparound supports. Initial development plans envision two houses, replacing Porchlight's existing rented homes (relocating 15-19 current beds), with additional homes to expand capacity and serve specialized needs (e.g., second stage recovery, long-term recovery for seniors, or young mothers in recovery).

The Canada Mortgage and Housing Corporation (CMHC) has awarded Solutions Lab funding to this initiative, enabling a rigorous co-design and prototyping process in 2024-2026. Through this process, Porchlight and its partners will develop and test the recovery campus model and create a roadmap to scale it across Canada, informing similar projects nationally.

Starting in mid-2025, the focus will be on planning, securing agreements, and launching the Solutions Lab. Over the project timeline of 2025-2026, the lab will prototype the housing model, explore financing options, and develop a framework

for scaling. Construction of the first home is targeted for 2026-2027, subject to funding and approvals.

Success will mean dozens of individuals at any time living in stable, recovery-oriented homes with integrated supports, breaking the cycle of shelter stays and relapse. It will also mean a validated prototype for recovery housing and a clear path to replicate the model in other communities; ultimately contributing to Canada's goals of increasing housing supply for those in the greatest need.

BACKGROUND

Problem Statement

Homelessness and addiction in Waterloo Region have grown to unprecedented levels, exposing a critical gap in the housing-health continuum. Addiction is now a leading factor in housing loss, yet addiction recovery homes remain severely limited (only ~19 beds in the region), resulting in long waits and high relapse as individuals cycle between treatment and homelessness.

Over the past several years, Waterloo Region has experienced an explosive growth in homelessness, accompanied by a surge in substance use issues among the unhoused population. According to the Region of Waterloo's Point-in-Time counts, the number of people experiencing homelessness increased from 1,085 individuals in 2021 to 2,371 individuals in 2024, representing a 119% increase over three years. This rapid escalation substantially exceeds both provincial and national trends, underscoring the urgency of expanding housing and support systems in the region (Nielsen, 2021; Koehler, 2024). This surge is attributed to a confluence of factors including the affordable housing shortage, rising cost of living, poverty, and the ongoing impacts of trauma and mental health and addiction challenges (Koehler, 2024). Chronic or long-term homelessness is also growing especially rapidly, increasing at roughly 28% per year since 2020 (Koehler, 2024). If this trend continues unabated, the region warns that the number of chronically homeless residents could triple by 2028.

Addiction, in particular, has become both a cause and a consequence of homelessness. In a national point-in-time survey, 25.1% of respondents identified addiction or substance use as a major reason for their most recent housing loss, making it the single most cited cause of homelessness (Quayum et al., 2021, p.4). Conversely, the experience of being homeless dramatically increases the likelihood of using substances. For example, it was found that the proportion of individuals reporting addictions grows from about 19% among those who are homeless for under 2 months, to 28.2% among those who are homeless for over 6 months (Quayum et al., 2021, p.4). In short, homelessness and addiction fuel each other in a cyclical manner, and prolonging homelessness exacerbates substance use while active addiction makes it harder to secure and maintain housing.

This spike in homelessness is straining local services. Emergency shelters in Waterloo Region operate at- or near-capacity (about 83% occupancy on average) and have

been stretched further by a recent influx of refugee claimants in the shelter system (Region of Waterloo, 2023, p.7). In 2023, the region invested roughly $40 million in its homelessness support system (from outreach and prevention to shelters and supportive housing), yet demand continues to outpace resources, and visible encampments have grown as many remain unsheltered (Region of Waterloo, 2023, p.7). Local officials note that Waterloo's experience reflects nationwide trends, where communities across Canada are seeing rising homelessness due to systemic issues like the shortage of affordable housing and the opioid/drug poisoning crisis (Koehler, 2024). These conditions underscore an urgent need for innovative solutions to both house people and support them in addressing concurrent challenges like addiction.

Demographics

Homelessness in Waterloo Region does not impact all groups equally; rather, it disproportionately affects certain populations. In particular, Indigenous peoples are vastly overrepresented among those experiencing homelessness. Indigenous individuals make up only about 1.7% of the region's general population, yet roughly 12% of all chronically homeless people on Waterloo's housing waitlist (PATHS) identify as Indigenous (Region of Waterloo, 2023, p.8). A 2021 point-in-time count similarly found 17% of survey respondents were First Nations, Inuit or Métis (Region of Waterloo, 2021). This mirrors the national picture: despite comprising just ~5% of Canada's population, 35% of homeless individuals identified as Indigenous in recent federal counts (homeless hub, 2025a). Centuries of historical trauma, racism, and lack of culturally appropriate services contribute to this overrepresentation (homeless hub, 2025a). Any effective program must therefore be attuned to Indigenous needs and involve Indigenous leadership to avoid perpetuating colonial harms.

Other marginalized groups are also disproportionately impacted. For example, 2SLGBTQIA+ individuals, especially youth, experience homelessness at far higher rates than their peers. An estimated 25-40% of homeless youth in Canada identify as 2SLGBTQIA+ even though they comprise only 5-10% of the overall youth population (homeless hub, 2025b). Locally, about 10% of people surveyed in Waterloo Region's homelessness count identified as transgender, Two-Spirit, or non-binary (Region of Waterloo, 2021), which indicates that gender-diverse individuals face barriers in the mainstream shelter system. These youth and adults often cite family rejection, discrimination in services, and safety concerns in shelters as factors driving them to the streets (homeless hub, 2025b).

Demographics in Waterloo's homeless population skew toward single adults, but include a mix of ages and backgrounds. In 2021, two-thirds of homeless survey

respondents were men (67%) and about one-third women (30%), and 10% identifying as gender-diverse (percentages total more than 100%, likely as a result of rounding and/or overlapping identity reporting categories used in Point-in-Time counts (Region of Waterloo, 2021). A majority were between ages 26 and 45, though there are also youth under 25 and older adults represented (Region of Waterloo, 2021). Veterans are also a smaller, but notable subgroup; national data suggests around 1-2% of shelter users are military veterans (Housing, Infrastructure and Communities Canada, 2024). Many of those who served in the military are living with trauma or difficulties with transitioning to civilian life. Families with children and those over the age of 65 experience homelessness as well, but in the Waterloo Region they form a smaller portion of the overall homeless cohort compared to single adults. Still, the housing crisis is putting more older adults at risk, like those on fixed-incomes facing rising rents (House of Friendship, 2025). Any comprehensive response must account for diverse needs – from youth fleeing unsafe homes to Indigenous and racialized people facing systemic barriers, to women escaping violence, to veterans and others with complex trauma. This calls for a range of tailored supports within the homelessness-housing system.

The Current System in Waterloo Region

Despite dedicated efforts, the current approaches and resources for homelessness and addiction in Waterloo Region are struggling to keep up, revealing significant gaps. Housing First, the philosophy of rapidly providing housing without preconditions and then offering wraparound supports, has been the core of local and national homelessness strategy for over a decade. Waterloo Region was an early adopter of Housing First programs (starting with STEP Home in 2007) and has expanded it across shelters and outreach services (Region of Waterloo, 2023, p. 53). However, stakeholders report that true Housing First implementation has faltered amid the growing crisis.

In theory, Housing First requires permanent housing plus wraparound supports, but in practice Waterloo's "Housing Stability System has struggled to adhere to a Housing First approach" due to fragmented coordination and a lack of adequate health and social supports integrated with housing (Region of Waterloo, 2023, p. 53). With the explosion of unsheltered homelessness, the system has shifted into "emergency response" mode (managing encampments and crisis shelter overflow) rather than long-term solutions (Region of Waterloo, 2023, p. 53). As one local expert observed, "To say we're a Housing First community is ringing less-and-less true given the lack of wraparound health supports that are inherent to the model and critical to its success" (Region of Waterloo, 2023, p.8). In short, housing alone is not enough if

people cannot access mental health care, addiction treatment, and other supports to stay housed.

The region's current supportive housing capacity (about 570 units with services) is insufficient for the hundreds in need (Region of Waterloo, 2023, p. 31), and wait times for subsidized housing stretch to years (House of Friendship, 2025). This leaves many vulnerable people cycling between shelters, hospitals, and the street, despite the Housing First framework.

Recovery housing refers to abstinence-focused, supportive living environments for people recovering from substance use disorders. Recovery housing is a critical step in the continuum between acute treatment (detox/in-patient and out patient rehabilitation) and independent living. Porchlight's two recovery homes (one for men, one for women) are unique in Waterloo Region in their focus on this piece of the continuum of care. These homes provide a structured, sober living environment with counselling and life-skills support. However, Porchlight's homes are not accessible and rely on rented, and therefore temporary, houses. Together, they accommodate only up to 19 residents and operate out of homes that are physically inaccessible and not designed for this purpose (Dearlove, 2023). Due to rental market pressures, the program has faced relocations and uncertainty, disrupting service continuity. Demand for this program also far outstretches supply: Porchlight reports that it maintains an ongoing waitlist of 1-2 years for a recovery bed (Dearlove, 2023). At current capacity, even if one person "graduates" every few months, it would take decades to serve the hundreds in need.

Many individuals cannot access any recovery-focused housing at all, ending up on the streets, in emergency she lters, or independent or other living situations where drugs-use is prevalent. This gap contributes to high relapse rates. For example, it is common for someone to spend weeks in a treatment facility working toward sobriety, only to exit back into an unsupportive setting where they are surrounded by triggers and temptation (Dearlove, 2023). Unsurprisingly, many quickly fall back into substance use under these conditions. This revolving door between rehab and homelessness is not only devastating for the individuals involved but also extremely costly for a community's overarching response and support system (in terms of repeat detox admissions, hospital visits, policing, etc.).

At the same time, more traditional "treatment-first" models have limitations that create gaps. Transitional recovery housing programs that exist in the region, like Porchlight, offer abstinence-based supportive housing for people transitioning out of residential addiction treatment (Waterloo Region Integrated Drugs Strategy, 2018). These "sober living" homes provide stable, drug-free environments for individuals committed to recovery, such as those waiting to enter rehab or those who recently

completed a rehab program (Waterloo Region Integrated Drugs Strategy, 2018). These housing programs fill a critical gap by giving people a safe place to live while they rebuild life skills and community connections in early recovery (Waterloo Region Integrated Drugs Strategy, 2018). However, access is limited, capacity is small, and the model generally serves those who have already achieved some stability through treatment.

Moreover, harm reduction as a strategy, while life saving, isn't always matched with pathways to recovery. Low-barrier shelters and drop-ins in Waterloo Region allow substance use on site or provide needle exchange and naloxone, aiming to keep people alive and engaged. The "Housing First" approach does not require abstinence, which reduces barriers to getting housed (Palepu et al., 2013). Yet challenges arise when ongoing addiction issues jeopardize housing stability. Some individuals placed in independent units (i.e. scattered-site housing) under Housing First often struggle with isolation, active substance use, and lack of structure, which can result in evictions or abandonment of housing.

The current system has difficulty serving those with the most complex dual challenges of addiction and homelessness. Many are labelled "hard to serve" when they cycle through shelters, treatment programs, and institutions (Johnston Consulting, 2013, p.6). In reality, these individuals often face severe trauma and health conditions. In fact, the average life expectancy of a chronically homeless person with substance use issues is only between 42-52 years of age (Johnston Consulting, 2013, p.6), compared to over 81 years of age for the general population (Statistics Canada, 2024). They require more intensive, coordinated care than either Housing First or short-term treatment alone typically provides.

In summary, neither a purely housing-focused nor a purely treatment-focused model has fully solved the issue. Rather, Housing First has successfully moved people off the streets (in some cities it cut homelessness by 60+% over time) and demonstrated cost savings in reduced shelter and hospital use (Region of Waterloo, 2023, p.53). But its effectiveness depends on housing availability and support services. With housing in short supply (Waterloo Region's rental vacancy is ~3.6% (CMHC, 2025a) and support resources stretched thin, many remain homeless or inadequately supported in housing. Treatment-centric approaches (like abstinence-based transitional housing or residential rehab programs) can yield personal recovery successes and sober living skills. Yet these programs often have limited slots and time-limited stays, and they may not engage people actively using substances who aren't ready or able to maintain abstinence. Those individuals still need help, or they risk drug poisoning, overdose, or continued homelessness.

The integration between health care, addiction services, and housing is incomplete. People who are homeless frequently lack access to primary health care and rely on emergency departments for crises (Johnston Consulting, 2013, p.6). Local data show heavy use of ERs and hospitals by homeless individuals. This is often due to many having nowhere else to recover after surgeries or acute illnesses (House of Friendship, 2025). While the COVID-19 period accelerated efforts to integrate health services into shelter settings, including models like House of Friendship's "ShelterCare," this approach is not new in Waterloo Region. For example, Cambridge Shelter Corporation has partnered with Langs to provide on-site primary care for nearly two decades. These models demonstrate the value of embedding health supports within shelter systems.

Despite these advancements, integration remains inconsistent across the system. Health, housing, and shelter services coordinate in many instances, but gaps in capacity, information-sharing, and continuity of care mean that individuals can still experience discharge to homelessness or difficulty accessing appropriate follow-up supports. Strengthening cross-sector collaboration and resourcing remains critical to preventing people from falling through service gaps. These long-standing integrated care models, whether formalized and branded or community-developed and sustained over years, highlight the need for stable funding and equitable recognition across municipalities. While coordination efforts exist, their scale and consistency do not yet meet the complexity of need in the region.

Fragmented services and program limitations are not unique to Waterloo Region; rather, they mirror a broader pattern across Canada, where well-established models like Housing First, transitional recovery housing, and harm reduction each serve important roles, but also create or perpetuate critical gaps.

Existing Models and Innovations in Ontario and Canada

Across Ontario and Canada, communities have developed various models to address homelessness and addiction. It's important to understand these existing approaches and their challenges in order to build on them:

Housing First (Scattered-Site Permanent Supportive Housing)

This model, widely adopted under Canada's federal *Reaching Home* strategy, provides individuals with immediate access to permanent housing (often apartments in the private market or non-profit housing) without requiring sobriety or program compliance. Ongoing support services (case management, referrals) are offered on a voluntary basis. Housing First has a strong track record of improving

housing stability. For example, the landmark At Home/Chez Soi study in five cities showed Housing First resulted in far greater long-term housing retention for people with mental illness and addictions, compared to treatment-first approaches (as cited by Region of Waterloo, 2023, p.92). It also can reduce public system costs. For instance, one Canadian trial saw a 49% reduction in costs for participants, through less use of emergency services (as cited by Region of Waterloo, 2023, p.97).

However, Housing First's success depends on available affordable housing stock and support capacity. Many Ontario communities struggle with extremely low vacancy rates and high rents (Waterloo's average 1-bedroom rent is now ~$1,776/month (CMHC, 2025b), making it hard to find units for Housing First clients. Even with a rent supplement in hand, many clients are screened out of the private market by landlord gatekeeping mechanisms that Housing First does not directly solve such as requests for current landlord references, acceptable credit scores, proof of savings for first/last month's rent, and informal assessments of whether an applicant will be a "liability" because of mental health, addiction behaviours and substance use histories, or past evictions. Canadian literature consistently flags the following as choke points for placements and tenancy sustainment:

- Credit, references & criminal/eviction history: People emerging from homelessness often lack recent positive tenancy references and have thin or damaged credit files, which landlords treat as proxy risk indicators; where a past eviction or justice-system involvement exists, applicants face categorical refusals. Studies of Canadian Housing First implementations and veteran programs describe these screens as routine barriers, prompting the need for head-leasing/guarantees and proactive landlord engagement to secure units (Forchuk, Richardson, & Atyeo, 2021; Forchuk et al., 2022; Marsella et al., 2020; Vasko & Gaetz, 2024).
- Stigma about mental health and addictions**:** Landlord risk perceptions are amplified when an applicant discloses psychiatric disability, visible trauma, or active/previous substance use. Evidence from Canadian veteran, transitional, and Housing First programs show stigma systematically depresses offer rates even when rent is guaranteed, necessitating peer support, tenancy coaching, and rapid response to concerns to prevent non-renewals (Novac, Brown, & Bourbonnais, 2009; Ray & Forchuk, 2011; Standing Committee on Veterans Affairs, 2019).
- Income instability and benefit delays: Even short bureaucratic lags in income supports (e.g., disability, pensions, rent supplements, etc) derail applications that require bank statements or up-front deposits. Veteran housing research highlights VAC processing delays and health-form requirements as recurrent

obstacles at lease-up and early tenancy, increasing the odds of “screen-out” or move-in failure (Fletcher et al., 2022; Forchuck et al., 2023; Forchuk & Peters, 2023; Veterans Affairs Canada, 2024).

- Harm reduction vs. landlord tolerance: While Housing First adheres to harm reduction, scattered-site tenancies rely on private tolerance for relapse, visitors, and behavioural variability. Programs report that without tightly coordinated wraparound supports, that is, fast clinical response, landlord mediation, and harm-reduction supports, evictions rise and units are lost to the portfolio (Employment and Social Development Canada, 2014; Bourque et al., 2015; Marsella et al., 2020).

Furthermore, if adequate wraparound supports (mental health care, addiction counselling, life-skills support) are not funded and coordinated, tenants may be housed but not healing. Waterloo Region’s experience highlights that insufficient supports undermine Housing First fidelity (Region of Waterloo, 2023, p.8). While harm reduction is inclusive, it can leave a gap for those who desire an abstinence-focused environment for their recovery.

Transitional Recovery Housing (Abstinence-Based)

Abstinence-based “second-stage” recovery homes are designed for people who have completed detox or inpatient and/or outpatient residential treatment and need a structured, sober environment (e.g., house rules, curfews, peer/accountability, life-skills support) and are transitioning into community-based living. While many residents move toward increasing independence, others may continue to access ongoing supports and this continued connection is both common and beneficial in sustaining long-term recovery. In Waterloo Region, Porchlight’s Recovery Supportive Homes align with this model by offering stable, recovery-oriented settings for people actively pursuing sobriety or post-treatment aftercare (program features and target population match what Canadian reviews describe as transitional, abstinence-based housing).

Findings from Canadian evaluations underscore both the contribution and the constraints of this model. Transitional programs can stabilize early recovery and build tenancy skills, but time-limited stays and discharge for relapse are common challenges. While those who need longer to stabilize, or who experience episodic use, risk falling back into homelessness if programs cannot flex around relapse or extend duration (Novac, Brown, & Bourbonnais, 2009; Ray & Forchuk, 2011). A second, persistent constraint is limited capacity relative to need. Even where outcomes are positive, transitional/abstinence-based beds reach only a fraction of eligible clients, particularly people with co-occurring conditions or those exiting institutions, leaving

a gap at the point of "step-down" from treatment (Novac, Brown, & Bourbonnais, 2009; Standing Committee on Veterans Affairs, 2019).

Supportive Housing with Harm Reduction

Permanent supportive housing and Housing First with no abstinence precondition consistently improve housing retention and reduce use of crisis systems when paired with adequate supports (Bourque et al., 2015; Employment and Social Development Canada, 2014; Montgomery, 2013). Canadian program syntheses also show harm-reduction-oriented housing successfully engages people with severe, concurrent disorders who are least well-served by abstinence-only programs (Forchuk, Richardson, & Atyeo, 2021; Forchuk et al., 2022; Marsella et al., 2020).

However, two well-documented weaknesses recur: (1) support intensity is often insufficient in scattered site supportive housing (tenants stabilize housing but not health when clinical/peer supports are thin), and (2) few explicit pathways to abstinence-based recovery for those who want it; tenants may remain safer but not progress toward their personal recovery goals without embedded, goal-oriented programming (Employment and Social Development Canada, 2014; Forchuk, Richardson, & Atyeo, 2021; Forchuk et al., 2022; Marsella et al., 2020).

Integrated Service Hubs

Emerging hub models seek to co-locate basic needs, clinical care, and short-term housing to reduce service silos. Canadian reviews support co-location/integration to improve uptake and continuity (Bourque et al., 2015; Forchuk, Richardson, & Atyeo, 2021). Yet the program design details matter: hubs that exclude core harm-reduction services (e.g., safe consumption, needle exchange) face strong criticism in Canadian literature because removal of low-threshold safety tools reduces engagement and increases preventable harms among people with severe use (Employment and Social Development Canada, 2014; Forchuk et al., 2022).

Community-Specific Initiatives

Across Canada, several population-specific housing and recovery initiatives have emerged in response to persistent gaps within mainstream Housing First and supportive housing programs. These initiatives demonstrate the value of tailoring service design to the lived experiences, cultural contexts, and support needs of priority populations. Lessons from these models offer strong transferability opportunities for the Building for Recovery initiative in Waterloo Region.

VETERANS

Veteran-specific housing models include tiny-home villages (e.g., *Homes for Heroes*), purpose-built supportive housing (e.g., *Veterans' House Ottawa*), and Legion/VETS Canada outreach programs with flexible financial assistance. These models frequently combine peer culture, on-site supports, and risk-transfer strategies (e.g., head leases, damage guarantees), which have been shown to support high tenancy retention and engagement (Bourque et al., 2015; Montgomery, 2013).

The Region of Waterloo has been a local leader through the Ending Veteran Homelessness Initiative, a Housing First and harm reduction-based program, which funds rent supplements through scattered-site placements, outreach, and wraparound supports with an explicit reconciliation and equity focus. As a delivery partner for this initiative, Porchlight has noticed that despite guaranteed rental supplements, Veterans often face landlord screening barriers, including: credit history, references, and eviction records and many require stabilization settings prior to scattered-site tenancy due to co-occurring health and addiction concerns. In response, Porchlight implemented headlease-sublease agreements with private market landlords and property managers.

INDIGENOUS PEOPLES

Indigenous-led housing providers (e.g., *Lu'ma Native Housing Society*, *Na-Me-Res*) offer culturally grounded supportive and transitional housing that integrates ceremony, Elders, land-based healing, and family/community reconnection. Research and parliamentary reviews demonstrate significantly better engagement and housing stability when Indigenous governance and programming are central. The K-W Urban Native Wigwam Project opened 30 new affordable units in Cambridge (2023) for First Nations, Inuit, and Métis households. The Region of Waterloo has also identified Indigenous-led transitional housing as a priority growth area. The scale of Indigenous-led recovery housing remains limited relative to need, and few programs integrate cultural programming with addictions recovery supports.

YOUTH (HF4Y)

Housing First for Youth (HF4Y) is an evidence-based adaptation of Housing First for ages 13–24, emphasizing rights-based access to housing, education and employment supports, and family or natural supports. Canadian research shows HF4Y improves outcomes when paired with intensive, long-term supports (Gaetz, 2017; Gaetz et al., 2023). HF4Y requires more intensive and sustained case management than adult programs, and scattered-site placements are less effective when educational, vocational, and relational supports are weak.

2SLGBTQIA+ YOUTH AND ADULTS

Canada's first 2SLGBTQIA+ transitional housing program, the YMCA Sprott House in Toronto, demonstrated increased safety, belonging, and housing stability for queer and trans youth. National research consistently shows that 25–40% of homeless youth identify as 2SLGBTQIA+, with experiences of family rejection, discrimination, and unsafe shelter conditions contributing to housing instability (as cited by Abramovich, 2020). Specialized programs are concentrated in major urban centres. Many regions lack identity-affirming, trauma-informed, and gender-affirming housing options (as cited by Abramovich, 2020).

WOMEN, CHILDREN, AND SURVIVORS OF GENDER-BASED VIOLENCE (GBV)

Second-stage shelters provide transitional, affordable housing with wraparound Intimate Partner Violence supports. Evaluations show these models reduce revictimization and improve housing stability when paired with legal, child care, income, and trauma supports (Maki, 2020; 2023; End Violence Association of Canada, 2020). Capacity remains constrained, and programs often exclude women with active substance use or complex trauma who still require safe housing with recovery supports.

PEOPLE WITH SEVERE CONCURRENT DISORDERS

Local examples such as Supportive Housing of Waterloo (SHOW) and Thresholds Homes and Supports provide permanent supportive housing with on-site services for people experiencing both mental illness and substance use (SHOW, 2025a). National evidence shows Housing First and Permanent Supportive Housing improves housing stability for this group when support intensity is adequate (Palepu et al., 2013; Peng et al., 2021). Many scattered-site models under-resource peer and clinical supports, and transitions from treatment back into independent tenancies often lead to relapse without sufficient follow-up (Kerman et al., 2018; Manuel et al., 2016).

NEWCOMERS AND RACIALIZED COMMUNITIES

Some supportive housing and Housing First programs have incorporated settlement services, language access, and employment bridging to address the compounded housing barriers faced by racialized and newcomer populations including: credit history gaps, documentation requirements, and discrimination in the private rental market.

Taken together, Waterloo Region's portfolio already includes Housing First and Permanent Supportive Housing, abstinence-based transitional recovery homes, and emerging hub-style integration. Yet placements are throttled by landlord screening

(credit, references, deposits), scattered sites often under-resource support intensity, and abstinence programs still discharge on relapse and often put caps on duration of stay; producing the very cycling we seek to end (Employment and Social Development Canada, 2014; Forchuk, Richardson, & Atyeo, 2021; Forchuk et al., 2022; Novac, Brown, & Bourbonnais, 2009; Ray & Forchuk, 2011).

OLDER ADULTS

Older adults are a growing segment of the homeless population in Waterloo Region and across Canada. Nationally, over one quarter of people experiencing homelessness are over the age of 50, and older homeless adults often experience age-related health issues, such as cognitive and functional decline, 10-20 years earlier than their housed peers (Gaetz et al., 2013; Canadian Observatory on Homelessness, 2021). Substance use is both a cause and a compounding factor: nearly 20% of older shelter users report addiction as a primary reason for housing loss, and many face limited access to age-appropriate treatment (Employment and Social Development Canada, 2019; Ploeg et al., 2008). In Waterloo Region's 2024 Point-in-Time Count, 16% of respondents were age 55 or older, and local providers report that the number of seniors entering shelters has doubled in the past two years, making them the fastest-growing demographic (Region of Waterloo, 2024; Piercey, 2024). Most are aged 50-64 and live on fixed incomes, often unable to afford housing without public benefits (SHOW, 2025b). Many report entering shelter primarily due to substance use and mental health challenges (Region of Waterloo, 2024). Despite some investment in senior-focused supportive housing (Piercey, 2024), older adults in Waterloo continue to face long waitlists, high eviction risk, and few recovery-oriented, age friendly housing options (Piercey, 2024). This highlights the urgent need for targeted, integrated housing and addiction supports.

Conclusion

The Waterloo Region, like many communities in Canada, is facing a systemic shortage of recovery-oriented housing for people with addictions. The status quo leaves a large segment of vulnerable people stuck: too unstable for independent housing, yet ill-served by shelters or Housing First Programs that do not require sobriety. There is a pressing need for innovative housing solutions that integrate addiction recovery supports. The Building for Recovery initiative directly responds to this gap, aiming to increase capacity and create a sustainable model that bridges healthcare and housing. By expanding recovery housing, the project will fill a missing piece in the continuum, providing a stable launchpad for individuals to rebuild their lives.

This aligns with broader policy recognition that housing stability is essential for successful recovery. For instance, federal studies note that people experiencing homelessness account for one in six opioid overdose/drug poisoning deaths in Canada (Morin et al., 2025). The results of this study underlines how life-and-death outcomes hinge on housing and support. Recovery homes offer a proven approach to break this cycle: when provided with supportive housing, individuals in recovery show reduced substance use and improved well-being (Morin et al., 2025), and that most can transition to independent living successfully. For example, Porchlight's own outcomes show over 80% of residents move on to permanent housing in the community (Dearlove, 2023). Expanding on this evidence, Building for Recovery seeks to dramatically scale up the availability of recovery-focused housing as an essential component in addressing homelessness.

Implications for Porchlight

The research and environmental scan confirm a clear and measurable problem: existing housing and addiction systems in Waterloo Region, and across Canada, are insufficiently integrated to meet the complex and intersecting needs of people who experience homelessness and substance use. While established approaches such as Housing First, abstinence-based recovery housing, harm reduction housing, and population-specific housing (e.g., for Veterans, Indigenous peoples, youth, 2SLGBTQIA+ communities, and newcomers/refugees) have individually demonstrated effectiveness, they leave significant gaps at their intersections. These gaps are especially pronounced for individuals who do not fit cleanly into one program model or who need more flexible, long-term recovery supports.

For Porchlight, this creates a strategic opportunity space: to design and prototype a tiered, recovery-oriented housing model that blends the stabilizing peer and community supports of abstinence-based recovery housing with the accessibility and harm-reduction principles of Housing First, while embedding culturally responsive and identity-affirming pathways for priority populations. By doing so, the Building for Recovery initiative can position itself as a nationally relevant model that complements rather than replaces, existing interventions, ultimately creating new connective tissue between silos in the current system.

The problem is clear: Waterloo Region and communities across Canada lack sufficient, integrated recovery-oriented housing options for people who experience both homelessness and substance use challenges, leaving many individuals to cycle between shelters, treatment programs, hospitals, and the street without a stable place to recover. It is well-documented through local data, regional reports, and

national evidence, and can be measured through indicators already tracked by system partners: housing retention, relapse rates, emergency room and hospital utilization, overdoses/drug poisonings, and tenancy stability. Improvement would mean reducing the number of people discharged from treatment or shelters into homelessness, increasing housing retention among high-barrier populations, and creating clear, supported pathways between harm-reduction and recovery. CMHC's own funding streams align strongly with these outcomes, including those related to housing stabilization, upstream prevention, and system transformation.

In designing our prototype, stakeholder engagement will be central. Porchlight will work with partners across housing, health, and social service ecosystems to co-create solutions that reflect lived experience and operational realities. This will include:

- High-impact, low-effort stakeholders such as housing providers, Indigenous-led organizations, and peer support networks, who can shape early program fidelity and cultural grounding;
- High-impact, high-effort stakeholders such as municipal governments, health partners, and provincial funders, whose policy alignment and resource commitments are essential for scaling;
- Individuals with lived/living experience, who will inform design from the outset and guide fidelity to recovery-oriented principles.

The design process will use a structured Design Thinking approach (aligned with CMHC Solutions Lab methodology) to explore two or more prospective solution pathways, each building on key insights from the literature and stakeholder consultations. These may include:

1. A relapse-tolerant recovery campus at Wanner Village that integrates abstinence-based and harm reduction supports in a flexible continuum;
2. A population-specific modular stream (e.g., Indigenous-led, youth/2SLGBTQIA+, veteran) embedded within the campus and transferable to other municipalities;
3. A head-leasing and landlord engagement strategy to unlock units in the private market while reducing risk for both tenants and landlords.

Stakeholder engagement will be designed not only to validate these concepts but to identify additional needs, promising practices, or system levers that may not have been captured in the literature. This will help ensure the prototype is adaptable to different municipal contexts; a key consideration for CMHC investment and national transferability.

Ultimately, the implications for Porchlight are both operational and strategic. Operationally, it means investing in flexible tenancy pathways, layered supports, and culturally responsive programming. Strategically, it means positioning Building for Recovery as a replicable systems-bridging model that will fill a recognized national gap between harm reduction, treatment, and permanent housing. This approach aligns directly with CMHC's goal of fostering innovation that can be scaled or adapted to diverse contexts, creating measurable impact on housing stability and health outcomes across Canada.

METHODOLOGY

Design thinking is a human-centered approach to problem-solving that blends creativity, collaboration, and evidence to create community-driven solutions. This lens draws from best practices across a combination of methods, including Soft Systems Methodology (SSM), Grounded Theory, and Participatory Design Research.

By taking this approach, the work begins with empathy and a deep understanding of the experiences of those at the center of the problem, then structurally moves through cycles of ideation, testing, and refinement.

In the Building for Recovery Solutions Lab, Design Thinking ensures that strategies for safe and culturally relevant solutions are co-created with the community, informed by lived experiences, and tested within real solutions. The resulting strategy will be rooted in people's realities, shaped by their perspectives, responsive to their needs, and designed to create genuine places of healing.

Engagement Activities

During Phase 2 we designed and executed a variety of engagement activities tailored to our different stakeholder groups. The following is a capture of the engagement activities completed. You can find a more fulsome description and listing of our Engagement Activities in our Engagement Plan and Engagement Tracking Document.

- 1:1 Interviews (x15)
- Onsites or Virtual Tours (x4)
- Survey (21 Invites, 3 Responses)
- Pop-Up Engagement Installations (x2 with roughly 10 Participants each)

KEY STAKEHOLDER ENGAGEMENT FINDINGS AND THEMES

Transportation is a major barrier.

Limited public transit creates long travel times for residents attending meetings, appointments, or jobs, contributing to isolation and frustration. Better transportation solutions are a prerequisite for successful recovery engagement.

Space configuration affects dignity, function and accessibility.

Room and home layouts directly influence residents' comfort, privacy, safety, and sense of progress. Participants value shared rooms early in recovery and private rooms as they stabilize. Other design considerations emerged such as keeping the houses as single floor dwellings to improve accessibility, creating adequate storage space and ample space around beds in shared rooms to improve privacy.

Community/common areas are essential to recovery and healing.

Connection and social interaction were described as central to healing. Shared spaces like courtyards, lounges, or multi-purpose rooms foster daily contact and accountability. Additional considerations emerged around centralized meeting spaces for residents to gather, smoke or chat. Designing for Indigneous residents would involve creating indoor and outdoor spaces.

Sober environment is preferred for recovery homes.

Participants emphasized the importance of maintaining substance-free spaces to protect recovery and reduce relapse risk. This standard creates safety and consistency across the housing model.

Program fit and intake screening matter.

Having residents at similar stages of readiness for recovery helps maintain house culture and stability. Poor fit can strain both staff and peers.

Capacity and staffing impact resident support.

Staff shortages limit the quality of support available to residents. Sustainable staffing ratios are necessary for consistent care and the safety of residents. Front-line staff stressed that each house needs adequate staffing; especially if we are considering

mixing genders. Understaffing brings the risk of burnout and liabilities on Porchlight if there are safety concerns. Based on stakeholder input we will be exploring a model that includes at least two on-site staff per 10 residents, use of trained peer workers or volunteers/housing monitors and partnerships with social work/graduate programs.

Access to the network is hard until you're in it.

Many people struggle to find or navigate recovery supports before joining a program. Building awareness and smoother entry points can help reduce the isolation experienced early in recovery.

Costs and rules can unintentionally create barriers.

Financial stress, limited employment access, and restrictions on vehicles create challenges that can undermine recovery. Flexibility and transparency are key.

Cultural belonging and circle practices strengthen recovery.

Culturally grounded approaches—like sharing circles, Elder guidance, and ceremony—create belonging, safety, and shared accountability. These practices are vital for inclusive design.

Feasibility and sequencing expectations are clear to participants.

Participants understand and support a phased approach to development that protects the natural landscape and minimizes disruption. Transparency builds trust in the process.

Program model and funding/income sources will determine sustainability.

Aligning our program model (who we care for and how we do it) will be informed by both community need and the availability of funding sources that target those needs. In our next stages of work, we will need to scan for funding opportunities to match our desired program design. Additionally, making up the balance of cost recovery through other sources of income (i.e. social enterprise) will likely be required and we will need to explore these options.

Resident safety needs to be part of the shared culture.

A crucial area of investigation and design is in creating a safe and healthy environment for program participants. This has implications for the mix of folks that we open the program up to. For example, 1) when exploring the feasibility of having men, women and genders of all kinds together, 2) understanding the implications of having children present if we include single and pregnant mothers in the program,

3) how we might create safety for queer or gender fluid folks based on their room accommodations, and/or 4) how Indigenous and non-Indigenous residents would be best integrated and supported. Our Engagement has uncovered key early learnings, but most importantly has pointed to a substantial amount of work that we need to yet do. Risks that were highlighted during engagement include: co-ed fraternization and romantic relationships between residents.

The current neighbourhood needs to be engaged.

Several sources highlight the need for proactive community engagement, noting neighbour complaints about the program's previous homes. The brief should include a clear community outreach strategy and consider the timing of communications. Early partnership with the church could help endorse the project before public announcements, framing the initiative positively and minimizing potential alarm.

Residents also suggested incorporating small-scale social enterprises such as a drop-in café, dry bar, an ice rink, transportation into town, or workshop space, to both strengthen community ties and generate supplemental income. Income-generating opportunities such as these, could significantly enhance the project's sustainability. A community café or kitchen using the church's existing facilities, trade-skills training for residents through cooking, serving, construction, maintenance work, local transportation initiatives, or partnerships involving animals (e.g., a doggy daycare or collaboration with National Service Dogs to train animals) would offer meaningful engagement for residents while improving community relations and offsetting operational costs

KEY EMERGING TENSIONS / TRADE-OFFS

As we engaged with different stakeholders, we began to identify multiple tensions or tradeoff decisions that we will need to consider in our final solution. These tradeoffs can also be thought of as design considerations or continuums that we might place our solution along. The following table shows four different categories of tensions, names the individual trade-off, gives the contrasting options or extremes of the continuum and finally articulates the design / operational implications.

Cluster	Tension / Trade-Off	Option A	Option B	Design / Operational Implications
GROWTH & SYSTEM INTEGRATION	**Scaling existing program ↔ Innovating on the model**	Grow the number of beds without changing the programming and populations served	Expand and evolve our program offering to tailor to our identified populations (i.e. Older Adults, Indigenous Community, 2SLGBTQIA+, Young and Single Mothers) or expanding the program to include other stages of the addictions recovery journey (i.e. detox)	Creates multiple elements of complexity around program and space design. Also creates potential barriers / opportunities related to funding
	Expansion speed ↔ Community need	Fast rollout to respond to strong community demand. (To give some scale to this, our current program has a 2-year waitlist and other addictions facilities have long waitlist as well)	Slower, phased approach to learn and iterate and ensure resource sustainability.	Impacts Porchlight's operation capacity and capability, the availability of funding/resources, and construction timelines
	Centralized services ↔ Distributed partnerships	All or many supports are located on-site	Residents connect to off-site community partners and supports	Determines staffing footprint, costs, and level of resident independence; affects partnership strategy.

Cluster	Tension / Trade-Off	Option A	Option B	Design / Operational Implications
PROGRAM PHILOSOPHY & RECOVERY APPROACH	**Housing Stabilization Journey ↔ Addiction Recovery Journey**	Residents are accepted directly from homelessness and/or substance use living	Residents are required to attend a detox program and have an initial stabilization of their housing situation before being accepted (closer to the current offering)	The current model leans more toward option B and may be more formalized into a staged approach including: short-term stabilization for clients without housing before moving into the recovery home. Further development of the intake system that matches residents' needs (including trauma backgrounds and stability levels) to the house environment, the use of processing groups to reduce emotional stress caused by changes, and possibly a short-term program track for the most vulnerable.

PROGRAM PHILOSOPHY & RECOVERY APPROACH	**Stability & structure ↔ Choice & agency**	Highly structured schedules and program phases	Self-paced, individualized recovery plans	Impacts staff workload and resident autonomy; balance consistency with empowerment.
	Program fidelity ↔ Cultural flexibility	Standardized curriculum and house rules	Adaptable program integrating diverse cultural and spiritual practices	Determines inclusivity and trust with newcomers, Indigenous, and racialized residents; affects training needs.
	Gender Separate ↔ Co-ed Houses	Gender specific houses at separate locations Similar to the current model. This preserves familiarity and reduces interpersonal risk but can exclude gender-diverse residents or couples and limit flexibility for family visitation.	Integrate all genders and relationship types into one campus or house. This increases inclusivity and replicates real-world diversity but raises safety concerns (e.g., fraternization, relationship breakdowns, attachment-related disruptions, and risk for trafficking or exploitation).	If co-ed, the program would need clear policies and staff support for any relationships/intakes for program fit and policies for safety. Explicit acknowledgment of the risk of co-ed fraternization and propose design/program safeguards (e.g. separate floors or houses by gender, relationship guidelines, dedicated social events, etc) to prevent relationship-related disruptions.

Cluster	Tension / Trade-Off	Option A	Option B	Design / Operational Implications
PEOPLE & STAFFING MODEL	**Professional staffing ↔ Peer / lived-experience leadership**	Clinician-led with formalized case management	Peer-led or co-led with trained lived-experience staff	Influences costs, trust, and authenticity; hybrid models may optimize both credibility and relatability.
	Operating sustainability ↔ Depth of care	Lean staffing, shorter stays, fee-based structure	High staff ratios, long stays, intensive programming	Drives financial feasibility vs. outcomes; dictates funding model and partnerships.
SPACE & LOCATION DESIGN	**Privacy / Individual Spaces ↔ Community / Shared Spaces**	Individual rooms, creating privacy for select individuals	Shared spaces (including bedrooms), communal activities and accountability	Impacts resident experience and property design. Also impacts a key accountability and safety feature of having a roommate during the recovery process. This is of particular importance when considering which populations we serve and how to house them together

SPACE & LOCATION DESIGN	**Urban ↔ Rural Campus location**	Urban or near-transit location	Rural / natural, secluded land-based site	Affects transport cost, accessibility, healing environment and community integration; may require shuttle or satellite supports.
	Christian Faith partnership ↔ Multi-faith / Spirituality accessibility	Church-anchored with shared values. The current model has seen the local church's involvement viewed as an asset (offering spiritual support if wanted)	Explicitly secular, multi-faith, welcoming space. Additionally, a program structure like this would need to acknowledge historical harms / foundations on which this program may be built/the connection to Mennonites, the land, etc., and harms to Indigenous people (by institutions like CMHC) as part of honest engagement.	Shapes perception, funding, and community trust; communications must clarify inclusivity. Option B would also require direct partnership / relationship with local Indigenous or other spiritual leaders.

PROTOTYPE DESIGN PRINCIPLES

These design principles will help us ensure that our solutions are responding to the needs of our stakeholders:

1. **Our solution should** provide reliable access to community (e.g., shuttle/car-share, scheduled rides) where transit is unreliable.
2. **Our solution should** implement rooming that progresses from shared to single occupancy based on time and stability.
3. **Our solution should** keep the recovery homes sober and encourage accountability by fostering community among residents with community programming
4. **Our solution should** include generous common areas (courtyard, lounge, multi-purpose room) to build daily connection.
5. **Our solution should** centre cultural safety and practices (circles, smudging-capable space, Elder presence, sweat lodge).
6. **Our solution should** strengthen intake, safety policies, and screening to support house culture, program fit, and staff capacity.
7. **Our solution should** address affordability and employment access (fees transparency, on-site/nearby work opportunities).
8. **Our solution should** phase construction with minimal disruption to the current residents and neighbours, while protecting valued natural assets (woods, gardens).
9. **Our solution should** include a social enterprise component as it will provide helpful programming and capacity building for residents and contribute to operating costs of the campus.

HOW MIGHT WE STATEMENTS

These HMW statements will be used as the starting points for our solution ideation.

1. **How might we design spaces that promote connection and accountability without compromising personal dignity and privacy?**
    - Draws from *privacy & progression ↔ community connection* and the design principle about shared and single-room progression.

2. **How might we embed cultural and spiritual flexibility into a consistent recovery framework?**
    - Connects to *program fidelity ↔ cultural flexibility* and the "our solution should centre cultural safety and practices" principle.

3. **How might we sustain quality care with limited staffing by blending professional expertise and lived-experience leadership?**
    - Relates to *professional staffing ↔ peer leadership* and *operating sustainability ↔ depth of care*; opens space for hybrid workforce models.

4. **How might we locate or connect homes so that residents experience both the healing power of nature and practical access to jobs, services, and supports?**
    - Balances *local access ↔ land-based setting*; aligns with the transportation and access findings.

5. **How might we communicate the values of our faith-based partnership while ensuring the homes remain inclusive for everyone?**
    - Reflects *faith partnership ↔ secular accessibility*; focuses on language, governance, and symbolic design choices.

6. **How might we phase growth and partnerships to prove the model quickly without losing community trust or connection?**
    - Integrates *expansion speed ↔ community readiness* and *centralized services ↔ distributed partnerships*; frames prototype planning and stakeholder engagement sequencing.

PROJECT PLANNING

The project is divided into five phases spanning from August 2025 - June 2026

Phase 1: Definition (AUGUST - SEPTEMBER 2025)

- Setting scope, engaging partners, and planning the process.

Phase 2: Discovery (AUGUST - OCTOBER 2025)

- Community engagement labs, and research to map challenges and opportunities.

Phase 3: Development (OCTOBER 2025)

- Co-design workshops and early prototypes.

Phase 4: Prototype & Testing (NOVEMBER 2025 - FEBRUARY 2026)

- Testing solutions with residents, affected communities and partners.

Phase 5: Roadmap (MARCH 2026 - MAY 2026)

- Documenting pathways for scaling and sustaining solutions.

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