FRASER VALLEY REGIONAL DISTRICT 2014 HOMELESSNESS SURVEY

Findings, Conclusions and Recommendations

Ron van Wyk, Mennonite Central Committee, BC
Anita van Wyk, Social, Culture and Media Studies, University of the Fraser Valley

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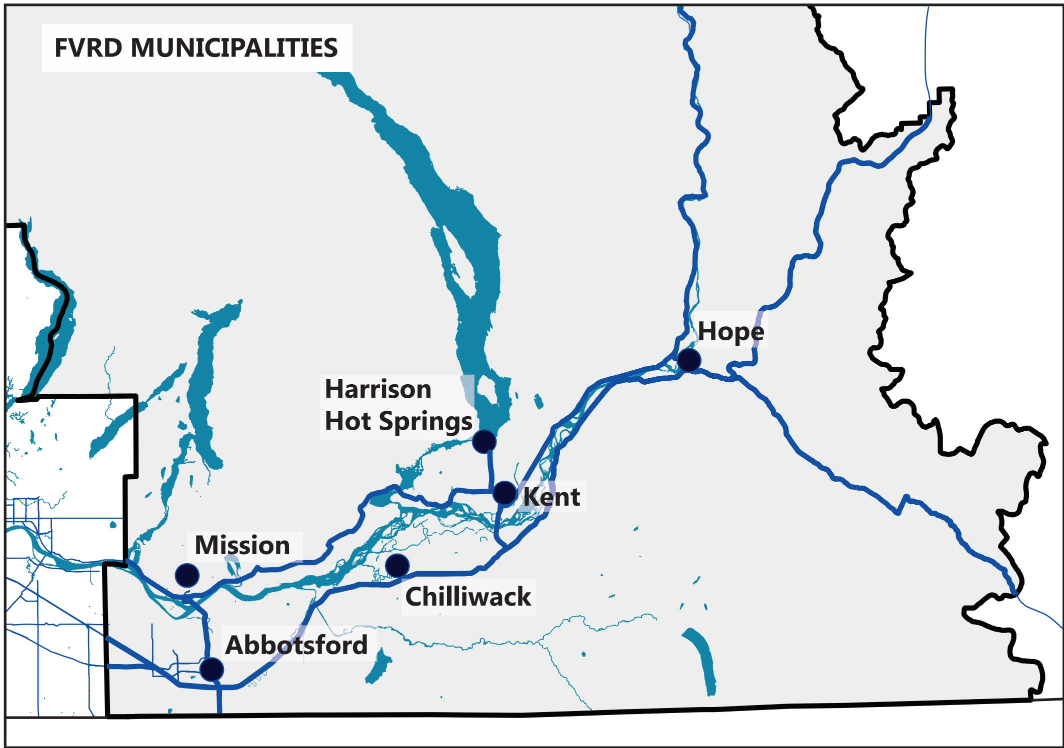

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Executive Summary

BACKGROUND

This 2014 report on homelessness in the Fraser Valley Regional District (FVRD) documents the process and findings, with analysis, of a 24-hour survey conducted March 11 and 12, 2014 in the communities of Abbotsford, Mission, Chilliwack, Agassiz–Harrison Hot Springs, Hope, and Boston Bar–North Bend.

The successful completion of the survey was made possible through the work of more than 50 volunteers, monetary and in-kind contributions from the FVRD, and in-kind contributions, mainly through staff time, from collaborating community agencies.

These are:

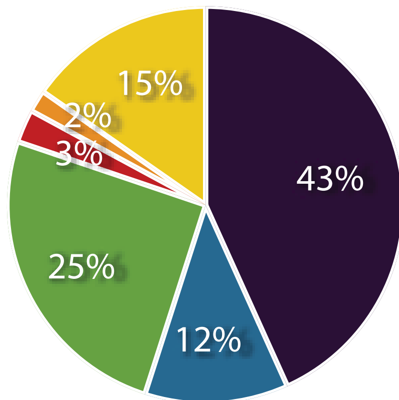
- Salvation Army, Abbotsford
- 5&2 Ministry, Abbotsford
- Abbotsford Community Services
- Cyrus Centre
- Women's Resource Society of the Fraser Valley
- Mission Friendship Centre
- District of Mission, Social Development and Planning
- Mission Community Services Society
- Youth Unlimited, Mission
- Pacific Community Resources Society, Chilliwack
- Salvation Army Chilliwack
- Chilliwack Community Services, Youth Outreach
- Ruth and Naomi's Mission Society
- Ann Davis Transition Society
- Fraser-Cascade School District 78
- Agassiz-Harrison Community Services Society
- Hope and Area Transition Society
- Boston Bar Enhancement Society
- Fraser Valley Regional District
- Fraser Health

"In the context of this survey, homeless persons are defined as persons with no fixed address, with no regular and/or adequate nighttime residence where they can expect to stay for more than 30 days"

FINDINGS

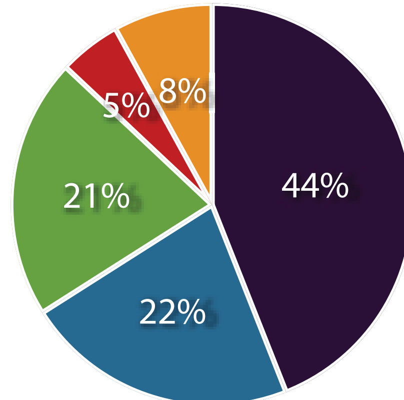
- 346 persons were found to be homeless:
  - 151 in Abbotsford
  - 75 in Mission
  - 73 in Chilliwack
  - 20 in Agassiz–Harrison Hot Springs
  - 22 in Hope plus 5 in Boston Bar

GRAPH 1: FVRD Population Percentages by City/Town



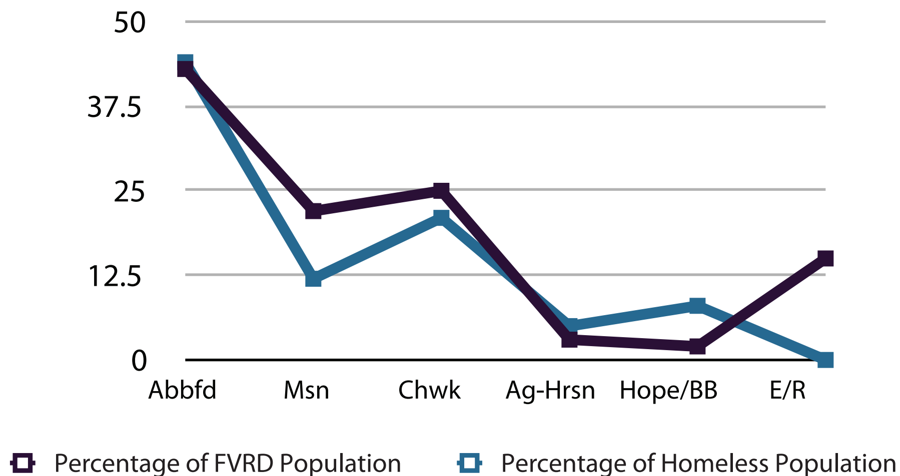
- Abbotsford
- Mission
- Chilliwack
- Agassiz-Harrison
- Hope/Boston Bar
- Electoral/Reserves

GRAPH 2: FVRD Homeless Population Percentages by City/Town



- Abbotsford
- Mission
- Chilliwack
- Agassiz-Harrison
- Hope/Boston Bar

GRAPH 3: Population Percentage and Homeless Population Percentage



Percentage of FVRD Population   Percentage of Homeless Population

ADDITIONAL FINDINGS

- In comparison with 2011, the number of homeless people interviewed in the FVRD has remained stable at 346 compared to 345.
- The numbers of homeless people interviewed have increased in Abbotsford and Mission, but the numbers in Chilliwack and Hope/Boston Bar have decreased while Agassiz–Harrison remained constant.
- Every homeless person has an individual story of his or her path into homelessness. *Structural factors*, such as lack of adequate income and affordable housing, *systems failure*, including transition from facilities or from care, and i*ndividual and relational factors,* such as mental illness, addiction, family dysfunction or disintegration, all contribute to homelessness.
- Lack of affordable housing is directly related to low wages, erosion of the social safety net, insufficient social housing inventory, and increased rental accommodation cost.
- Chronically homeless people are conservatively estimated to be in the 20%-30% range, or 75 100 people. This is higher than the 15 - 20% that is conventionally seen as the percentage of homeless people in Canadian jurisdiction specific homeless populations.
- 37% of respondents, or 112 individuals, experience long-term homelessness (one year or longer).
- 35% of respondents live outside in makeshift shelters or other outdoor places.
- Almost a quarter or 24% of those who live outside indicated a dislike in the emergency shelters as a reason for not accessing emergency shelters. Reasons for "dislike" include "too many rules," "I don't like the rules," "feels too much like an institution," "I don't want to be with addicts and crazy people," etc.
- The total number of shelter beds in the Upper Fraser Valley in 2014 is 141, compared to 64 in 2011, 41 in 2008 and 28 in 2004.
- The total number of beds in transition houses in the Upper Fraser Valley is 71, compared 61 in 2011, 65 in 2008 and 60 in 2004.[1]
- The total number of youth shelter beds is 30 in 2014 compared to 2 in 2011 and 8 in 2008 and 0 in 2004.
- Males constitute the majority of homeless persons, i.e. 60%.
- 45% of homeless persons are in the age category 30-49 years, and 19% are 50 years or older.
- 24% of homeless persons self-identified as Aboriginal (Abbotsford, 32; Mission, 18; Chilliwack, 25; Agassiz-Harrison and Hope, 8).
- Just over half (52%) of the homeless persons have lived in FVRD communities for 6 years or longer.

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[1] For the sake of continuity and comparison with previous reports, this report includes shelter beds, youth shelter beds, and transition beds for women fleeing violence or abuse. For a more complete list of social housing, see the FVRD Social Housing Inventories, available from http://www.fvrd.bc.ca/INSIDETHEFVRD/REGIONALPLANNING/Pages/AffordableHousingandHomelessness.aspx

- Welfare and disability benefits are the source of income for 43% of the homeless persons.
- 41% of the population lives with an addiction to substance use, and 22% live with a mental health issue.
- 26% indicated that they have been impacted by service change or withdrawal. The most common examples cited are “refused welfare” or “being cut off welfare”.

CONCLUSIONS

1. There remains a need for permanent supportive housing based on the housing first approach for those who live with mental illness and/or addiction to substance use; transition (second-stage) housing is also needed for those coming out of treatment and those released from incarceration.
2. Homeless people are subject to stress both because of the factors that made them homeless and because of the experience of being homeless. Poor diet, stress, cold and damp, along with inadequate sleeping arrangements, sanitation and hygiene, increase the risk of health problems and decrease life expectancy.
3. Homelessness in itself is an “agent of disease." As such, homeless people are more exposed to and more likely to develop health problems than the general population, as living conditions predispose them to be particularly at risk of developing ill health.
4. People in FVRD communities who live chronically homeless suffer from a variety of chronic and acute illnesses that are aggravated by life on the streets.
5. Chronic emotional and mental illness complicates daily existence and can mask acute illnesses or prevent people from accessing services and receiving much needed medical care and therefore remains trapped in chronic homelessness.
6. Chronically homeless persons are people who cannot function in housing that assumes independent living without support. They are unable to fit into independent housing and thus get evicted. What this population—also recognized by the term ‘concurrent disorders’—requires is housing that can respond adequately to their needs..
7. The longer a person is homeless, the greater likelihood that preexisting and emergent health problems worsen (including mental health and addictions), and there is greater risk of criminal victimization, sexual exploitation and trauma and a much greater risk of involvement in the justice system.
8. Professional medical attention and community relationships are two key elements of care in relation to people who live homeless. People are more willing to think about treatment and other solutions if they feel trusted and understood. A relationship built on empathy creates a sense of belonging and is critical for people’s well-being. It makes them feel they are worthwhile and can play an active role in their own treatment.
9. In addition to a paradigm shift in the delivery of mental health care, it is also necessary to provide more than surface support such as food, clothing, emergency shelter, soup kitchens, etc. *High-need clients, such as those living with concurrent disorders and who are chronically homeless, require a full integration of mental health and addiction services in addition to health care and housing*. Evidence suggests that the current system of

care picks and chooses instead of offering the whole set of services needed, so clients with the most complex needs get no care and drop out of the system. This reality aggravates the problem of inadequate care for those who live homeless.

10. It is not adequate care for a person with mental and/or substance abuse challenges to be housed without supportive service or to receive services without housing.

11. Housing needs to be inclusive of everything, from housing to medical care to psychiatric treatment to provision of food.

12. Supportive housing, inclusive of psychosocial rehabilitation, is seen as a leading practice in providing services and housing more effectively and efficiently to homeless persons.

13. Housing models must meet the needs of the whole person, with involvement in day-to-day support. It is imperative that participants not be constrained by exit deadlines.

14. A fully integrated system that makes "any door the right door" means that people with concurrent disorders experiencing homelessness can enter the service system through any service door, be assessed, and have access to the full range of comprehensive services and support.

15. The following service strategies or approaches lead to improvements in mental health and substance use disorders among homeless individuals with concurrent disorders:

    - client choice in treatment decision-making
    - positive interpersonal relationships between clients and providers
    - assertive community treatment approaches
    - supportive housing
    - non-restrictive program approaches

16. Supportive case management is indispensable to successful service delivery to people living homeless.

17. Emergency shelters do not seem to be the most effective and efficient way to deal with chronic homeless persons who live with mental health issues and/or substance use addiction. This sub-population needs long-term or permanent supportive housing or housing with professional, wrap around supports.

18. Housing-first models are predicated on the assumption that all individuals, regardless of substance misuse, are entitled to a safe place to live. They are also predicated on the assumption that addiction recovery is more likely to be successful when secure housing is met. Housing-first models encourage clients to seek addiction treatment but do not make it mandatory before housing is provided.

19. The current Canadian response to homelessness relies heavily on emergency responses such as shelters and crisis health care. However, federal funding and community response is rapidly shifting towards Housing First priorities based on the strong body of evidence supporting its effectiveness.

RECOMMENDATIONS

1. FVRD communities must give serious consideration to evidence-based housing solutions inclusive of the housing first approach[2] in policies and practices addressing homelessness in FVRD communities. It is imperative that this is implemented in FVRD communities in order to provide good care and make progress with homelessness reduction.

2. Take immediate steps to move toward the creation of a more adequate housing spectrum through housing first provisioning and more comprehensive and farther in reach mental health and addictions services.

3. Provide 100-150 "Housing First" units across FVRD communities based on the estimated number of chronically homeless persons in each community.

4. Implement Assertive Community Treatment (ACT) Teams in FVRD communities that facilitate an integrated model of care embracing empathetic therapeutic relationship building.

5. Establish a community based housing resource and connect centre that will act as a hub where homeless persons or persons at risk of homelessness can access services and receive counseling and support.

6. Focus community care efforts on establishing a coherent and comprehensive intervention to implement housing and care.

7. Capitalize on and expand by means of partnerships with existing community agencies the reach of housing first options through a scattered site approach (e.g. Raven's Moon Resource Society's Model in Abbotsford).

8. Leverage municipal governments and social service sector to advocate for both an increase in welfare shelter allowance and expansion and lengthening of rent subsidies as part of homelessness outreach and support funding from BC Housing.

9. Approach Federal Government and advocate for federal housing funding for FVRD communities that fall between proverbial cracks in funding streams for greater metropolitan areas and small rural communities. See Appendix 4 for further information regarding funding.

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[2] See Appendix 3

1. Introduction

1.1 Survey Background

Homelessness in the Fraser Valley Regional District (FVRD) has been empirically confirmed in 2004, 2008, 2011, and again in 2014 through tri-annual surveys[3] of people who live homeless (Van Wyk & Van Wyk, 2005, 2008, 2011). The 2014 homelessness survey in the FVRD was completed with the collaboration of the following organizations:

- Salvation Army, Abbotsford
- 5&2 Ministry, Abbotsford
- Abbotsford Community Services
- Cyrus Centre
- Women's Resource Society of the Fraser Valley
- Mission Friendship Centre
- District of Mission, Social Development and Planning
- Mission Community Services Society
- Youth Unlimited, Mission
- Pacific Community Resources Society, Chilliwack
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- Fraser-Cascade School District 78
- Agassiz-Harrison Community Services Society
- Hope and Area Transition Society
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- Fraser Valley Regional District
- Fraser Health

"In the context of this survey, homeless persons are defined as persons with no fixed address, with no regular and/or adequate nighttime residence where they can expect to stay for more than 30 days"

[3] As has been the practice since 2004, and in conjunction with the organizers of the Metro Vancouver tri-annual homeless count, the survey is limited in the number of questions asked in order to keep it manageable given the overall methodological nature of this type of survey.

The same communities included in the 2004, 2008 and 2011 surveys were included in the 2014 survey:

- Abbotsford
- Mission
- Chilliwack
- Agassiz–Harrison Hot Springs
- Hope/Boston Bar–North Bend

See community-specific survey reports at the end of this document for analysis and recommendations for Abbotsford, Mission, Chilliwack, and Agassiz/Hope. Additionally, see the Appendices for information on the context within which homelessness continues to unfold in the Lower Mainland of BC, information on evidence-based housing solutions—including housing with wrap around support—and the housing first approach.

1.2 Survey Objectives

The objectives of the survey were to:

- Determine whether homelessness is increasing or decreasing in the region;
- Provide reliable data to support the work by the FVRD, municipal governments and the social services sector in working toward solutions regarding homelessness including the need for additional affordable and supportive housing in the region;
- Continue to increase awareness and understanding of homelessness and the services and approaches to service delivery that are needed to continue to constructively respond to homelessness by preventing and reducing it; and
- Inform all levels of government, policy makers, and community based organizations about the extent of local homelessness and the need for continued investment by both provincial and federal governments in social housing and concomitant support services in FVRD communities.

1.3 Defining Homelessness

Different definitions of homelessness present considerable obstacles to comparative research and therefore effective problem solving. The federal government has twice worked towards an official definition of homelessness, once in 1999 and once in 2008. The first definition divided homelessness into three, time-based categories of chronically homeless, cyclically homeless, and temporarily homeless (Casavant, 1999). The 2008 attempt also defined homelessness in three categories, but they reflected the state of housing rather than the time unhoused by di-

viding the categories into absolute homelessness, the hidden homeless, and the relative homeless. The latter category is the most controversial and includes those who reside in substandard shelter or who may be at risk of homelessness (Echenberg, 2008).

Citing the need for national clarity on the issue, in September of 2012, the Canadian Homelessness Research Network (CHRN) released an official Canadian Definition of Homelessness. CHRN claimed that without an agreed-upon, national definition, governments and community groups could not effectively work together to address the problem (CHRN, 2012). As part of research for CHRN, Gaetz (2011) conducted a thorough literature review of current and historical definitions in use around the world and particularly in Canada. The Canadian definition most closely resembles the European typology and outlook, with additional Canadian perspective.

The CHRN defines homelessness as "…the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it" (CHRN, 2012). The typological definition includes four categories: **1) Unsheltered**, or absolutely homeless and living on the streets or in places not intended for human habitation; **2) Emergency Sheltered**, including those staying in overnight shelters and shelters intended for those fleeing family violence; **3) Provisionally Accommodated**, which refers to those who lack security of tenure or are temporarily housed (such as "couch surfers" or people in institutional care); **4) At Risk of Homelessness**, referring to people whose current economic or housing situation is precarious and does not meet health and safety standards.

Hulchanski, et al. (2009:6) put forward the following point that reflects a changing socio-economic reality in Canada: "Starting in the 1980s homelessness came to mean a poverty that includes being unhoused. It is a poverty so deep that even poor-quality housing is not affordable. Canada has always had many people living in poverty. But it was only in the 1980s that more and more people found themselves not only poor, but unhoused".

The CHRN definition of homelessness represents progress in providing a national definition of homelessness that reflects the sociological context of being *unhoused*. It provides an opportunity for communities to coalesce around common language that reflects the context and complexities surrounding homelessness.

This study considers two major factors in defining homelessness: the importance of maintaining consistency with previous FVRD surveys and similar research in Metro Vancouver in order to make useful comparisons, and the desire to include the variety of situations in which homeless persons can be found.

Therefore, in the context of this survey, homeless persons are defined as persons with no fixed address, with no regular and/or adequate nighttime residence where they can expect to stay for more than 30 days. This includes persons who are in emergency shelters, safe houses, and transition houses. It also includes those who are living outside and "sleeping rough", in reference to people living on the streets with no permanent physical shelter of their own, including people sleeping in parks, in nooks and crannies, in bus shelters, on sidewalks, under bridges, or in tunnels, vehicles, railway cars, tents, makeshift homes, dumpsters, etc., and those who "couch surf", meaning they sleep at a friend's or family member's place for a night or two or three, then move on to another friend, etc.

1.4 Methodology and Ethical Considerations

A 24-hour snapshot survey method was used to enumerate as accurately as possible the number of homeless people in the FVRD. The survey was conducted on March 11 and 12, 2014, and coincided with a similar survey conducted in Metro Vancouver. Following the research methodology utilized in the 2004, 2008, and 2011 FVRD surveys and prior research in other communities, this survey included nighttime and daytime components for data collection[4].

1.4.1 Methodological Challenges

It is important to note that a 24-hour snapshot survey provides at best only an **estimate** of the number of homeless people at a point in time. It does not capture each and every homeless person. As far as could be ascertained, no known ethical method exists that will provide a 100% accurate number of homeless people in a given region. For reasons mentioned below, surveys to determine an estimate of the number of homeless people are known to "undercount". **Therefore, it is reasonable to assert that in all likelihood there are more homeless people in the FVRD than the number determined by this survey.**

Enumerating homeless persons poses longstanding difficulties. Layton (2008) explains that the problem of counting homeless people, even those who live rough in outside locations, is that the single most important survival tactic is being invisible. This makes it practically impossible to reliably count homeless persons. For example, it is difficult to measure the extent of homelessness in certain sub-populations--such as women with children--who are often invisible homeless persons, since safety concerns precipitate coping strategies that rarely include the visible aspects of homelessness, such as sleeping in public places. Women and children will often couch surf, relying on friends or families, turning to emergency shelters only as a last resort. Therefore, the invisible nature of certain segments of the homeless population makes enumeration difficult.

The homeless estimate in this survey represents only the number of homeless people who were identified by the interviewers over a 24-hour survey period on March 11 and 12, 2014. Although this number is in all probability an undercount of the number of homeless people residing in the FVRD, it nevertheless does provide an indication of the need for additional housing options and thus for planning purposes at municipal government level.

For purposes of further comparison, estimates derived from snapshot surveys may be compared with HIFIS data (Homeless Individuals and Families Information System). As far as could be determined, HIFIS data is not available for FVRD communities included in this survey. In the absence of HIFIS data, researchers can also rely on what is called a period prevalence estimate, which is obtained by arranging with various services providers in the communities under study to keep accurate records, using a standardized form, of the number of homeless people who make use of their services over a period of time, e.g., one year, six months, or three months.

[4] The methodology used in the 2014 FVRD homelessness survey is similar to what was used in 2004, 2008 and 2011 in the FVRD and Metro Vancouver homelessness counts and is recognized across jurisdictions in Canada and USA as ethical, valid and reliable to estimate the number of people who live homeless in a community.

1.4.2 Ethical Considerations

In keeping with the principles of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, this project recognizes that “the end does not justify the means.” In other words, carrying out the survey should not harm any of the people involved (both interviewers and interviewees) physically, emotionally, or financially. The survey should in no way compromise the dignity of the persons surveyed or jeopardize their ability to receive services.

Accordingly, the training of volunteers included this important component and incorporated a discussion of “do’s” and “don’ts” pertaining to confidentiality, non-intimidation, and non-coercion. Furthermore, interviewers applied the following approach to ensure that the survey was conducted in accordance with accepted ethical guidelines:

- Interviewers had to agree to keep shared information confidential, assure anonymity of interviewees, and only interview persons if they freely complied, based on informed voluntary consent.
- Interviewees were clearly informed about the nature of the project and were not deceived in order to elicit a response.
- Interviewers were selected from among people who have experience with people living homeless, an awareness of the realities contributing to homelessness, empathy for persons in this situation, and ease in relating to homeless persons.

2. Extent of Homelessness in the FVRD in2014

2.1 Number of Homeless People in FVRD Communities

The FVRD communities included in the survey were Abbotsford, Mission, Chilliwack, Agassiz–Harrison Hot Springs, Hope, and Boston Bar–North Bend. The total number of homeless people surveyed during the 24-hour period, March 11 and 12, 2014 was 346 persons, distributed across the region in different communities, as shown in Table 1.

TABLE 1: Number of Respondents Surveyed by Community

Community	2014 n	2014%
Abbotsford	151	43.6
Mission	75	21.7
Chilliwack	73	21.1
Agassiz-Harrison Hot Springs	20	5.8
Hope	22	6.4
Boston Bar-North Bend	5	1.4
Total	346	100

Comparing this result with the 2011 survey that enumerated 345 persons as living homeless, indicates that the overall number of homeless persons surveyed in the FVRD remained flat and thus below the number of 465 surveyed in 2008; the highest number to date in the FVRD since the first count in 2004 when 413 persons were counted as homeless. Nevertheless, based on the 2014 survey findings, Abbotsford and Mission have seen an increase in the number of homeless persons while Chilliwack and Hope have seen reduced numbers of people living homeless.

CHART 1: FVRD Homeless Count Totals 2004-2014

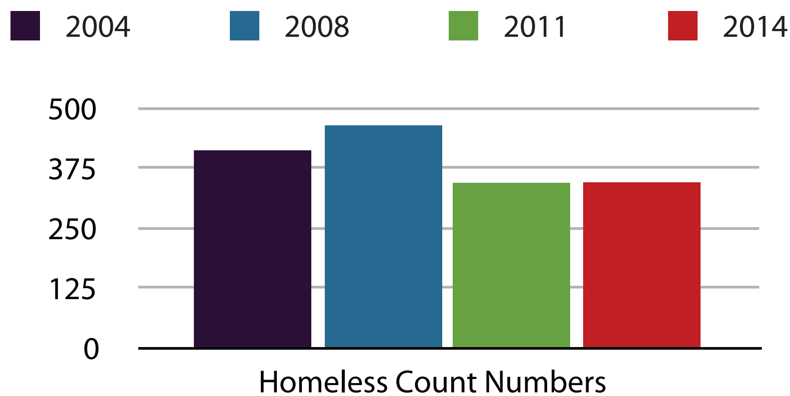
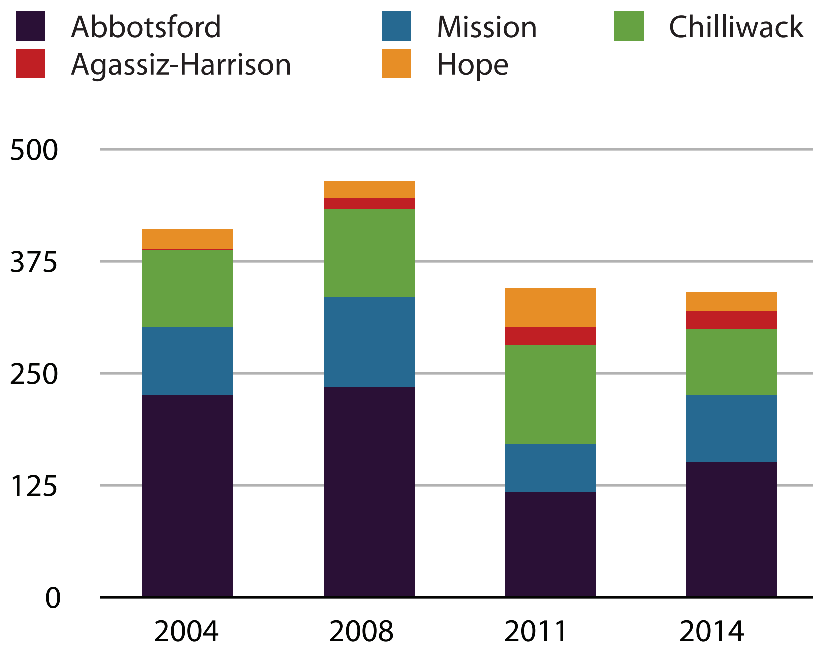
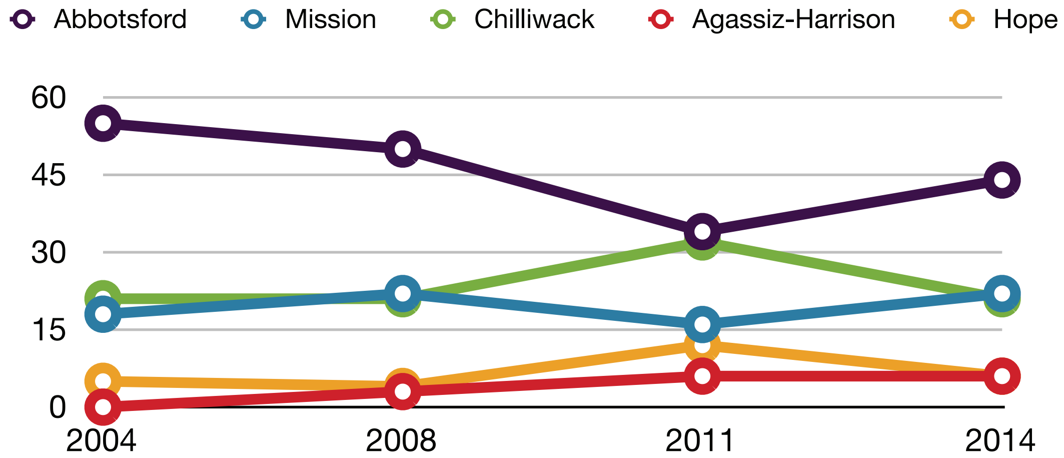


CHART 2: Municipal Homeless Count Totals 2004-2014



As shown below in Graph 4, the proportion of the FVRD's homeless population living in Abbotsford has dropped overall (although it has risen slightly since 2011). Agassiz-Harrison has seen a small but steady increase. Despite aberrations in 2011, Chilliwack, Hope, and Mission have maintained a relatively steady percentage of the region's homeless population..



GRAPH 4: Percentages of FVRD Homeless Population from 2004-2014, by Community

2.2 Reasons for Homelessness

The reasons for being homeless cited by respondents in this survey are reflected in Table 2.

TABLE 2: Reasons for Being Homeless[5]

Reason Given	2014 n	2014%
Inadequate income	211	32.6
Rent too high	116	18.0
Family breakdown/abuse/conflict	89	13.7
Evicted	52	8.0
Health/Disability	11	1.7
Addictions	60	9.3
Criminal history	45	7.0
Poor housing conditions	42	6.5
Pets	8	1.2
Other	12	2.0
Total Response	646	100.0
No Response	42	
Total	688	

[5] Number does not add up to 151 as respondents could check off more than one option.

Half of the respondents (50.6%) claimed that the reason for homelessness related to the issue of affordability, i.e., inadequate income and unaffordable rent, which is an example of a structural cause. A further 13.7% of respondents cited family breakdown/abuse/conflict as the reason for homelessness, followed by health/disability, addictions, criminal history related reasons at 18.0%, and poor housing conditions, pets and "other" reasons combined at 9.7%.

It is evident from the survey results that while personal issues may precipitate homelessness in the Fraser Valley, systemic structural factors play a significant role. Research has shown that there are often precipitating factors leading toward homelessness, including job loss, loss of permanent housing due to eviction, family breakdown, or illness (Buckland et al., 2001, p. 4). Homelessness can result when precipitating factors are compounded by structural and systemic factors such as shifting provincial or federal policy.

Youth "aging out of care" is another important contributing factor, specifically to youth homelessness. A variety of policy issues present barriers to housing for youth leaving provincially-funded foster care. The province withdraws all responsibility for a youth's housing, funding, and support services when he or she turns 19 years old. According to Rutman, Hubberstey, Barlow, and Brown (2005, p. 38) only half (49%) of youth living in foster care in Victoria, British Columbia feel prepared to leave care at the age of 19.

For both youth and women, family violence and/or breakdown are often precipitating factors for homelessness. Family violence, abuse, concurrent disorder, and "aging out of care" are just a few of the personal tragedies that can propel people into homelessness. Without adequate social support, certain segments of the population, most notably the poor, are at increased risk of losing their housing. Once housing is lost, regaining it can be an overwhelming challenge, particularly for persons who suffer from mental, cognitive, or substance addiction challenges. For these people, housing may be more complicated, requiring a comprehensive approach that extends beyond merely providing a roof over one's head.

The Canadian Homelessness Research Network's official Canadian definition of homelessness refers specifically to the reasons behind homelessness: "[Homelessness] is *the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioral or physical challenges, and/or racism and discrimination*. Most people do not choose to be homeless, and the experience is generally negative, unpleasant, stressful and distressing" (CHRN, 2012).

Traditional social policy historically operated on a theoretical understanding of homelessness as a result of personal failing. But despite the theoretical assumption of personal agency, typical solutions did not tend to allow for personal responsibility (Mott, Moore & Rothwell, 2012). In contrast to this approach, much of the academic narrative in recent years follows the structural issues and failings that have contributed to homelessness (Hulchanski, Gaez 2010). Still, solutions exclusively reflecting this approach have little to do with the personal choices of homeless people—even while they offer important systemic evaluation. Most recently, advocates emphasize the interplay of varying factors in their analysis and recommendations. This analysis often includes personal choice and readiness as factors of success.

Current Discourse

Hulchanski et al. (2009 p.5) lay out a detailed historical narrative depicting the rise of the contemporary problem of homelessness as a direct cause of structural changes beginning in the early 1980s. Tax cuts, cutbacks in social programs, and a shift in national government priorities

to home ownership coincided with the dramatic rise of homelessness across Canada. Gaetz echoes this analysis when he writes that "shifts in government policy have led to a cut in support for low-income individuals and families, and a reduction in the affordable housing stock" (Gaetz 2010, p. 21). Family violence, addiction, mental illness, poverty—these factors existed prior to the emergence of the "homelessness crisis." What precipitated the crisis was a confluence of economic and political changes on a structural level.

Some, while agreeing with this analysis, have added an additional, concurrent factor. Judy Graves, long-time advocate for the homeless in Vancouver, states: "Homelessness is not a problem of poverty. It is a problem of prosperity" (Graves, 2014). Graves refers to the financial state of the surrounding community, citing gentrification as a primary cause of increasing marginalization and vulnerability of poorer people. Gaetz also cites increasing prosperity as coinciding, alongside income inequality, with increasing homelessness: "Evidence from Statistics Canada census data shows that while there was an overall increase in wealth over the previous quarter century, this growth has been for the most part concentrated in the upper quintile" (Gaetz 2010, 22). So the question that relates to homelessness is not whether or not government policy works at creating wealth; it is whom it works for. The Organization for Economic Cooperation and Development reports that since the mid-1990s, income inequality in Canada has been on the rise (OECD 2011). This again ties back to structural factors.

To put this into context, the average Shelter to Income Ration (STIR) of households in the greatest core housing need in the FVRD is 50.2. There are 11,000 households in the FVRD spending on average more than half of their income on housing, and this being an average, one can only assume that a significant number of these households are actually spending more than 50% on housing. In contrast, households not in core housing need spend on average 20% of their income on housing.

TABLE 3: Average STIR of Households in Core Housing Need

Community	Households in Core Housing Need	Average Household Income	Average Shelter Costs	Average STIR
Fraser Valley	11,000	$20,679	$811	50.1
Abbotsford	5,300	$21,845	$852	50.0
Chilliwack	2,790	$17,630	$722	51.6
Mission	1,495	$22,459	$893	51.1
Hope	415	$16,671	$658	50.9
Kent	135	$17,607	$709	48.4
Harrison Hot Springs	170	$24,332	$929	48.5

Sources: FVRD, CMHC (census-based housing indicators data[6]

[6] The data in this table is based on 2006 Census data – the most recent data available. The difference between 2001 and 2006 data is minimal. 2011 data is questionable because NHS survey was voluntary and therefore different methodologically from 2006.

The root of the affordability problem and its implication for homelessness is two-fold. First, there has been a steady decline in the number of affordable housing units available in British Columbia over the last 15 years. In many Canadian cities, low cost rental units have been lost to such things as strata conversion and redevelopment, which further decreases the inventory of safe, good-quality, affordable homes (CMHC, 2003). This has resulted in increased rents and increased competition for these limited affordable units. Secondly, as the cost of rent has risen over the last 15 years, the incomes of people in the lowest socio-economic bracket have stagnated. The result is a vulnerable population that cannot afford housing in British Columbia and across Canada. This devastatingly high STIR can partially be explained by the dramatic increase in the market price of housing (fueled by low interest rates and a growing economy) that has driven up the subsequent price of rents. As rents have gone up, the number of available rental units has declined.

The CMHC (2008) has identified people living alone, female lone parents, renters, immigrants, and aboriginals as being statistically more likely to be part of the population that experiences unaffordable housing. It is also known that social assistance recipients make up a very high proportion of high-risk renter households (Buckland et al., 2001). Rules and regulations that govern social assistance benefits can also make it difficult for homeless individuals to find permanent shelter. In this regard, Buckland et al. (2001) state: “Frequently, the exhaustion of financial assets is an a priori condition of receiving any financial assistance, yet this creates an additional hurdle for homeless individuals who cannot otherwise accumulate enough resources to cover first and last month’s rent” (p. 13–14).

Buckland et al. (2001) sum up the economic structural constraints upon homelessness, focusing on the relationship between inequality and polarization, by stating that polarization “helps explain why homelessness and core housing needs appear to have continued to grow in the mid to late 1990s, notwithstanding rising average incomes and an expanding total housing supply” (p. 11). Polarization deepens low incomes at one end of the income distribution and raises affluence at the other. This in turn affects housing through gentrification and the conversion of low-cost housing to high-end housing. In other words, while the housing supply has increased for higher-income households, the supply of low-cost housing has decreased for low-income households, creating a housing crisis that has resulted in increased homelessness.

Nevertheless, structural factors are not the only considerations in the current discourse. Calgary outlined a comprehensive set of causes of homelessness in its 10 Year Plan to End Homelessness that arose from extensive research and advocacy among the homeless community. Calgary experienced more than a 700% increase in its homeless population from 1992-2008; its plan provides an instructive and vested analysis (Calgary Homeless, 2). The report asserts that there is no one pathway to life on the streets; rather, *homelessness results from a combination of systemic and environmental conditions plus a cumulative series of risk factors and triggering events* (Calgary Committee, 21). Risk factors include poverty, addiction or mental illness, physical disability, family conflict, time in foster care, and a lack of education and supportive relationships. Triggering events can include a financial or health crisis, family conflict, unchecked addiction and mental illness, or crime—either as victim or perpetrator. The Calgary analysis also includes factors that lead to the “trap” of chronic homelessness, including employment and system barriers, emergency shelter environment, and lack of affordable housing (Calgary Committee, 21).

In an extensive report on the State of Homelessness in Canada in 2013, Gaetz et al state the cause of homelessness as “an intricate interplay between structural factors, systems failures and individual circumstances” (Gaetz et al, 13). *Structural factors* are economic and societal

issues such as a lack of adequate income, access to affordable housing, or the experience of discrimination. *Systems failures* can include difficult transitions from various facilities and institutions or the lack of support for immigrants and refugees. *Individual and Relational factors* refer to personal circumstances such as traumatic events, personal crisis, or mental health and addictions challenges. Thus, Gaetz seems to make a distinction between the structural reasons of "how we got here" (Gaetz 2010) to the complex interplay of factors that now determine "how we stay here" (Gaetz et al).

Most recently, in April 2014, the Mental Health Commission of Canada released its At Home/ Chez Soi research demonstration project. The project followed more than two thousand participants for two years; it was the world's largest trial of Housing First and covered 5 major Canadian cities. Mental illness was a prerequisite for qualifying as a research subject, so the report offers an unparalleled depth of analysis not only of Housing First strategies but also of the interplay of factors that lead to the chronic homelessness of this vulnerable population. For example, 56% of participants did not complete high school, and many experienced early childhood trauma and leaving home to escape abuse. Twenty-nine percent had Post-Traumatic Stress Disorder (Guering, 15). In Winnepeg, participants were exposed to six different categories of child abuse and/or neglect before the age of 18. Forty-nine percent reported a history in foster care (Distasio, 7).

Hulchanski et al, in addition to the detailed narrative history of structural causes of the contemporary onset of homelessness as a social problem, also provide a helpful narrowing down of determining factors for the present. They assert that homelessness is *not* a complex problem: "After all these years of research and policy analysis and documenting the lived experience of those affected and those who provide support services, we know what the causes of the problem are. … When individuals or families run into a serious difficulty in one or more of three key areas that support a decent standard of living, they may find themselves unhoused and potentially on a downward spiral. The three areas are: housing, income, and support services" (Hulchanski, 9).

Thus, every homeless person has an individual story of his or her path into homelessness. As discussed above, structural factors, such as lack of adequate income and affordable housing, systems failure, including transition from facilities or out of care, and individual and relational factors such as mental illness, addiction, family dysfunction or break down all contribute to homelessness.

As Buckland et al. (2001) explain:

> The vast majority of Canadian studies accept the view that the homeless are not the authors of their own fate, but have been rendered vulnerable by underlying structural/systemic factors. Many of the homeless . . . do suffer from serious personal difficulties which are an important underlying cause of their state of homelessness. However, those difficulties are themselves influenced or caused by underlying structural/systemic factors, and few if any studies exist which argue that increased homelessness has been caused by a rising incidence of personal problems independent of changing social and economic circumstances. (p. 3)

Thus, the assertion can be put forward that policy changes, change in the economy, and social issues have all played a role in the increase in homelessness in Canadian cities, including communities in the FVRD. **(See Appendix 1 for more detailed analysis of the socio-political,**

socio-economic and socio-cultural context within which homelessness has taken root in British Columbia.)

2.3 Duration of Homelessness

Aubry, et al analyzed data from Toronto, Ottawa, and Guelph in 2013 and found that 88-94 percent of the homeless population are transitionally homeless, 3-11 percent are episodically homeless, and 2-4 percent are chronically homeless (Aubry 2013). Trypuc found that 80 percent of the Canadian homeless population experience transitional homelessness, and 20 percent remain homeless for more than 3 months (Trypuc 2009). The Trypuc review used a more general analysis of various, although older, studies.

In their national report on homelessness in Canada in 2013, Gaetz, et al estimated, based on an analysis of shelter data the number of homeless people in various categories i.e. chronically homeless, 4,000-8000 people; episodically homeless, 6,000-22,000 people, transitionally homeless, 176,000-188,000 people (Gaetz 2013). Gaetz et al found that the longer a person is homeless, "the greater likelihood that preexisting and emergent health problems worsen (including mental health and addictions) and there is greater risk of criminal victimization, sexual exploitation and trauma … [and] a much greater risk of involvement in the justice system" (Gaetz 2013).

In Calgary, data from 2009-2012 followed the general national trend: the vast majority of homeless stay in shelters for only a short period of time (84%), where a lesser amount experience episodic and longer-term stays (14%) and the least amount experience longer-term homelessness (2%) (Calgary Homeless Foundation, 2014). However, between 1997 and 2002, the percentage of people reporting homelessness lasting longer than one year doubled (Calgary Winter PIT, 2014).

Based on his research Gaetz, et al (7) concludes that people "…who are chronically homeless or episodically homeless form a smaller percentage of the overall homeless population, but at the same time use more than half the emergency shelter space in Canada and are most often the highest users of public systems". Since most people are able to leave homelessness with little support, diverting resources to better address the problem of chronic homelessness could open up more space in overall resources for homelessness and therefore help catch those who are at risk of becoming "trapped" in the homeless cycle (see Calgary Committee, 2008 for an analysis of this cycle).

The latest homeless count in Vancouver deviates from the national studies. Forty-one percent of homeless participants in the 2014 count reported being homeless for one year or more. The count revealed that sheltered homeless were more likely to be homeless for a shorter period of time (Greater Vancouver, 2014).

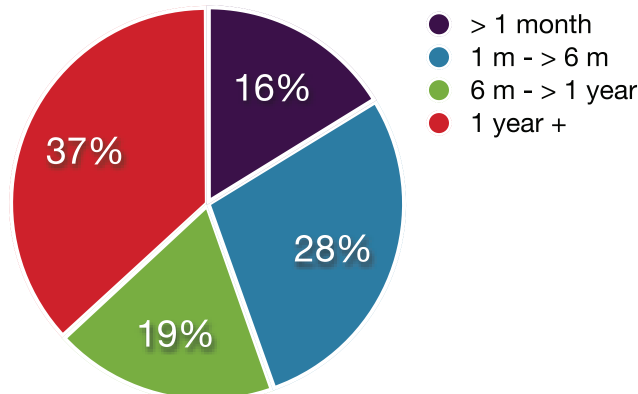
The respondents in the 2014 FVRD homeless survey were asked to indicate how long they had been homeless. Those who had been homeless for a year or longer constituted 36.9% which is similar to findings from Metro Vancouver, while 18.5% indicated they had been homeless for more than six months but less than a year, 28.4% for more than a month but no longer than six months, and 16.2% for less than a month (see Table 4).

TABLE 4: Duration of Homelessness

Duration	2014 n	2014%
less than 1 month	49	16.2
1 month - > 6 months	86	28.4
6 months - > 1 year	56	18.5
1 year +	112	36.9
Total Response	303	100
No Response	43	
Total	346	

Based on the above, it is apparent that a substantial number of persons (55.4%) who live homeless in the FVRD are experiencing relative longer-term or perhaps even chronic homelessness.

GRAPH 5: Duration of Homelessness Percentages 2014



2.4 Health Problems

Survey respondents were asked to report on their health problems; 20.7% of respondents reported a medical condition, 15.2% reported a physical disability, 41.7% indicated they live with an addiction, and 22.4% with a mental illness. The phenomenon of people living with both mental health and addictions issues is also referred to as concurrent disorder. **(See Appendix 2 for more detailed discussion about concurrent disorders in relation to homelessness).**

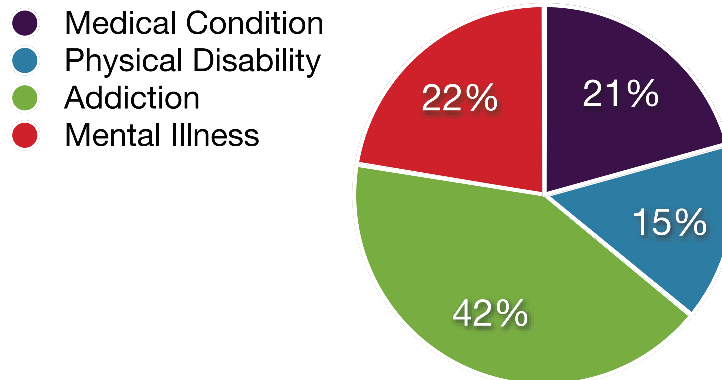
It is thus reasonable to argue that chronic emotional and mental illness complicates daily existence, and can mask acute illnesses or prevent people from accessing services and receiving much needed medical care and therefor remains trapped in chronic homelessness. Based on the information above, it is reasonable to assert that a substantial proportion of homeless per-

sons in the FVRD suffer from a variety of chronic and acute illnesses that are aggravated by life on the streets.

TABLE 5: Reported Health Problems

Health Issue	2014 n	2014%
Medical condition	95	20.7
Physical disability	70	15.2
Addiction	192	41.7
Mental illness	103	22.4
Total Response	460	100
No Response	79	
Total	539	

GRAPH 6: Percentage of Various Health Problems 2014



According to Hulchanski (2004), homelessness in itself is an “agent of disease". Homeless people are more exposed to and more likely to develop health problems than the general population, as living conditions predispose them to be particularly at risk of developing ill health. For example, they are at greater risk of being infected with communicable diseases (Alperstein & Arnstein, 1988; Miller & Lin, 1988; MacKnee & Mervin, 2002). Furthermore, homeless people are subject to stress because of the factors that made them homeless and because of the experience of being homeless. Poor diet, stress, cold and dampness, along with inadequate sleeping arrangements, sanitation and hygiene, increase the risk of health problems and decrease life expectancy. Thus, temporary shelter camps such as the one on Gladys Avenue in Abbotsford is clearly further aggravating the already extremely compromised health and well-being of people who reside in such encampments. It thus behooves the local community to rally around this phenomenon in order to provide a humane and durable solution.

Hwang, et al conducted an eleven year follow-up study of 15,100 homeless and marginally housed (people living in shelters, rooming houses, and hotels) across Canada. The study con-

cluded that this population lives with a much higher mortality rate than expected on the basis of low income alone. Life expectancy was 19 percent lower among males and 12 percent lower among females than the general Canadian population. Factors included tobacco-related diseases, alcohol and drug abuse, less access to care and help controlling chronic conditions, mental illness, exposure to deadly violence, and suicide (Hwang, 2009).

Trypuc found that the suicide rate among the homeless population is 40 times higher than the national average (Trypuc, 2009). The report stated that the average life expectancy of a homeless person in Canada is 39 years—half the national average.

Given the duration of homelessness (see Table 4) above and the reported health issues prevalent among homeless persons in the FVRD (see Table 5) above, it is safe to assert that there are people who are chronically homeless in FVRD communities. Begin et al (1999) identify three subgroups of homeless people namely chronically homeless people, cyclically homeless persons and temporally homeless persons.

The ***chronically homeless*** includes people who live on the periphery of society and who often face problems of drug or alcohol abuse or mental illness. It is estimated that this subgroup constitutes about 10–15% of the homeless population in a given locale. These are the so-called hard to house, but this label is problematic; perhaps it is rather a case of current housing provisions not being geared to provide support to high-needs clients.

The ***cyclically homeless*** includes individuals who have lost their dwelling as a result of some change in their situation, such as job loss, a move, a prison term, or a hospital stay. This group must from time to time use safe houses or soup kitchens, and includes women who are victims of family violence, runaway youths, and persons who are unemployed or have been recently released from a detention centre or psychiatric institution.

The ***temporarily homeless*** includes those who are without accommodation for a relatively short period. Likely to be included in this category are persons who lost their home as a result of a disaster (e.g., fire, flood, war) and those whose economic and personal situation is altered by, for example, marital separation or job loss.

In FVRD communities this category or subgroup of chronically homeless people is estimated to be higher than the conventional 15–20% range within Canadian based jurisdiction specific homeless populations. Based on "duration of homelessness" (Table 4) above and the prevalence of mental health and addictions issues as reported by homeless persons (Table 5) above, the number of people who live chronically homeless in FVRD communities could conservatively be estimated in the range of 75 - 100 people.

2.5 "Sheltered" and "Unsheltered" Homeless Persons

The number of homeless persons surveyed in the FVRD in official shelters was 99 or 31.1% and those surveyed outside totaled 112 or 35.3% (see Table 6 below). The latter include those who slept in their cars/campers. Those who reported that they were sleeping at the homes of friends/family (couch surfing) totaled 107 or 33.6%. The proportion of homeless people surveyed outside of shelters remains substantially high at 35.3% or 112 persons. The category of homeless people "outside" was 28.4% or 75 in 2011, 48.7% or 199 in 2008 and 46.4% or 169 in 2004 thus there is a slight reduction in the proportion of homeless people who still live "unshel-

tered". Thus, more work needs to be done to provide sustainable and permanent housing to people who continue to live outside.

The number of women counted in transition houses[7] in 2014 is 17 or 5.3% compared to 34 or 12.9% in 2011, 21 or 5.1% in 2008 and 42 or 11.5% in 2004.

TABLE 6: Accommodation on Night Survey

Place Stayed	2014 n	2014%
Transition House	17	5.3
Shelter	77	24.2
Youth Shelter	5	1.6
Outside	94	29.6
Car/camper	18	5.7
Friend/Family's place	107	33.6
Total Response	318	100
No Response	28	
Total	346	

The respondents were also asked to state their main reasons for not having used a transition house or a shelter the previous night. The biggest proportion falls into the category "able to stay with friend/family" (50.3%). The proportion of those who cited "turned away" as the reason for not having stayed in a shelter is 11.7%. The category "turned away" includes reasons such as the shelter was full, they had used up their allotted days, their gender was inappropriate, or they were turned away for no reason. The category "dislike" (15.1%) includes responses such as not liking the rules, not wanting to share accommodation with drug addicts, privacy issues, not feeling safe, afraid of theft, etc. (see Table 6).

Similar to findings from the 2014 FVRD point-in-time survey, the Vancouver 2014 point-in-time count found that the most common reason why homeless persons did not stay at a shelter was the option to stay with a friend (27%). The second main reason (21%) was that they did not like shelters (uncomfortable with the other people, dislike of rules, dirty/smelly, theft/violence); again similar to FVRD 2014 findings (see Table 7 below). Other reasons given were perceived lack of safety, bedbugs or pests, turned away, lack of transportation to shelter, lack of knowledge about shelters, Some people were concerned about their pets, or did not want to separate from their spouses or partners (Greater Vancouver, 2014).

Toronto provides an analysis of shelter complaints through its Central Intake system and complaint call-in program. Reasons for not using shelters include not liking a particular shelter, could not get shelter with a pet, no available beds for couples, dislike of communal setting (particularly

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[7]For the sake of continuity and comparison with previous reports, this report includes emergency and extreme weather shelter beds, youth shelter beds, and transition beds for women fleeing violence or abuse. For a more complete list of social housing, see the FVRD Social Housing Inventories, available from http://www.fvrd.bc.ca/INSIDETHEFVRD/REGIONALPLANNING/Pages/AffordableHousingandHomelessness.aspx

if the shelter had guests with mental health issues), difficulties with location (not near enough to programs and services), not wanting to be “bothered” by staff, being refused service due to the presentation of unacceptable and dangerous behaviors (Abrahams, 14).

Gaetz, et al’s 2013 State of Homelessness in Canada report refers to the “rough sleeper” population that generally avoids the shelter system because of rules, concerns about safety and health, the issue of pets, or fear of being separated from partners (Gaetz, 2013).

TABLE 7: Reasons for not staying in Shelter/Transition House

Reason	2014 n	2014%
Turned away	31	16.6
Stayed with friend/family	51	27.3
Dislike	44	23.5
Did not know about shelter	2	1.1
Couldn’t get to shelter	9	4.8
No shelter in Community	11	5.9
Slept in car/camper	0	0.0
Other	39	20.8
Total Response	187	100
No Response	61	
Total	248	

In 2012, the Canadian government released its first-ever National Shelter Study. The report used shelter data collected over an extended period of time to determine an overall portrait of the shelter-using population in Canada. The report stated:

“*Though not all homeless people regularly use them, emergency shelters are often the first point of contact for those experiencing absolute homelessness. Emergency shelter use thus serves as the best available indicator for understanding national trends in the size and composition of the homeless population*” (Segaert, iv).

The National Shelter Study did not include Violence Against Women shelters, transition houses, or extreme weather shelters. The study reported that there has been no significant change (from 2005-2009) in the total number of people using emergency shelters; however, the proportion of children and families has increased, and the length of stay has also increased. The study estimated that the minimum extent of homelessness in Canada, based on emergency shelter use, is 150,000 individuals (Segaert, 26-27).

In another national report, Gaetz, et al reveal that the national median length of stay in an emergency shelter is 50 days; however, 29% stay only one night (Gaetz, 7). Their report also analyzed point in time data from ten Canadian cities. From this data, they report that there are 4 people staying in emergency shelters for every person sleeping rough, and 1 unhoused or provisionally sheltered person for every 4 people staying in emergency shelters (Gaetz, 24).

Aubry, et al evaluated four years of shelter data from three Canadian cities of different sizes in Ontario: Toronto, Ottawa, and Guelph. They found that 88% of shelter users experienced a small number of homeless episodes for short periods of time. A smaller group (9-11%) experienced multiple, but still short, periods of shelter use. The smallest group had fewer episodes of shelter use, but for long periods of time (2-4%) (Aubry, 2013).

A growing number of Canadian cities use point-in-time counts; however, the methodology has not been coordinated, and some major cities still do not conduct counts. The most recent counts of the three major cities dealing with homelessness reveal the following:

- **Vancouver:** For the 2014 count, 66% of the homeless population was sheltered (including provisional shelters). On the night of the count, 11% of the homeless population (317 individuals) were turned away from emergency and transition shelters. Most of the time, this was because the shelters were full. In some cases, the individuals were "not appropriate for the facility" (Greater Vancouver, 13-15).

- **Calgary:** Calgary's 2014 Winter point-in-time count reported that out of 100% of the homeless population, 54% of the homeless population were in emergency shelters, 35% were in short-term supportive housing, 6% were in systems, and 6% were sleeping rough (Calgary Homeless Foundation 2014, 6).

- **Toronto:** Through its Shelter Management Information System, Toronto provides the most comprehensive shelter use tracking in Canada. Shelter census data is collected daily and includes family shelters and motel-based shelters. In 2013, Toronto's homeless population was approximately 5200 individuals (Shapcott, 2013). The approximate average of nightly shelter stays was 3900 – around 75% of the homeless population (Toronto, 2014). Every single night, the city's shelter statistics show empty beds; anecdotally, however, people continue to report 1) a lack of shelter bed availability, 2) lack of knowledge of how to access shelter system, 3) overcrowding of shelters, and 4) an increase in deaths of people who are homeless (Abrahams, 14).

Out of the three cities, Vancouver had the largest percentage of unsheltered homeless. This could have something to do with the milder weather in Vancouver during the time of the count (as compared to Calgary's winter count).

2.6 Shelter and Transition Beds in the Upper Fraser Valley[8]

The total number of shelter beds in the Upper Fraser Valley in 2014 is 141, compared to 64 in 2011, 41 in 2008 and 28 in 2004. The break down per community is as follows:

[8] For the sake of continuity and comparison with previous reports, this report includes emergency and extreme weather shelter beds, youth shelter beds, and transition beds for women fleeing violence or abuse. For a more complete list of social housing, see the FVRD Social Housing Inventories, available from http://www.fvrd.bc.ca/INSIDETHEFVRD/REGIONALPLANNING/Pages/AffordableHousingandHomelessness.aspx

- Abbotsford – 35 (25 emergency shelter beds plus 10 extreme weather beds)[9]
- Chilliwack – 57 (47 emergency shelter beds plus 10 extreme weather)
- Hope – 14 (4 emergency shelter beds plus 10 extreme weather)
- Mission – 35 (20 emergency shelter plus 15 cold and wet weather beds)

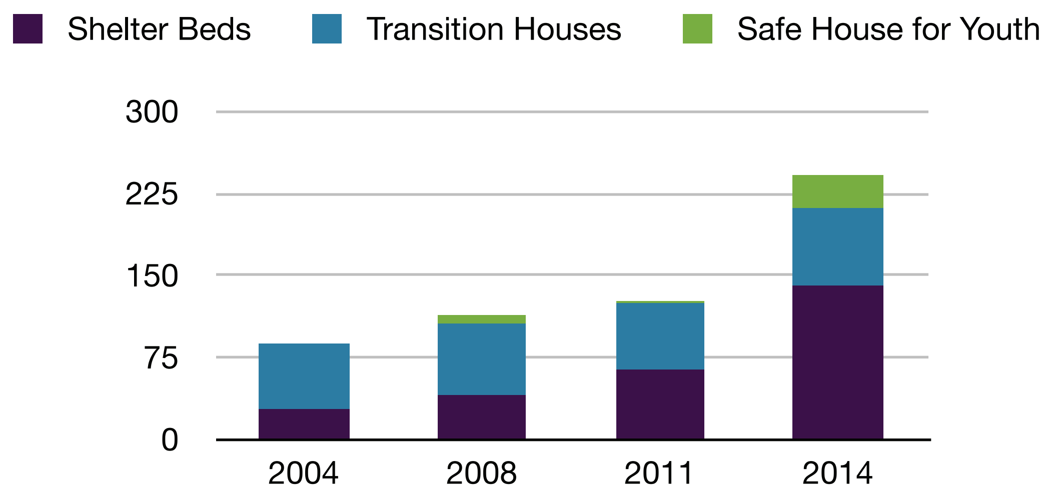
The total number of beds in women's transition houses[10] in the Upper Fraser Valley is 71 compared 61 in 2011, 65 in 2008 and 60 in 2004.

- Abbotsford – 12 beds
- Aldergrove – 10 beds
- Mission – 10 beds
- Chilliwack – 31 beds (Ann Davis 12; Xolhemet 19)
- Hope – 8 beds

The total number of youth shelter beds is 30 in 2014 compared to 2 in 2011 and 8 in 2008 and 0 in 2004.

- Abbotsford – 14
- Chilliwack – 16

CHART 3: Shelter Beds and Transition Houses in the FVRD from 2004-2014



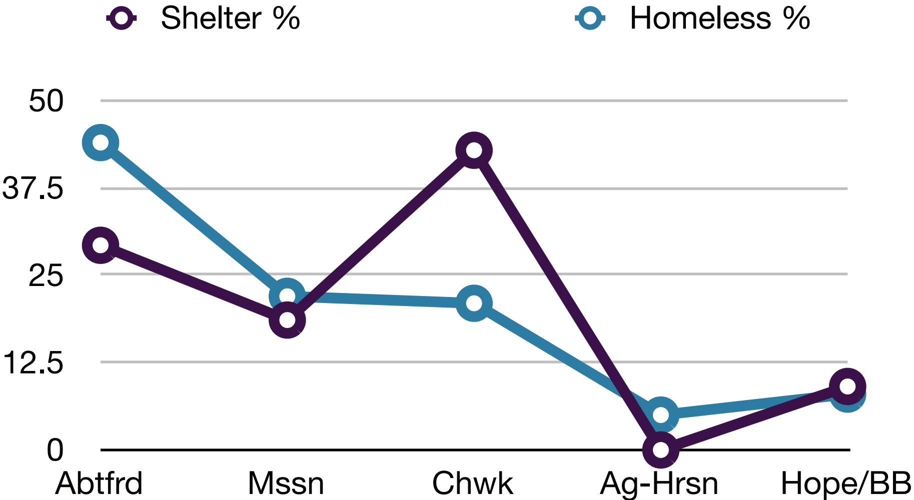
[9] According to the Salvation Army in Abbotsford, Coordinator of Extreme weather beds, the total number of beds available varies depending on the time of the fall/winter season. Thus, Abbotsford has available in 2014/15 a maximum of 40 adult and 10 youth extreme weather beds to a minimum of 30 adult beds and 10 youth beds.

[10] Only in reference to transition houses for women who have left an abusive relationship and need safe and supportive temporary housing provided by the transition houses.

TABLE 8: 2014 Numbers of Shelter and Transition Beds by Community[11]

Community	Shelter Beds	Beds in Transition Houses	Youth Safe House Beds
Abbotsford	35	22	14
MIssion	35	10	0
Chilliwack	57	31	16
Agassiz-Harrison	0	0	0
Hope/Boston Bar	14	8	0
TOTAL	**141**	**71**	**30**

GRAPH 7: Shelter/Transition Bed Percentage and Homeless Percentage, by Community



[11] For a more complete list of social housing, see the FVRD Social Housing Inventories, available from http://www.fvrd.bc.ca/INSIDETHEFVRD/REGIONALPLANNING/Pages/AffordableHousingandHomelessness.aspx

2.7 What Will End Homelessness for You?

When asked what would end their homelessness, respondents indicated that access to more affordable housing was the most common barrier to them finding a home. A significant proportion (15%) indicated that finding employment will end homelessness for them.

TABLE 9: What Will End Homelessness For You?

Solution	2014 n	2014%
Affordable housing	108	45.2
Employment	36	15.1
Higher income	47	19.7
Overcoming addiction	11	4.6
Support/Advocacy	18	7.5
Other	19	7.9
Total Response	239	100.0
No Response	107	
Total	346	

3. Who are the Homeless?

3.1 Profile of Homeless People in the Upper Fraser Valley

Stereotypes of homeless persons typically conjure up images of vagrants, alcoholics, and somewhat crazy adult males. There are numerous flaws inherent in such stereotypes. The most important among these is that they are inaccurate and contribute to misunderstanding of the social and political contexts of homelessness (Reid et al., 2005, pp. 238–239).

The homeless population in Canada at any given time will be comprised of several groups, including, but not limited to, persons with severe addictions and/or mental illness (Patterson et al., 2008), families (CMHC, 2003b), seniors, children, youths, persons with disabilities (Thomson, 2003), and aboriginals (Krupp, 2003). Single men constitute the majority of the visible homeless, according to the National Homeless Initiative, a fact confirmed by four surveys in the FVRD since 2004.

The following information, obtained from homeless people surveyed in Upper Fraser Valley communities, is discussed in this section:

- Gender
- Age
- Aboriginal Presence
- Community of origin
- Source of income
- Usage of medical services and other services

3.1.1 Gender

A review of both point-in-time counts and emergency shelter stays across Canada reveals that women avoid shelters more than men (Gaetz, 2013). According to the National Shelter Study, single adult males between the ages of 25 and 55 make up 47.5% of the homeless population. The mean age of shelter occupants is 37. Just 1.7% of shelter users were over the age of 65, and 1% of shelter users were under age 16 and unaccompanied by an adult. Approximately 20% of shelter users were youth. Seventy-three percent of the emergency shelter population was male, and 26.2% female. Violence Against Women shelters were not included in the study (Segaert, 2012).

Women represent a unique at risk population in the homeless demographic because many of them are either fleeing violence or are at risk of violence once they become homeless. Burczycka & Cotter report on a 2010 national point-in-time shelter for abused women count. Among

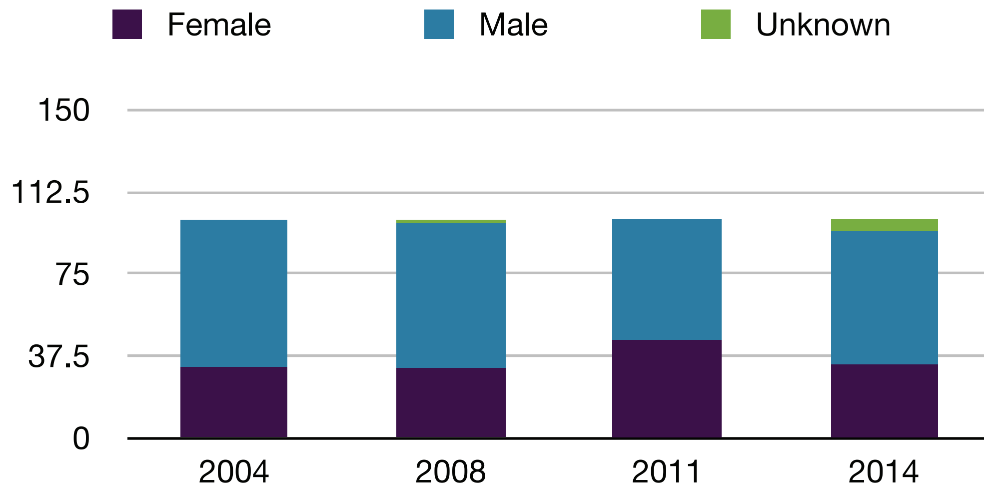
women staying in shelters or transition homes, 71% cited abuse as the reason for admission. Sixty percent had not reported the abuse to police (Burczycka, 5). Poverty is also a main reason for homelessness among women, and since women are the most common head of households for homeless families, poverty and the threat of violence also affect their children.

The gender distribution of homeless people surveyed in the Upper Fraser Valley in 2014 breaks down into 60.7% males and 33.8% females, a change from the 2011 survey that found a 45% and 55% female and male breakdown. The 2014 gender breakdown is in line with findings from the 2004 and 2008 surveys where the gender breakdown was along the lines of a one third/ two thirds split (Van Wyk & Van Wyk, 2005, p. 12; 2008, p. 29).

TABLE 10: Gender of Surveyed Respondents

Gender	2014 n	2014%
Male	210	60.7
Female	117	33.8
Unknown	19	5.5
Total	346	100

CHART 4: Respondent Gender 2004-2014



3.1.2 Age

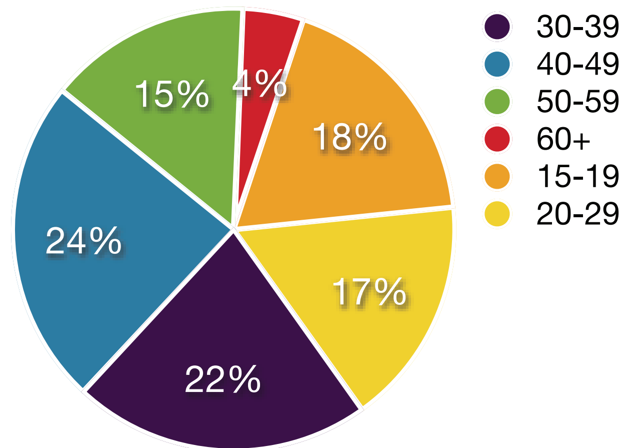
Similar to the 2004, 2008 and 2011 surveys, the biggest proportion of homeless respondents in 2014, 61.9% fell in the 20–50yr age group (Van Wyk & Van Wyk, 2011 p. 29; 2008 p. 29; 2005 p. 12).

Graph 8 shows that the single largest proportion of respondents (23.7%) was in the 40-49 years cohort. A significant number of the respondents (21.6%) were 30-39 years old. There were 47

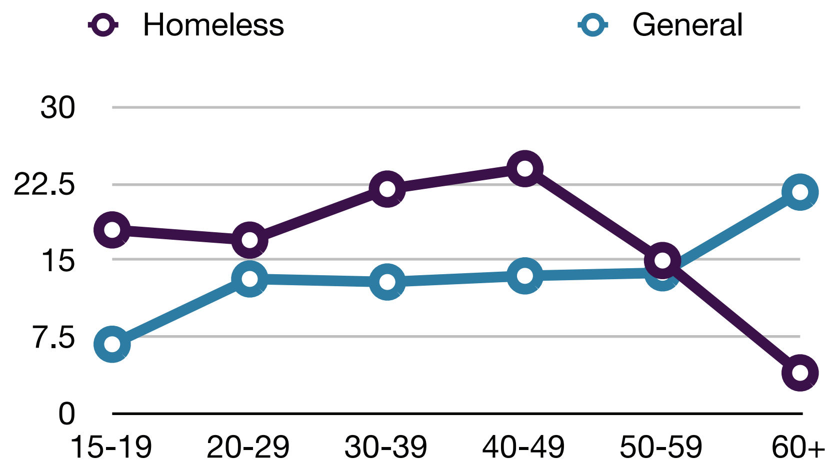
(14.73%) respondents in the 50–59 year age group and 14 or 4.4% 60+. This latter group is dealing both with homelessness and with the physical and psychological challenges involved in the process of growing older.

A significant proportion, 18.1% of respondents was between 15 and 19 years of age. A study by Gaetz, et al (2013) on youth homelessness points to the unique set of factors that contribute to youth homelessness (Gaetz, Youth, 2013). The report advocates a focus on prevention and supports rather than emergency response measures such as shelters, day programs, and law enforcement. It is interesting to note that the report mentions family as a potentially vital resource in the support network, given that family conflict and/or abuse is so often a factor in youth homelessness.

GRAPH 8: Age of Surveyed Respondents



GRAPH 9: Age Distribution of Homeless in Relation to General Population



Source: BC Stats

Homelessness affects health and life expectancy in significant ways. Homeless Canadians are more likely to die younger and to suffer more illnesses than the general Canadian population. Many factors contribute to the lower life expectancy of homeless people, including lack of social support networks, education, unemployment, living conditions, personal health practices, biology and genetic endowment, lack of availability of health services, etc.

3.1.3 Aboriginal Presence

Belanger, et al, note that to date "…., no comprehensive, official national enumeration of the urban Aboriginal homeless population has been conducted, nor has the existing data been compiled or analyzed" (Belanger, 29). However, evidence both anecdotal and compiled from homeless counts support the established consensus that the Aboriginal population is over-represented among homeless people (Belanger, 2012; Gaetz, 2013). In a literature review of Aboriginal Homelessness, Patrick notes that the Canadian Aboriginal populations tend to be homogenized in the majority of academic literature (Patrick, 2014). Since many Aboriginal cultures exist, and not all may have experienced colonization and assimilation the same way or have identical relationships with reserves and government agencies, any treatment of Aboriginal homelessness as a separate issue must also take into account varying Aboriginal cultures (Patrick 2014).

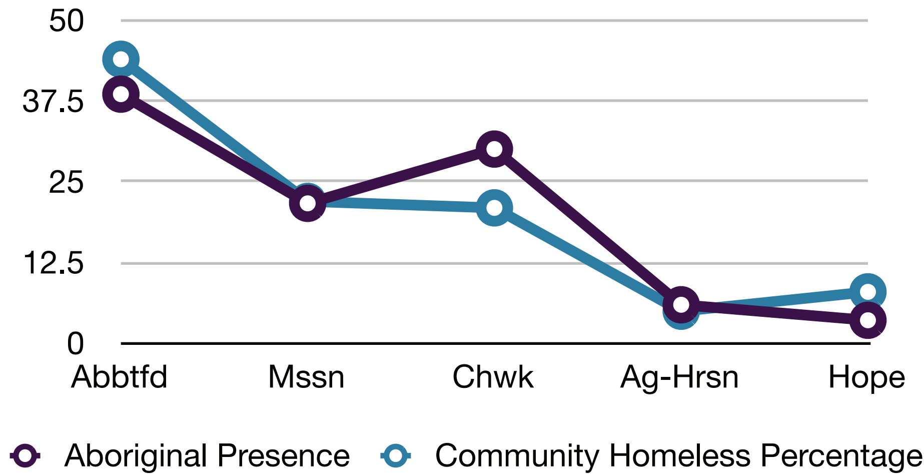
The respondents in the 2014 FVRD survey were asked to indicate whether they self-identify as Aboriginal. Eighty three or 23.9% self-identify as Aboriginal, which is similar to the 2011 finding. In 2008, the proportion "Aboriginal" constituted 32.1%. Of those who self-identified as Aboriginal in 2014, 32 (38.6%) were in Abbotsford, 18 (21.7%) in Mission, 25 (30.1%) in Chilliwack, 5 (6.0%) in Agassiz–Harrison, and 3 (3.6%) in Hope (see Table 11).

The literature indicates that Aboriginal homeless persons have special needs that must be considered — e.g., cultural appropriateness, self-determination, and traditional healing techniques (Beavis, Klos, Carter, & Douchant, 1997). It fell outside the scope of the 2014 survey to make further determinations in this regard. Suffice to say that the notion of providing culturally appropriate services for Aboriginal persons likely remains valid as service delivery models are implemented at community level.

TABLE 11: Aboriginal Presence among Homeless Respondents, by Community

Community	2014 n	2014%
Abbotsford	32	38.6
Mission	18	21.7
Chilliwack	25	30.1
Aggasiz-Harrison	5	6.0
Hope	3	3.6
Total Response	83	100.0

TABLE 10: Aboriginal Percentage and Homelessness Percentage, by Community



3.1.4 "Home" Community

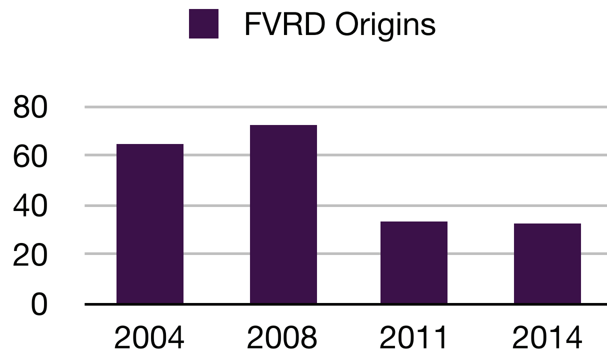
Respondents were asked to indicate the community that they moved from to the FVRD community where they were interviewed. Similar to 2011, the biggest proportion of respondents, 32.7%, is from FVRD communities. In 2011 this proportion was 33.4%. The proportion that moved here from Metro Vancouver constitutes 27.3% compared to 23.2% in 2011; those from rest of BC make up 18.5% compared to 12.1% in 2011; those from rest of Canada constitute 19.1% (23.2% in 2011) while 5 or 2.4% came from abroad compared to 3.0% in 2011. These responses differ from findings based on the 2004 and 2008 surveys, when the percentage of respondents from FVRD communities was 64.8% in 2004 and 72.7% in 2008[12] (Van Wyk & Van Wyk, 2004, p. 14; 2008, p. 33).

TABLE 12: Where Did You Move Here From?

Home Community	2014 n	2014%
FVRD	67	32.7
Metro Vancouver	56	27.3
Rest of BC	38	18.5
Rest of Canada	39	19.1
Out of Country	5	2.4
Total Response	205	100.0
No Response	141	
Total	346	

[12] In 2008, the question was asked differently.

CHART 5: Percentage of Homeless Population with FVRD Origins from 2004 - 2014



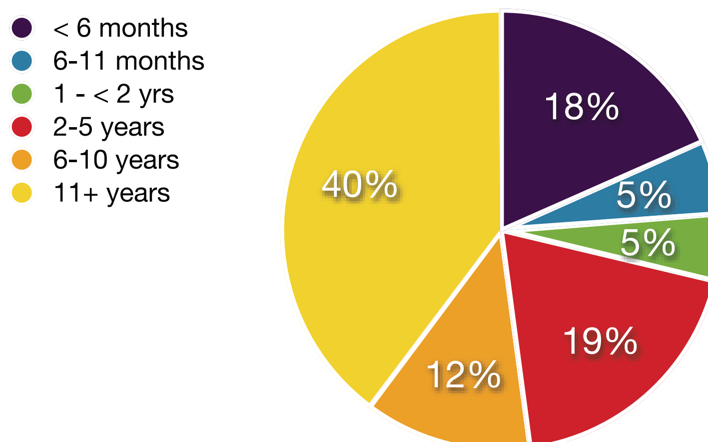
3.1.5 Length of Residence in Local Community

Survey findings reveal that just over half (52.1%) of the homeless persons surveyed have lived within the FVRD for 6 years or longer, with 19.2% living here between 2 and 5 years and 28.7% residing in FVRD communities less than two years.

TABLE 13: How Long Have You Been Living in the Community?

Length of Residency	2014 n	2014%
Less than 6 months	48	18.4
6-11 months	14	5.4
1 year - 23 months	13	4.9
2-5 years	50	19.2
6-10 years	32	12.3
11+ years	104	39.8
Total Response	261	100.0
No Response	85	
Total	346	

GRAPH 11: How Long Have You Been Living in the Community?



3.1.6 Source of income

Welfare was indicated by 29.6% of respondents to be their source of income, followed by 13.1% (11.0% in 2011) receiving disability allowances. This compares with 4.8%, 28.4% and 42.8% who reported welfare as their source of income in 2004, 2008 and 2011, respectively (Van Wyk & Van Wyk, 2005 p. 25; 2008 p. 35: 2011 p. 33). See Table 14 below.

The welfare and disability rates and the shelter portion of $375 per individual included in the $610 to approximately $1,000 per month welfare or disability allowance makes it very challenging if not impossible for people dependent upon this type of income to afford market housing. This is further compounded given that the typical basement or apartment rent in FVRD communities is within the range of $500 - $800. Given this reality, an argument can be made that part of the solution to reducing homelessness relates to higher welfare rates and/or longer term rent subsidies. Current rent subsidy funding linked to homelessness outreach and prevention from BC Housing is limited to one year. Substantial numbers of persons who live homeless, given their entrenched barriers and challenges, require more than a year to stabilize and achieve housing security; in some cases, ongoing rent subsidies are required given current market rental rates and welfare rates.

The number of respondents reporting welfare as a source of income dramatically increased from 4.8% in 2004 to 28.4% in 2008 to 42.8% in 2011, and it has dropped to 29.6% in 2014. This fluctuation most probably relates to the introduction of Homelessness Outreach Programmes in FVRD communities after 2004 and then again stricter eligibility criteria and longer waiting periods relating to the application process to qualify for income assistance introduced over the past 2-3 years.

The percentage of respondents who indicated employment as their source of income is 7.9% for 2014. In 2004 this was at 29.2%, 21.3% in 2008 and 12.4% in 2011. Thirty six or 8.7% reported no source of income. This number is about half of the proportion, 18.6% who reported no source

of income in 2011. Homeless persons typically hold unskilled, seasonal, and lower-paying jobs. The level of income associated with this type of employment makes it challenging to save money for emergencies, such as periodic or seasonal unemployment, or to secure the kind of economic stability that would prevent homelessness (Van Wyk & Van Wyk, 2005, p. 26), hence campaigns or support in some community circles for an increase in the minimum wage or the introduction of living wages.

TABLE 14: Source of Income

Source	2014 n	2014%
Welfare	122	29.5
Disability benefit	54	13.1
Employment	33	7.9
EI/CPP/WCB/OAS/GIS	14	3.4
Binning/panhandling	64	15.5
Family/Friends	41	10.0
No income	36	8.7
Other	49	11.9
Total Response	413	100.0
No Response	54	
Total	467	

3.1.7 Affected by Change or Withdrawal of Services

Respondents were asked whether they have been affected by change or withdrawal of services in FVRD communities. Almost three quarters or 74.0% reported that they were not affected while 26.0% reported that they have been impacted. Examples of how they have been affected relate to being refused welfare, having been dropped from welfare role or long waiting period after application and before welfare payments are made.

TABLE 15: Affected by Change or Withdrawal in Services

Affected by Change/Withdrawal in Services	2014 n	2014%
Yes	65	26
No	185	74
Total Response	250	100
No Response	96	
Total	346	

3.1.8 Usage of Services

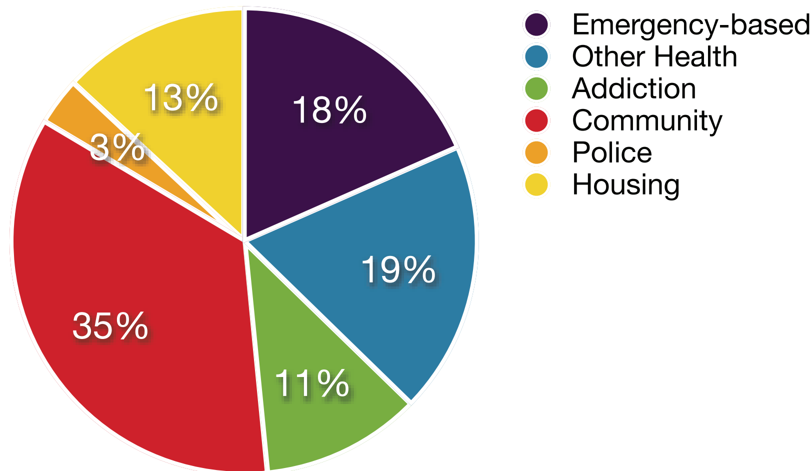
Based on the 2014 homelessness survey in FVRD communities, 231 or 66.8% (two thirds) of the 346 respondents reported that they have accessed various services over the past 12 months. Table 15 below indicates the extent to which various services were used by people who live homeless. For example, and not surprising given the reality of living homeless, meal programs and food banks are accessed by 71% and 62% respectively. Outreach services and drop-in services are utilized by 63% and 60% respectively. Other services accessed are:

- Emergency room - 58%
- Hospital - 40%
- Health clinic - 34%
- Addiction services - 53%
- Mental health services - 33%
- Employment services - 33%
- Extreme weather shelter - 36%
- Needle exchange - 23%

TABLE 15: Usage of Services

Service	2014 n	2014%
Ambulance	75	32
Emergency Room	133	58
Hospital (non-emergency)	92	40
Dental Clinic or dentist	54	23
Mental Health	77	33
Addiction	122	53
Extreme Weather Shelter	84	36
Employment/Job help services	76	33
Probation/Parole	52	23
Drop-in	139	60
Food Banks	143	62
Meal programs/Soup kitchens	164	71
Health clinic	78	34
Newcomer	7	3
Transitional housing	39	17
Housing help/Eviction prevention	23	10
Needle exchange	54	23
Outreach	146	63
Legal	29	13

GRAPH 12: Usage of Services by Category[13]



Various other homeless studies and point-in-time surveys report the following regarding usage of services in the selected communities:

Toronto: Sixty-three percent of the homeless population used some form of housing-related services, including drop-ins (40%), extreme weather beds (18%) and assessment and referral (26%). Sixty-nine percent of the homeless population reported using health and treatment services, including the hospital (46%), health clinics (43%), ambulance service (26%), harm reduction (15%) and detox (13%). Thirty-eight percent of homeless survey participants reported the use of ID services, 33% reported food bank or community kitchen use, 23% reported using job supports, and 20% reported using legal clinics (City of Toronto, 2013).

Vancouver: Meal programs (46%), hospital emergency rooms (42%), and drop-in centres (40%) were the three services most used by homeless survey participants. Thirty-eight percent of participants used health clinics, and 24% used addiction services. Unsheltered homeless were more likely to use meal programs, drop-in centres, outreach services, food banks, ambulance, and parole services. Sheltered homeless were more likely to use health clinics, employment, dental, mental health, and transitional housing (Greater Vancouver, 2014).

Red Deer: Over 60% of homeless people used drop-in services, soup kitchens, and the emergency room. Less than half of survey respondents used health clinics and hospitals; however, of the top 10 services used, 6 were health-related. Thirty percent of the respondents used outreach services, and less than 20% obtained help finding or keeping housing. Less than one third of respondents used food banks, whereas meal programs were among the highest-used services (Red Deer, 2012).

Saskatoon: The most-used services were health clinics (61% unsheltered, 45% sheltered). Hospital and emergency rooms were the second most-used service (39% unsheltered, 29% sheltered). Shelters were the third most-used service besides health clinics and emergency rooms (Findlay, 2012).

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[13] The police category does not include arrests, which could also be viewed as an emergency service. A higher percentage of non-Community based service usage would be evident if arrests were included.

Cost Benefit Analysis in relation to service usage

Much recent research addresses the issue of the "cost of homelessness," particularly in the United States (Culhane, 2011; Mares, 2010; Mondello, 2009; Poulin, 2010; Sadowski, 2009). Many Canadian homeless reports or surveys contain a section on cost analysis, with varying statistics according to the region and/or studies cited. The most oft-cited Canadian reports determine sometimes startlingly high comparative costs of homelessness in three main areas: emergency shelters, hospital patient care, and prison services (Shapcott, 2007; Hwang, 2011; Kellen, 2010). It is clear from the literature (both American and Canadian) that chronically homeless persons tend to use the most expensive services, and *finding solutions, such as Housing First, that move service use from institutions to community-based services improves cost effectiveness as well as reduces chronic homelessness*. That said, there are questions as to whether or not Housing First is as cost-effective in areas where emergency services may be less expensive (Kertesz, 2009).

In a general overview of the cost of homelessness in Canada, Gaetz (2012) determines that shifting the focus from emergency response to prevention and rehousing makes economic sense. Emergency services will always be needed, but the most cost-effective goal is that no one should be homeless and using emergency services for longer than a few weeks (Gaetz, et al 2013).

Considerations Relating to Cost Analysis

Two main points are of note relating to the reliability of economic data and the ethics of relying exclusively on the question of economic efficacy. Gaetz (2012) issues several cautions with respect to cost-analysis data: 1) access to administrative data from services that homeless people access is often restricted; 2) there is not always consistency in reporting actual operating costs for shelters; 3) studies can be biased in their selection of high needs clients who use a higher intensity of services; 4) the shelter system can actually supplant the use of needed medical services, so when people are housed, their medical care costs could—in some circumstances—actually rise. So cost analysis is not always as straight-forward as reports sometimes assert.

Secondly, in an analysis of evidence-based policy-making procedures, Stanhope & Dunn bring to attention an additional weakness in the cost analysis of Housing First policies: the jettison of moral imperative from the debate (Stanhope & Dunn, 2011). When convincing policy makers to act by appealing primarily to the logic of dollars and cents, advocates can actually place themselves, and those they are attempting to help, in a weaker position.

Chronically homeless people are the most visible of the homeless population. They are the most "distasteful" or "off-putting" to the public, and the most detrimental to the business sector. While large amounts of Canadian federal dollars are allocated towards the Housing First strategy, community policy-makers might benefit from an assessment of future needs. It seems quite clear that Housing First reduces chronic homelessness significantly, and most often at a reduced cost to the community. However, with rising income inequality and an increase of family homelessness (Segaert, 2012), what services (and dollars) will be available for other at-risk populations—populations that are not as easily cost effective? What about the complexities of youth or family homelessness? What about the hidden homeless population?

When moral imperative disappears from the discourse, social problems with more complex needs and solutions could suffer a decrease in attention and resources. Success in housing

chronically homeless people should not draw attention away from other vulnerable populations in crisis or systemic factors that perpetuate their predicaments (Kertesz & Weiner, 2009).

4. Evidence-Based Practice

Treatment First

Often associated with or sometimes known as the Continuum of Care (COC) model, the Treatment First (TF) paradigm emphasizes the primacy of strict substance use treatment programs in getting people housed. The model assumes the necessity for homeless persons to develop skills and/or levels of readiness before they are ready for the responsibility of maintaining permanent housing. Shelters and Transition homes, while not necessarily wedded to the TF approach, are part of the COC model. One American study of chronically homeless persons using shelters determined that the shelter model is most effective when providers offer a place that feels like home, where persons are respected and their challenges are acknowledged (Lincoln et al., 2009).

The TF paradigm most often employs a case management model, where one caseworker manages a caseload of 25-30 clients or more. When case management is associated with TF, case managers are expected to uphold strict rules and move service users along a linear continuum of care (Henwood & Padgett, 2011). Case management is often criticized for a lack of one-on-one attention, strict rules, and consumer disengagement; however, greater program flexibility may help to reduce service user drop-outs from case management models (Stanhope et al., 2009).

Critics of TF maintain that service users' personal circumstances become obstacles that must be addressed in order to receive permanent housing (Byrn et al 2014). Studies do show that TF consistently demonstrates a reduction in addiction severity (Kertesz 2009); however, housing remains problematic (Goering, 2014; Mares, 2011; Henwood & Padgett, 2011).

Housing First

Housing First (HF) also known as Permanent Supported Housing (PSH) is described by Byrne et al. as subsidized housing matched with supportive services (Byrne et al. 2014). HF emphasizes client choice and control over housing and supportive services; it also functionally separates the receipt of housing and supportive services (Byrne et al., 2014). Housing First models in Canada operate under the following principles: 1) Immediate access to housing with no housing readiness conditions; 2) Consumer choice and self-determination; 3) Recovery orientation; 4) Individualized and person-driven supports; 5) Social and community integration (Goering et al., 2014). It should be noted that the emphasis on consumer choice can actually cause deviations in faithfulness to HF priorities (Matejkowski & Draine, 2009).

Critics of HF maintain that allowing substance use while offering housing amounts to "enabling." However, the evidence tends to refute this notion. Two different studies of HF and individuals with alcohol problems found that although the HF program did not require treatment, partici-

pants actually decreased their alcohol use (Collins et al., 2012; Larimer et al., 2009). In longitudinal comparative studies, there were no significant group differences in alcohol and drug use between TF and HF participants (Padgett, 2006; Mares 2011). In fact, in a study comparing the TF and HF approaches, Henwood & Padgett (2011) found that TF providers became consumed with finding housing, whereas HF providers were able to focus more on treatment.

Many recent studies address the level of effectiveness of HF pilot programs. A longitudinal study in Minneapolis, Minnesota determined that HF programs decrease both homelessness and criminal activity (DeSilva et al., 2011). In review of HF research from 1992-2012, Rog et al (2014) found that a moderate level of evidence determines that the HF model reduces homelessness, increases housing tenure, decreases use of emergency services, and results in increased service user satisfaction.

Byrne, et al. performed a longitudinal study of community-level data to determine if HF actually decreased community levels of chronic homelessness. Previously, almost all HF models were studied on the basis of individual data. The study determined that communities that add relatively more HF units show steeper declines in chronic homelessness over time (Byrne et al., 2014). Additionally, the study found that two year retention rates of HF are over 80%, and the costs are partially or completely offset by reductions in use of health, mental health, criminal justice, emergency shelters, and other public services (Byrne et al. 2014).

Mental Health Commission of Canada Study

The At Home/Chez Soi research demonstration project followed more than 2,000 participants in 5 Canadian cities (Vancouver, Winnipeg, Toronto, Montréal and Moncton) for two years. It was the world's largest trial of Housing First (HF), and the final report was released in 2014.

Participants in the study were recruited from the streets and shelters; all participants were both mentally ill and homeless (average experience of homelessness was 4.8 years). Participants in the HF case study groups were provided with an apartment of their own, a rent supplement, and one of two types of support services: those with high needs received support from Assertive Community Treatment (ACT) teams, and those with moderate needs received Intensive Case Management (ICM). Participant outcomes were compared with Treatment as Usual (TAU) groups in each city.

In the last six months of the study, 62% of HF participants were housed all of the time compared to 31% of TAU participants. Housing results in the HF study were similar for ACT and ICM participants. Sixteen percent of HF participants were housed none of the time versus 46% of TAU participants. Quality of life and community functioning were significantly greater among HF participants, although TAU participants also experienced increased community functioning and quality of life. Mental health and substance use symptoms improved similarly for both HF and TAU.

In the cost analysis, every $10 invested in HF resulted in an average savings of $9.60 for ACT participants and $3.42 for ICM participants compared with the TAU groups. For the 10% of participants with the highest costs at study entry, every $10 invested resulted in an average savings of $21.72.

In this study, the closer the study groups operating according to the Housing First principles, the more effective they were in housing stability, quality of life, and community functioning principles.

5. Summary of Findings

The following summarizes the main findings of this survey:

- In comparison with 2011, the number of homeless people interviewed in the FVRD has remained stable at 346 compared to 345.
- The numbers of homeless people interviewed have increased in Abbotsford and Mission, but the numbers in Chilliwack and Hope/Boston Bar have decreased while Agassiz–Harrison remained constant.
- Every homeless person has an individual story of his or her path into homelessness. Structural factors , such as lack of adequate income and affordable housing, systems failure, including transition from facilities or from care, and individual and relational factors tors, such as mental illness, addiction, family dysfunction or disintegration, all contribute to homelessness.
- Lack of affordable housing is directly related to low wages, erosion of the social safety net, insufficient social housing inventory, and increased rental accommodation cost.
- Chronically homeless people are conservatively estimated to be in the 20%-30% range, or 75 to 100 people.This is higher than the 15 - 20% that is conventionally seen as the percentage of homeless people in Canadian jurisdiction specific homeless populations.
- 37% of respondents, or 112 individuals, experience long-term homelessness (one year or longer).
- 35% of respondents live outside in makeshift shelters or other outdoor places.
- Almost a quarter or 24% of those who live outside indicated a dislike in the emergency shelters as a reason for not accessing emergency shelters. Reasons for “dislike” include “too many rules,” “I don’t like the rules,” “feels too much like an institution,” “I don’t want to be with addicts and crazy people,” etc.
- The total number of shelter beds in the Upper Fraser Valley in 2014 is 141, compared to 64 in 2011, 41 in 2008 and 28 in 2004.
- The total number of beds in transition houses in the Upper Fraser Valley is 71, compared 61 in 2011, 65 in 2008 and 60 in 2004.[14]

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[14] For the sake of continuity and comparison with previous reports, this report includes emergency and extreme weather shelter beds, youth shelter beds, and transition beds for women fleeing violence or abuse. For a more complete list of social housing, see the FVRD Social Housing Inventories, available from http://www.fvrd.bc.ca/INSIDETHEFVRD/REGIONALPLANNING/Pages/AffordableHousingandHomelessness.aspx

- The total number of youth shelter beds is 30 in 2014 compared to 2 in 2011 and 8 in 2008 and 0 in 2004.
- Males constitute the majority of homeless persons, i.e. 60%.
- 45% of homeless persons are in the age category 30-49 years, and 19% are 50 years or older.
- 24% of homeless persons self-identified as Aboriginal (Abbotsford, 32; Mission, 18; Chilliwack, 25; Agassiz-Harrison and Hope, 8).
- Just over half (52%) of the homeless persons have lived in FVRD communities for 6 years or longer.
- Welfare and disability benefits are the source of income for 43% of the homeless persons.
- 41% of the population lives with an addiction to substance use, and 22% live with a mental health issue.
- 26% indicated that they have been impacted by service change or withdrawal. The most common examples cited are “refused welfare” or “being cut off welfare”.

6. Conclusions

The following summarizes the main conclusions of this survey:

1. There remains a need for permanent supportive housing based on the housing first approach for those who live with mental illness and/or addiction to substance use; transition (second-stage) housing is also needed for those coming out of treatment and those released from incarceration.
2. Homeless people are subject to stress because of the factors that made them homeless and because of the experience of being homeless. Poor diet, stress, cold and damp, along with inadequate sleeping arrangements, sanitation and hygiene, increase the risk of health problems and decrease life expectancy.
3. Homelessness in itself is an “agent of disease". As such homeless people are more exposed to and more likely to develop health problems than the general population, as living conditions predispose them to be particularly at risk of developing ill health.
4. People in FVRD communities who live chronically homeless suffer from a variety of chronic and acute illnesses that are aggravated by life on the streets.
5. Chronic emotional and mental illness complicates daily existence and can mask acute illnesses or prevent people from accessing services and receiving much needed medical care and therefore remains trapped in chronic homelessness.
6. Chronically homeless persons are people who cannot function in housing that assumes independent living without support. They are unable to fit into independent housing, and thus get evicted. What this population, also recognized by the term “concurrent disorders”, requires is housing that can respond adequately to their needs e.g. Housing First Approach.
7. The longer a person is homeless, the greater likelihood that preexisting and emergent health problems worsen (including mental health and addictions) and there is greater risk of criminal victimization, sexual exploitation and trauma and a much greater risk of involvement in the justice system.
8. Professional medical attention and community relationships are two key elements of care in relation to people who live homeless. People are more willing to think about treatment and other solutions if they feel trusted and understood. An empathetic relationship creates a sense of belonging and is critical for people’s well-being. It makes them feel they are worthwhile and can play an active role in their own treatment.

9. In addition to a paradigm shift in the delivery of mental health care, it is also necessary to provide more than surface support, such as food, clothing, emergency shelter, soup kitchens, etc. High-need clients, such as those living with concurrent disorders and who are chronically homeless, require a full integration of mental health and addiction services in addition to health care and housing. Evidence suggests that the current system of care picks and chooses instead of offering the whole set of services needed, so clients with the most complex needs get no care and drop out of the system. This reality aggravates the problem of inadequate care for those who live homeless.

10. It is not adequate care for a person with mental and/or substance abuse challenges to be housed without supportive service or to receive services without housing.

11. Housing needs to be inclusive of everything, from housing to medical care to psychiatric treatment to provision of food.

12. Supportive housing, inclusive of psychosocial rehabilitation, is seen as a leading practice in providing services and housing more effectively and efficiently to homeless persons.

13. Housing models must meet the needs of the whole person, with involvement in day-to-day support. It is imperative that participants not be constrained by exit deadlines.

14. A fully integrated system that makes “any door the right door”— means that people with concurrent disorders experiencing homelessness can enter the service system through any service door, be assessed, and have access to the full range of comprehensive services and support.

15. The following service strategies or approaches lead to improvements in mental health and substance use disorders among homeless individuals with concurrent disorders:

    - client choice in treatment decision-making
    - positive interpersonal relationships between clients and providers
    - assertive community treatment approaches
    - supportive housing
    - non-restrictive program approaches

16. Supportive case management is indispensable to successful service delivery to people living homeless.

17. Emergency shelters do not seem to be the most effective and efficient way to deal with chronic homeless persons who live with mental health issues or substance use addiction, or both. This subpopulation needs long-term or permanent supportive housing or housing with professional wrap around supports.

18. Housing-first models are predicated on the assumption that all individuals, regardless of substance misuse, are entitled to a safe place to live. They are also predicated on the assumption that addiction recovery is more likely to be successful when secure housing is met. Housing-first models encourage clients to seek addiction treatment, but do not make it mandatory before housing is provided.

19. The current Canadian response to homelessness relies heavily on emergency responses such as shelters and crisis health care. However, federal funding and commu-

nity response is shifting towards Housing First priorities based on the strong body of evidence supporting its effectiveness.

7. Recommendations

1. FVRD communities to give serious consideration to evidence based housing solutions inclusive of the housing-first approach[15] in policies and practices addressing homelessness. It is imperative that this is implemented in order to provide good care and make progress with homelessness reduction.

2. Take immediate steps to move toward the creation of a more adequate housing spectrum in FVRD communities through housing first provisioning and more comprehensive and farther in reach mental health and addictions services.

3. Provide 100 to 150 "Housing First" units across FVRD communities based on the estimated number of chronically homeless persons in each community.

4. Implement Assertive Community Treatment (ACT) Teams in FVRD communities that facilitate an integrated model of care embracing empathetic therapeutic relationship building.

5. Establish a community based housing resource and connect centre that will act as a hub where homeless persons or persons at risk of homelessness can access services and receive counseling and support.

6. Focus community care efforts on establishing a coherent and comprehensive intervention to implement housing and care.

7. Capitalize on and expand by means of partnerships with existing community agencies the reach of housing first options through a scattered site approach (e.g. Raven's Moon Society's Model in Abbotsford).

8. Leverage municipal governments and social service sector to advocate for an increase in welfare shelter allowance and expansion and lengthening of rent subsidies as part of homelessness outreach and support funding from BC Housing.

9. Approach Federal Government and advocate for federal housing funding for FVRD communities that fall between proverbial cracks in funding streams for greater metropolitan areas and small rural communities.

[15] See Appendix 4

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Appendix 1:

The Socio-Political, Socio-Economic and Socio-Cultural Context within which Homlessness has Taken Root

Over the past 20+ years, government policies have eroded social safety nets, decreased social spending, deinstitutionalized mental health care, and downloaded national housing policies to the provinces and territories. From 1993 to the early 2000s, British Columbia and Quebec were the only provinces that continued to fund new social housing projects[16].

The general view among researchers and practitioners working in this field is that there was not much homelessness in Canada before the mid-1990s. Up to that point, Canada had a social housing policy that was quite effective in providing affordable housing to low-income earners. When the national housing program was cancelled in the early 1990s, professionals and practitioners predicted that homelessness would result. In British Columbia, the provincial government did continue with the provisioning of social housing through BC Housing[17] but could not keep up with the demand in the absence of federal funding levels, resulting in a reduction in the number of units being built. The effect of this reduction was compounded by a decrease in welfare support, introduced in British Columbia at the same time. The situation was further aggravated by the increase in the cost of housing, which was rising, and continues to rise more quickly than peoples' incomes and welfare rates, resulting in a widening gap between income and cost of housing, with more and more people falling through the cracks in housing provisioning.

A concomitant factor was the start, at roughly the same time, of the drug epidemic in the Lower Mainland of British Columbia, resulting in drugs being more widely available in Vancouver. People with drug induced behaviours had more difficulty staying housed. Furthermore, the patient capacity at Riverview Hospital[18] was reduced, resulting in patients being discharged. Those discharged had some community support attached to them and were placed in communities. However, other people who needed this type of care and support had nothing; there was no appropriate housing to accommodate people with severe mental health issues and/or substance ad- diction, and their concomitant needs.

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[16] Through British Columbia Housing Management Commission (BC Housing) the province of British Columbia continues to fund social housing projects.

[17] British Columbia Housing Management Commission (BC Housing) is a Crown agency. Its mandate is to fulfill the provincial government's commitment to the development, management, and administration of subsidized housing under the Housing Act. BC Housing was established in 1967.

[18] Riverview is a mental health facility located in Coquitlam, British Columbia, and it operates under the governance of British Columbia Mental Health and Addiction Services.

In terms of British Columbia housing policy prior to 2000, affordable[19] rental housing was primarily designed for families or seniors. In the early 2000s, government housing programs were expanded to include single persons as well as people who were considered homeless or at risk of homelessness. These units were allocated and rented out using the traditional landlord–tenant model. Based on this model, the understanding was that the landlord was not to interfere with tenants, and the precepts of the Residential Tenancy Act had to be followed. This type of housing provisioning was clearly designed for people who could function and live independently. It was not supportive housing. For people with mental health issues, there were some group homes. More recently, the Province of British Columbia introduced the Supported Independent Living (SIL) Program for mental health clients. Each of these clients now has a SIL worker, but there is a caseload limit, with the result that clients are expected to live fairly independently with very minimal support. Those who need more support are still left wanting and many end up living homeless.

During this era (late 1990s into the 2000s), those living with substance addictions were accommodated as long as the usage or addiction was, relatively speaking, under control, allowing them to still manage independently in their housing. That scenario is quite different from the challenges associated with the more recent population described as chronically homeless. Chronically homeless persons are people who cannot function in housing that assumes independent living without support. They are unable to fit into independent housing, and thus get evicted. What this population, also recognized by the term “concurrent disorders”, requires is housing that can respond adequately to their needs.

Inadequate Health Care Response

According to one of the psychiatrists interviewed (Van Wyk, Van Wyk, 2011a), “behaviours related to poly-substance use or mental illness often lead to behaviours which put your home at risk.” Medical care often focuses on health issues and ignores mental conditions, substance use disorders, and/or homelessness (SAMHSA Health Information Network, 2003). According to Leal et al. (1999) and Susser et al. (1997), 50% of the homeless population who have been diagnosed with schizophrenia also use intravenous drugs.

Physician, community, and social care are equally important determinants to prevent homelessness and lead to healthy living (National Coalition for the Homeless, 2009; Garcia-Nieto et al., 2008). Professional medical attention and community relationships are therefore two key elements of care. Patients are more willing to think about treatment and other solutions if they feel trusted and understood. An empathic relationship creates a sense of belonging and is critical for people’s well-being. It makes them feel they are worthwhile and can play an active role in their own treatment.

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[19] For the purposes of this report, the term “affordable housing” refers to housing that is provided to lower-income households in need of below-market-rate housing. It includes housing that has value-added services like social supports and supervision. It may be publicly owned and funded, or publicly supported, either through capital or operating funds, under management by not-for-profit or cooperative societies. Included in this definition is a range of facilities and programs, such as emergency shelters, supported independent living contracts, and subsidized independent rental apartment units. Policy tools to make housing affordable to low-income residents include: rent supplements for market rental housing; units that cap household spending on rent at 30% of gross income; rent controls; and regulations that protect the existing stock of rental housing or subsidize the development of new rental housing stock.

Typically, within the current regime of service delivery, clients are not screened in terms of their background, trauma, and other experiences. Within the system there is a lack of awareness of how addiction and mental illness interface, and thus there is a failure to properly understand that, for instance, if a person is psychotic, and using drugs, and HIV positive, this constellation of issues can only be addressed if the person receives adequate and seamless mental health care, addiction care, housing, and support services. As a result of the development of specialized medicine, and specialization in society in general, roles and information flows are so specific that sometimes basic factors and facts related to health behaviour are unknown. Furthermore, the health care system is not covering high-need clients, who are only seen in emergency rooms and acute care settings.

It is an unfortunate reality that society ignores people with mental health issues. They do not have the support that is typically available to and taken for granted by others in society, yet the prevailing regime of care expects them to live independently, something which they cannot manage. Nevertheless, this expectation of independent living is linked to a societal view that institutionalization is no longer a proper option. People who live with mental illness, drug addiction, or a concurrent disorder have different housing needs, but under the current system they are for the most part left to provide for themselves.

There has always been and will always be a portion of the population who struggle with limited life skills, who fall into addictions, and who do not have the ability to maintain or manage relationships, a job, or money. There has never been a time when society did not have people with mental illness. Certainly during the past 25 years, since deinstitutionalization in Canada, we continue as a society to have a great deal of mental illness. Closing down mental health institutions did not make mental illness go away.

In addition to a paradigm shift in the delivery of mental health care, it is also necessary to provide more than surface support, such as food, clothing, emergency shelter, soup kitchens, etc. High-need clients, such as those living with concurrent disorders, require a full integration of mental health and addiction services in addition to health care and housing. When there is limited capacity, as is the case in Canada, the system picks and chooses instead of offering the whole set of services needed, so clients with the most complex needs get no care and drop out of the system. This reality aggravates the problem of inadequate care for this population.

The key to any successful program has to be communication, not just between staff and clients, but amongst agencies as well. Treatment works best with a limited number of staff and on a one-to-one basis (Abelló, Fisher, & Sitek, 2010). Muir (2010) has found that meeting with clients on an individual basis improves their social skills and overall quality of life. Inclusion of homelessness has to be a main focus in mental health intake, mandating that an individual's basic needs must be met first. Long-term government funding is essential to run successful programs, and in the long run will prevent expensive psychiatric inpatient hospitalizations (National Coalition for the Homeless, 2009; Kessell, Bhatia, Bamberger, & Kushel, 2006).

Inadequate Discharge Planning and Case Dropping

The lack of discharge planning for mental health patients leaves individuals with concurrent disorders particularly vulnerable to homelessness. A study on inadequate discharge planning in London, Ontario conservatively estimated 194 incidents of such discharges in 2002 (Forchuk, Russell, Kingston-MacClure, Turner, & Dill, 2006, p. 301–308). Patients with mental illness who are discharged without appropriate housing plans experience increased vulnerability, resulting in

costly re-hospitalization. In comparison with singly-diagnosed clients, those with concurrent disorders are more likely to be homeless and unemployed (Todd et al., 2004).

Clients are often dropped or their case files are closed because the clients, as one interviewee put it, “weren’t going anywhere so their spot needed to be filled by someone on the waiting list, or the support that the particular client needs does not exist.” The biggest stumbling block for these individuals is that mental health issues and addictions mask each other, and the individuals’ slow progress is perceived to be no progress.

Appendix 2:
Concurrent Disorders and Homelessness

Within the discourse about concurrent disorders and homelessness, the argument is made that people do not choose to disengage from the social structure to the point where they become homeless. Based on feedback from interviewed homeless persons, there always seems to be something that compels people down the road toward homelessness (Van Wyk and Van Wyk, 2011a). For example, the history of trauma is extensive and runs deep among the chronically homeless population. Included are people who have been horribly abused. According to data from interviews, this seems to be the rule rather than the exception. For instance, as children they have been used to gratify the sexual needs of adults. Examples of abuse include what happened in residential schools,[20] ongoing sexual abuse, and other forms of emotional and physical abuse that are present in society—e.g., spousal abuse, assault, and violence. Linked to this is the impact of the early onset of addictions to narcotic substance use. The question then is, what is the addiction a function of? As one interviewee stated:

If you were being abused, and no one was protecting you or advocating for you, and this was going on for years and years and years and a parent of yours was so depressed that they couldn't even address any of it, then what would you do? You'd try to numb that, wouldn't you?

The results are dropping out of school early, getting into trouble with the law, diminished opportunities, poverty, and in many cases eventually homelessness.

Thus, it would appear that a combination of conditions, chances, and choices, including broad living conditions of poverty, isolation, the socio-economic and socio-cultural conditions the person was born into, play a role in determining this path of disengagement and alienation from "normal" society. They don't feel they belong; they feel on the outside. The loss of family and friends is one of the worst things that can happen to an individual. Given these realities, chronically homeless persons have not had much role modeling about how to develop a support network and activate it when they need it. They also feel a lot of mistrust, and it is difficult for them to believe that there are actually people who genuinely want to support them. It can take many years for them to develop trust, as its absence is due to a lack of functional relationships and the resultant psychosocial dislocation.

It can thus be asserted that the variables contributing to people who live with concurrent disorders becoming chronically homeless are multiple and intertwined. At play is a combination of poverty, unemployment, and cognitive and social behavioural challenges that merge to create poverty in all its dimensions—i.e., material, physical, emotional, and spiritual. Poverty in turn results in limited options. Add to this the absence of community care and the high cost of housing, and the end result is chronic homelessness. Clearly, this complex interplay among variables presents challenges to the way health and social care are currently provided.

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[20] This reference is to the Indian residential schools in Canada that were established by the Government of Canada in the nineteenth century to serve its then policy of assimilating Aboriginal people into "European" Canadian society. Under this policy, approximately 150,000 Aboriginal children were removed from their parents and communities, and forced to attend these residential schools. The last residential school closed in 1996. Since the 1990s, many cases of child sexual abuse at these schools have come to light.

Contributing to chronic homelessness is the revolving-door nature of some mental health care facilities—in other words, organizations that cater only to treating mental health issues, but fail to address substance use disorders and/or homelessness, often aggravate the situation by releasing individuals who have no fixed address back onto the street (SAMHSA Health Information Network, 2003). Furthermore, in the absence of housing providers equipped to house and care for this population, these individuals become the so-called chronically homeless because there are not enough community-based housing facilities and services for them.

Housing that is available may not be equipped for people who present multiple issues and behaviours brought on by mental illness or drug addiction, or a combination of mental illness and drug addiction. The general sense among those interviewed is that there are too many barriers to access housing that does exist, and where housing is available, too little support is attached. As one interviewee stated:

This population has been accumulating in the street for 20 years, aging in place. They are "barriered" by non-profit housing, they are "barriered" by government housing policy, and they are "barriered" by services. They remain in the street until they become so ill that they die in the hospital or until they die on the street by a variety of mechanisms.

Most homeless people, with or without concurrent disorders, cite a lack of financial resources as the primary reason for their state of homelessness (Buckland, Jackson, & Smith, 2001). Mojtabai (2005, p. 176) found few differences between participants who were mentally ill and those who were not, regarding their perceived reasons for housing loss or continued homelessness. "Financial and interpersonal problems were the most commonly perceived reasons for the most recent loss of housing and insufficient income, followed by unemployment and lack of suitable housing, the most common perceived reasons for continued homelessness." This reality was also verified by a survey done among chronically homeless persons in the Fraser Valley as part of the data gathering for a study done for the Homelessness Partnering Secretariat, Canada, and has been previously confirmed by homelessness surveys done in 2004, 2008, 2011 in the Fraser Valley Regional District (van Wyk & van Wyk, 2005, 2008, 2011, 2013).

For example, for a person with multiple and persistent barriers who receives $610 per month in the form of Income Assistance in British Columbia, including a shelter allowance of $375 per month, it is very difficult, if not impossible, to find housing that is safe, clean, and stable. The system is complicated and hard to navigate as it is; imagine the challenge when the system needs to be navigated by a person with a concurrent disorder, compounded by lack of support, inadequate income, internal anger, and mistrust. Even when such individuals do find a place, the chances are good that they will not get along with the neighbours or, due to low income, they will end up in shady homes or apartments. The latter is typically unsafe housing and within an environment that works against stability and improvement. Through their behaviour, they burn their bridges, resulting in lack of support from family or friends.

Appendix 3:

Leading Practices in Housing Chronically Homeless Persons

Traditionally, and most probably still in some instances today, persons presenting as "difficult to house"—which often included those with mental health and/or addiction problems—were perceived as needing to become "housing ready" before being provided with stable housing. Clients then progressed through a series of congregated living arrangements, receiving residential addiction and mental health treatment. One major critique of the traditional intervention is that clients return to the street when they drop out before the end of the process (Mancini, Hardiman, & Eversman, 2008, p. 103). Another shortcoming is that clients are moved from one facility to another during the process. These moves are particularly disruptive for clients with concurrent disorders, and are not conducive to building relationships and community.

Housing or access to a building and a roof over one's head but without the needed support services has proven to be unsuccessful. It is not enough for the person with mental and/or substance abuse challenges to be housed without supportive service or to receive services without housing. As stated by two interviewees: "To house a person without support poses too much risk to everybody else"; "supportive service is not just something that is done by an outreach van or by a supervised injection site. Housing needs to be inclusive of everything, from housing to medical care to psychiatric treatment to provision of food."

Somers et al. (2007, p. 2) state that the preponderance of evidence indicates supportive housing is an essential component of an effective overall therapeutic and rehabilitation strategy for individuals with mental diagnosis and/or substance abuse issues. Supportive housing, inclusive of psychosocial rehabilitation, is seen as a leading practice in providing services and housing more effectively and efficiently to homeless persons (Dumas, 2007; Homeless Link, 2009; Mission Australia Community Services, 2008; Blankertz & Cnaan, 1994). To help rehabilitate individuals affected by both homelessness and either mental health disorders or addiction issues, the program they participate in must seek to improve quality of life as well as reduce the chance of recidivism (Muir, 2010; Garcia-Nieto et al., 2008). Community-based residential programs that focus on rehabilitation are necessary to help participants develop the requisite skills to be functioning members of the community (Blankertz & Cnaan, 1994, p. 11). Housing models must meet the needs of the whole person, with involvement in day-to-day support (Wright, 1988). It is also important that participants not be constrained by exit deadlines.

To achieve positive outcomes in housing and caring for chronically homeless persons, two variables must be present, namely willingness and timing (Goering, Tolomiczenko, Sheldon, Boydell, & Wasylenki, 2002). According to Thompson, Pollio, Eyrich, Bradbury, and North (2004), positive outcomes are not possible without the "willingness" of the community to address social problems such as homelessness, mental illness, and substance abuse. Positive outcomes are also dependent on the "willingness" of the person at the centre of the social problem to take part in supportive programs. Positive outcomes are not possible if the "timing" is not right. No matter how "willing" and how positive the participant feels about supportive living arrangements, the time is not right if the participant has strong ties and relationships with a past destructive environment—for example, drug dealers. Timing is also crucial when a person is discharged from a treatment centre. Transition and separation are traumatic. Timing, therefore, is important to create a "gradual, empathic separation" and also plays an important role in preventing recidivism of homelessness (Herman, Conover, Felix, & Nakagawa, 2007).

The past 20 years have seen an increasing awareness and practice of integrated treatment for psychiatric and substance use issues in individuals experiencing concurrent disorders. For homeless individuals with concurrent disorders, integrated models of care that increase levels of

communication, cooperation, and trust amongst providers positively affect their access to services (Rosenheck, Resnick, & Morrissey, 2003). In past practice, mental health, addiction, and housing services were all independently provided. People living with concurrent disorders often encountered, and in many cases still encounter, multiple barriers accessing services. Clients presenting at mental health services were often denied care until their addiction issues were resolved. Conversely, clients seeking addiction services were often denied services until their mental health issues were resolved. Schutt et al. (2005) found that homeless clients with concurrent disorders were reluctant to live in a rule-oriented environment. Most often, however, clients were not screened for concurrent disorders, and treatment failed because it was based upon a faulty understanding of a client's genuine problems.

Integrated models of care are now becoming the norm for supporting persons with concurrent disorders. This conceptual and practical shift recognizes the multiple needs of those experiencing homelessness and concurrent disorders, and provides individuals access to an array of services (mental health care, substance abuse treatment, housing services, benefits and income support application assistance, educational and vocational services, etc.), based upon an individual's wants and needs (Rickards et al., 2010). Service providers interviewed (Van Wyk and Van Wyk, 2011a) emphasized the importance of client-centred service delivery based first and foremost on client needs. O'Campo et al. (2009, p. 965) argue that services need to be in line with client needs rather than organized around efficiencies or expertise in service delivery. This approach puts a high emphasis on client choice in treatment decision-making (Anucha, 2010).

The following leading practices are seen to represent this changing approach toward supported housing and care based on integrated service delivery.

Critical Time Interventions (CTI)

Critical Time Intervention (CTI) can be defined as "an empirically supported, time-limited case management model designed to prevent homelessness and other adverse outcomes in people with mental illness following discharge from hospitals, shelters, prisons, other institutions and from the street" (Herman et al., 2007; Jones et al., 2003). Coinciding with the participant's willingness and timing is the importance of the individual's personal relationships with the service providers (Susser et al., 1997, as cited by Thompson et al., 2004). The ability of the individual to convey needs and opinions and become part of an encouraging community setting without being socially isolated is imperative for a positive outcome. The premise of CTI is to "facilitate affiliation with social supports and community resources for people who have moved from a shelter, the streets, a psychiatric hospital, or the criminal justice system to the community" (Herman et al., 2007).

CTI treatment programs include access to stable housing, psychiatric care, medications, counseling, outreach, case management, family, work, and rehabilitation groups on an ongoing basis for up to 10 years (Jones et al., 2003). The three main phases of CTI are "transition, try out and transfer of care" (Herman et al., 2007; Jones et al., 2003). *Transition* focuses on providing dedicated support, including the formalization and implementation of a transitional plan, *try out* focuses on the development of problem-solving skills, and *transfer of care* focuses on the process of creating ongoing support networks.

CTI appears to be one of the most effective approaches that contribute towards successful interaction of individuals with mental health and/or substance abuse issues within the homeless population. Timing is critical, as the person must be "ready and willing". Other important CTI fac-

tors are patience, perseverance, and tolerance. These are equally important for both the client and the interventionist. According to one interviewee, “It’s not like you can say: We’re dating and if you screw up we’ll never talk again.” The client often moves “two steps forward, one step back, or three steps sideways.” The focus should be to build on the “forward steps”. One of the most important challenges in creating supportive housing is absence of the “willingness” stage. Dishonesty, lack of commitment, mistrust, failure to follow through on promises, drug use, and unwillingness to follow protocols and to live within clear, consistent, and reasonable boundaries are major challenges and often signs of “unwillingness”. In addition, protocols with health authorities are important for the individual to receive appropriate medical treatment and medication.

Supportive Housing and Assertive Community Treatment (ACT)

The Critical Time Intervention concept of supported housing contributed towards the growth and development of supported housing schemes (Rudkin, 2003, in Wright & Kloos, 2007). Complementing housing programs of this nature are services like physical health care, mental health treatment, peer support, life skills (money management, daily living), and education or employment opportunities (National Coalition for the Homeless, 2009). Long-term support is combined with the efforts of housing providers and health authorities. This model seeks to ease self-sufficient living through mental health services, financial aid, and Assertive Community Treatment (ACT) teams (Wright & Kloos, 2007).

An ACT team is essentially a “multidisciplinary team” that utilizes a low client-to-staff ratio (10:1) through shared caseloads. Other elements of an ACT team are firm outreach (including regular home visits), daily team meetings, individualized treatment plans, staff availability 24 hours a day, and medication management (McGraw et al., 2010). For homeless individuals experiencing concurrent disorders, integrated ACT care increases levels of communication, cooperation, and trust (Rosenheck et al., 2003). According to Rickards et al. (2010), the shift towards ACT models enhances access to mental health care and housing services.

In the United States, the Centre for Mental Health Services (2003, p. 36) developed a blueprint for creating and managing services necessary for homeless persons with concurrent disorders. The blueprint emphasizes the importance of a fully integrated system that makes “any door the right door”—meaning that people with concurrent disorders experiencing homelessness can enter the service system through any service door, be assessed, and have access to the full range of comprehensive services and support.

Although integrated models such as ACT have been shown to be effective for supporting individuals with concurrent disorders, numerous practical challenges have been identified. Drake et al. (2001, p. 469) argue that implementation of dual diagnosis programs requires changes at the policy level that include regulations on training and supervision for clinicians. The success of ACT teams depends on training and on regulated operational principles (Centre for Addiction and Mental Health, 2006). McGraw et al. (2010) and Foster, LeFauve, Kresky-Wolff, and Rickards (2010) argue that recruiting and retraining designated concurrent disorder specialists is challenging and leads to staff shortages.

Comprehensive, Continuous, Integrated System of Care (CCISC)

The Comprehensive, Continuous, Integrated System of Care (CCISC) model emphasizes integration of care, empowerment of clients, disease diagnosis, and individualized recovery treatment. Evidence suggests that the CCISC model reduces substance use and mental health

symptoms, and contributes towards improved residential stability (Foster et al., 2010; McGraw et al., 2009; Tsai et al., 2010; Young, Clark, Moore, & Barrett, 2009; Harrison, Moore, Young, Flink, & Ochshorn, 2008; Power & Attenborough, 2003). According to Tsai et al. (2010) and Wright and Kloos (2007), hospitalization, homelessness, and incarceration rates fall and overall improvement is noticeable in the individual's psychosocial well-being. Also, a decline in psychiatric symptoms is observed after diagnosis and engagement in recovery treatment (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005, as cited by Wright & Kloos, 2007). Counseling and one-to-one contact are key characteristics of the recovery process (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009). Evidence suggests that the recovery process leads to declines in cocaine and alcohol use (Schumacher, Usdan, Milby, Wallace, & McNamara, 2008).

In another fairly recent Canadian study, O'Campo et al. (2009, p. 965) examined both scholarly and non-scholarly literature to explore program approaches and elements that lead to improvements in mental health and substance use disorders among homeless individuals with concurrent disorders. The researchers identified the following program strategies:

- client choice in treatment decision-making
- positive interpersonal relationships between clients and providers
- assertive community treatment approaches
- supportive housing
- supports for instrumental needs
- non-restrictive program approaches

Supportive Therapeutic Relationships

Nobody does well without relationships. People do better when they feel safe, when they have food, and when they have meaningful and supportive personal connections. For people who live marginalized and socially isolated, relationships have typically broken down. If one has a certain level of integration into a community, it is easier to avoid risks, stabilize, engage in community interactions, build social networks, and perhaps even find employment. Relationships lead to stability and mitigate social exclusion. People are more willing to think and talk about treatment and other solutions if they feel trusted and understood. This is what empathic relationships are about.

Relationships are absolutely imperative when working with, for instance, people who live with fetal alcohol syndrome disorder (FASD). In this regard, the role of a supportive case manager cannot be overemphasized. As people settle in housing, they feel safer, they start to look out for one another, they start to give back and to take ownership in their place and each other. This then provides a good foundation on which to build training about healthy relationships and sexual behaviour. As one interviewee states: "It varies, anywhere from learning to be more respectful [to] learning to be more community-focused on what the needs of their little community are."

It is imperative to remember that building supportive relationships requires patience and the modeling of resilience, as the circle of connection and support widens. Forging these supportive relationships takes time, hard work, patience, and perseverance. Tolerance is also needed toward the ambiguity, "craziness", and "chaos" of people's lives. Under this prevailing reality, stability is difficult to achieve. For example, when a person with multiple and persistent barriers or with a concurrent disorder moves inside, think of the tasks that this person needs to complete in a context where life skills have been lost through living outside—or where such skills were never

fully gained because the person went through so many different homes and/or experienced deep trauma growing up, with the result that they simply did not develop those basic skills.

For many, entering into relationships is difficult, and the unfortunate reality is that a person suffering from severe mental illness will be rejected by almost everyone. Mental illness creates a worldview that is so unique to the person bearing it that he or she is not going to find anybody who shares very much of that personal experience. According to those we interviewed, many of the relationships they have learned in the street relate to the rituals of substance abuse. Based on interviews with service staff, when people move from the street into housing, their addictive substance use drops. Moving inside does not in and of itself cure the addiction or end it, but there is likely to be much less use of addictive substances than on the street. One reason is that the person can hide from predatory dealers; another is that they do not need the substance to substitute for a feeling of safety, as they did on the street. So based on data obtained from facility operators, it is apparently not unusual for people to move inside and immediately begin weaning themselves from the majority of the drugs that they were taking. However, by leaving the drug culture, or spending less time in the drug culture, they also lose the existing friends that they had outside, and because they are still using to some extent, they do not find a normal social group. They cannot be adopted into a church. They cannot be taken to sing in the choir. They are not particularly welcome in community centres, where they may still have street-involved behaviours or anti-social behaviours. So the loneliness that can arise when a person leaves the street and comes inside has to be dealt with through the skills of the support worker, who first forms a bond with that person, and then helps him or her transfer the bond to other people in a housing environment. Thus, the importance of a therapeutic relationship cannot be overstated.

The Promise of Housing First

The literature is clear that effective treatment for homeless people with concurrent disorders requires comprehensive, highly integrated, client-centered services, as well as stable housing. Housing is essential both during and following treatment. There is growing evidence that supported housing is essential, regardless of treatment. Safe and secure housing, with an integrated service team, is a key factor for residents/program participants to address their substance use issues by becoming abstinent, reducing their substance use, or reducing the negative impacts of their use. It is imperative to understand that in the context of providing housing to chronically homeless people, housing becomes the platform from which services are delivered in order to facilitate social inclusion. In this regard, the notion or concept of "housing first" represents a significant value shift in how housing is provided to people with concurrent disorders. It is a value shift in housing provision that needs to be embraced by Abbotsford as a community. Housing first options are desperately needed in Abbotsford in order to provide effective and efficient care to people who experience chronic homelessness in Abbotsford.

Housing First is provided with flexible service based on need regardless of eligibility for income assistance, lifestyle, condition (e.g. intoxication) or number of times receiving the service, in a building that is accessible to everyone, regardless of physical condition, while acknowledging that acuteness of health needs, behavior or level of intoxication, may limit the ability of a provider to give service (Social Planning and Research Council of BC, 2003, p. 29). Two Canadian studies (Kraus et al., 2005 and Patterson et al., 2008) have identified the need to provide homeless persons who have substance use issues with a "housing-first" model (also referred to as low-barrier housing).

"Housing first" involves the direct provision of permanent, independent housing to people who are homeless. Central to this idea is that clients will receive whatever individual services and assistance they need to maintain their housing choice. The housing is viewed primarily as a place to live, not to receive treatment (Kraus et al., 2005). Housing-first models are predicated on the assumption that all individuals, regardless of substance misuse, are entitled to a safe place to live. They are also predicated on the assumption that addiction recovery is more likely to be successful when secure housing is met. Housing-first models encourage clients to seek addiction treatment, but do not make it mandatory before housing is provided. A conscious effort is made to ensure that nothing will get in the way of successfully keeping a roof over someone's head. That means that although the client may have an addiction issue that is not approved of, housing will not be refused and all support necessary will be provided to reduce the harm that may come from using drugs or alcohol. The reasoning is that support and care will remain in place, which is necessary for the relationship to remain intact, which in turn will contribute to the building of trust, in the belief that through continuing support and care, the person will come to a decision point in favour of choices toward a healthier lifestyle. The reasoning is furthermore that keeping people housed and providing ongoing support based on empathic therapeutic relationships will prevent people from going back to the street again or ending up in housing settings where they will be evicted and wind up on the street.

The Canadian Housing and Mortgage Corporation (as cited in Kraus, 2005) found that people who are homeless, even if they have substance use issues and concurrent disorders, can be successfully housed directly from the street if they are given the right supports when they want them. If the goal is to end homelessness, evidence suggests that the housing-first approach would make this possible.

Based on professional evidence to date it can be posited that Abbotsford will greatly benefit from a housing first approach. Housing first can be delivery through a scattered site approach and/or on a particular site.

Appendix 4:
Homelessness Prevention & Housing Provisioning: Federal and Provincial Funding

FEDERAL FUNDS

Homelessness Partnering Strategy (HPS) Funds**

Employment and Social Development Canada (ESDC) announced an addition of $600 mil- lion ($115 million per year) for the Homelessness Partnering Strategy (HPS). The strategy emphasizes a Housing First approach; however, some funds are set aside for non-Housing First homelessness needs.

3 HPS Funding Streams:

- 61 Designated Communities (none in the FVRD)
- Rural and Remote (Tier 1 priority: communities under 25,000; Tier 2 priority: communities over 25,000)
- Aboriginal Homelessness (Off-reserve)

All FVRD communities are eligible for the Rural and Remote and Aboriginal funding streams; however, certain communities have little chance of accessing the Rural and Remote stream because of size. Additionally, the Aboriginal stream is specifically for addressing Aboriginal needs and should be managed by Aboriginal agencies. Neither streams have a substantial amount of funds.

Investment in Affordable Housing (IAH) Funds

Canada's Economic Action Plan 2013 designated $1.25 billion ($253 million per year) in investing in affordable housing. In the IAH program, federal dollars match provincial dollars. British Columbia will receive more than $300 million over 5 years. See below under BC Housing for program details.

Canada Mortgage and Housing Corporation (CMHC) Funds

Seed Funding

Financial assistance to conduct the initial activities needed to develop a proposal for an affordable housing project.

- Up to $10,000 available as non-repayable
- Up to $10,000 available as an interest-free loan (repayable if housing project proceeds)

** See Appendix for further detail on HPS funds

Proposal Development Funding

PDF consists of repayable, interest-free loans that facilitate the development of affordable housing. PDF helps with up-front expenses required to bring the proposal to the mortgage financing stage.

- Up to $100,000 available (project must increase affordable housing stock and meet affordability criteria)

Veteran's Affairs Canada (VAC) Funds

Emergency Funds

Homeless or other low-income veterans can access the Emergency Fund to assist them when there are no other income sources available. Contact VAC for assistance: **1-866-522-2122** ; information@vac-acc.gc.ca ; Service Canada Centre or VAC Area OfVice.

PROVINCIAL FUNDS (BC Housing)

Note: The programs described below address affordable housing and homelessness; how- ever, ***existing provincial funds have already been allocated***. BC Housing could potentially consider new projects on a case-by-case basis.

Aboriginal Housing Initiative (AHI)

Run through the Aboriginal Housing Management Association (AHMA), the AHI uses federal funds to offer rent assistance and social housing.

Community Partnership Initiative (CPI)

CPI uses provincial funds to help low to moderate-income households with affordable home ownership by assisting housing providers with financing and interim construction.

Emergency Shelter Program (ESP)

ESP uses provincial funds to provide emergency shelter units, seasonal shelter services, drop-in services, and other specialized programs for those who are homeless or at risk of homelessness. Services can include overnight shelter, meals, hygiene (including laundry), and gateway services. Clients do not pay.

Extreme Weather Response (EWR) Program

The EWR program uses provincial funds to assist those who are absolutely homeless to access shelter under extreme weather conditions. Funds cover staff costs, food, laundry, transportation, and first aid costs.

Federal-Provincial Housing Initiative (FPH)

Investment in Affordable Housing (IAH funds (see Federal Funds above) contribute to the development of affordable housing apartments in the province. Municipalities and community

partners also contribute through property tax exemptions, waived developmental costs, land equity and/or capital cost contributions.

Homeless Outreach Program (HOP)

The HOP programs assists people who are homeless or at risk of homelessness. Provincially funded. Costs covered include staffing, administration, overhead costs, and rent supplements. Outreach workers are often the first point of contact with the housing and support services for homeless individuals.

Homeless Prevention Program (HPP)

IAH funds go towards rent supplements to identified at-risk groups facing homelessness, including youth transitioning out of foster care, women at risk of violence or who have experienced violence, people leaving institutional care, and individuals of Aboriginal descent. These supplements assist in accessing private market rental housing.

Independent Living BC (ILBC)

ILBC provides rental and support services for seniors and people with disabilities who need assistance to live independently but do not require residential care. Funding contracts for operations have already been awarded; however, non-profits operating subsidized units continue to receive rent supplements.

Provincial Homelessness Initiative (PHI)

Target groups for PHI include people who are homeless or at risk of homelessness, including those with drug or alcohol addiction, mental illness or concurrent disorders, women and children fleeing abuse, and Aboriginal people.

Non-Profit Partnerships: Initial phase offered capital grants to non-profit providers. Federal and provincial funds continue to provide non-profits with funding for support services.

Preserved Affordable Housing (SROs): Funding is available for additional renovation for Single Room Occupancy hotels.

Local Government Partnerships (MOUs): BC Housing partners with municipalities to construct new affordable housing developments. Funds are provincial.

Provincial Housing Program (HOMES BC)

BC partners with non-profits to provide long-term operating agreements or rent supplements.

HOMES BC Regular: Serves families and seniors. Contracts to providers have already been awarded; continual rent subsidies available for clients.

HOMES BC Homeless-at-Risk/Low Income Urban Singles: Contracts already awarded; continual subsidies available. Program serves those who are homeless, persons at risk of homelessness, and low income urban singles.

HOMES BC Rent Support: All agreements have already been awarded; no new money is available for new rent supplement agreements. However, some newer agreements can be renewed.

Provincial Rental Assistance Program (PRAP): Disabled

PRAP helps low-income persons with disabilities. Contracts have already been awarded. Rental supports available until 2019-2021.

Provincial Rental Assistance Program (PRAP): Seniors

PRAP provides rental assistance to seniors. Contracts expire between 2015-2021.

Rental Assistance Program (RAP)

Provides cash assistance to low-income, working families to help with monthly rent payments in the private market.

Shelter Aid for Elderly Renters (SAFER)

SAFER provides monthly cash payments to subsidize rents for eligible BC seniors who are 60 or over and who rent their homes.

Women's Transition Housing and Supports Program

Provincial funding supports safe homes, transition houses, and second stage housing for women fleeing domestic violence. Funding includes initial contact, shelter, personal supports, referrals, and service linking.

APPENDIX 4-A:
Information of HPS Funds

The implementation of Housing First will be accomplished through "a balanced approach that ensures that communities adopt Housing First (HF) as a cornerstone of their plan to address homelessness, yet retain some flexibility to invest in other proven approaches that complement Housing First and reduce homelessness at the local level." Some funds are still available for non-Housing First responses to homelessness.

Must meet fidelity criteria, the most primary of which is client choice

Applicants are expected to perform community-level research on homelessness and engage partners at the local and provincial level--including the private and non-profit sectors.

Maximum amount of contribution funding per project cannot exceed $125m over Five years. Maximum of grant funding cannot exceed $250,000 over Five years (grants are for projects that are low risk and focused on research and knowledge development).

Eligible Activities

Emphasis on due diligence: HPS funding being used to fill gaps that are not covered by provincial or municipal funds

Examples of HF Eligible Activities

- Housing First readiness (consultation, coordination, planning, assessment
- Client intake and assessment, connecting to permanent housing, accessing services, data tracking

Non-HF Eligible Activities

- Individualized support services (for homeless and those at-risk of homelessness)
- Capital investments: cannot be HF-dedicated funding. Includes construction, renovation, purchase of furniture/vehicles/equipment,

HF & Non-HF Activities

- Coordination of resources and leveraging (determining systems model, identifying & improving services, partnership development of broader systemic approach, working with housing sector)
- Improving data collection and use (demographic research, tracking clients, collection & sharing)
- Administrative activities of Community Entity (not to exceed 15% of HPS annual allocation)

Ineligible Activities

HF Funding

- Building or purchasing facilities
- Core functions of an ACT treatment team (direct service of clinical or medical) All

Funding

- Affordable housing construction, emergency shelter construction
- Emergency housing funding or direct income assistance
- Medical/clinical staff

- Daycare
- On-reserve activities
- Software development

APPENDIX 4-B:

61 Designated Communities

The federal government has designated 61 communities across Canada as having a significant problem with homelessness. Eighty per cent of HPS funds go to these communities. The designated communities in BC are as follows:

- Kamloops
- Kelowna
- Nanaimo
- Nelson
- Prince George
- Vancouver
- Victoria

It is unclear why the FVRD and its communities have not been “designated”, as homelessness has been identified as an issue since at least 2004 when the first Homelessness Count was undertaken.

Serious challenges remain for communities in the FVRD that rely on government funding to support homeless initiatives.

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APPENDIX 5

FRASER VALLEY REGIONAL DISTRICT
2014 HOMELESSNESS SURVEY

Findings, Conclusions and Recommendations

City of Abbotsford
City of Chilliwack
District of Mission
Districts of Hope and Kent

Ron van Wyk, Mennonite Central Committee, BC
Anita van Wyk, Social, Culture and Media Studies, University of the Fraser Valley

To be read in conjunction with primary 2014 Homelessness Survey Report

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APPENDIX 5

FRASER VALLEY REGIONAL DISTRICT 2014 HOMELESSNESS SURVEY

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To be read in conjunction with primary 2014 Homelessness Survey Report

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- Mennonite Central Committee, British Columbia
- Salvation Army, Abbotsford
- The 5and2 Ministries
- Women's Resources Society of the Fraser Valley

Last but not least an acknowledgement to the Fraser Valley Regional District for its financial and in-kind contribution towards the survey and the report.

1. Introduction

1.1 Report Background

Homelessness in Abbotsford has been empirically confirmed in 2004, 2008, 2011 and again now in 2014 through a survey[1] of people who live homeless (van Wyk & van Wyk, 2005, 2008, 2011).

Following on these previous surveys, the 2014 homelessness survey in Abbotsford was conducted via a collaborative effort involving the following organizations:

- Abbotsford Community Services Society – Abbotsford Food Bank
- Cyrus Centre, Abbotsford
- Elizabeth Fry Society
- Fraser Valley Regional District, Strategic Planning and Initiatives Department
- Mennonite Central Committee, British Columbia
- Salvation Army, Abbotsford
- The 5and2 Ministries Abbotsford
- United Way of the Fraser Valley
- Women's Resource Society of the Fraser Valley

[1] As has been the practice since 2004, and in conjunction with the organizers of the Metro Vancouver tri-annual homeless count, the survey is limited in the number of questions asked in order to keep it manageable given the overall methodological nature of this type of survey.

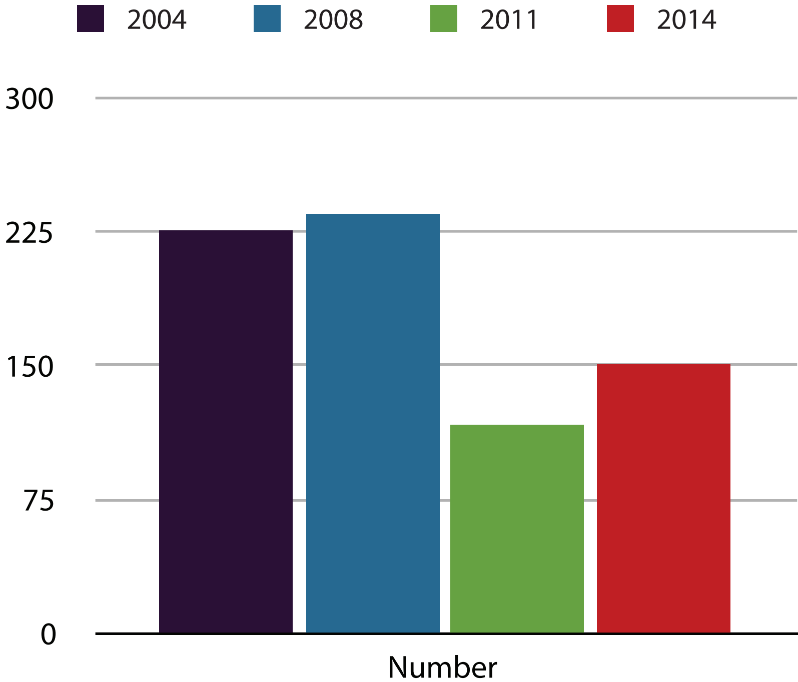
2. Extent of Homelessness in Abbotsford 2014

2.1 Number of Homeless People Interviewed in Abbotsford in 2014

One hundred and fifty one (151) homeless people were surveyed during the 24-hour period, March 11 and 12, 2014, in Abbotsford.

Comparing this result with the 2011 survey indicates that the overall number of homeless persons surveyed in Abbotsford is up by 29% since 2011. However, the number is lower than the 235 and 226 homeless persons interviewed in 2008 and 2004 respectively.

GRAPH 1: Abbotsford Homeless Count Totals 2004 - 2014



2.2 Reasons for Being Homeless

The reasons for being homeless cited by respondents in this survey are reflected in Table 1.

TABLE 1: Reasons for Being Homeless[2]

Reason Given	2014n	2014%
Inadequate income	73	28.4
Rent too high	34	13.3
Family breakdown/abuse/conflict	22	8.6
Evicted	16	6.2
Health/Disability	20	7.8
Addictions	45	17.5
Criminal history	12	4.7
Poor housing conditions	21	8.1
Pets	2	0.8
Other	12	4.6
Total Response	257	
No Response	25	
Total	282	

Just over forty percent of the respondents (42%) claimed that the reason for homelessness related to the issue of affordability, i.e., inadequate income and unaffordable rent, which is an example of a structural cause. A further 17% cited addictions as the reason for homelessness with 8% of respondents citing family breakdown/abuse/conflict as the reason for homelessness. Health reasons were cited by 7% and 6% said they were evicted, most of them probably for non-payment of rent.

2.3 Duration of Homelessness

The respondents were asked to indicate how long they had been homeless. Those who had been homeless for a year or longer constituted 42.6%, a substantial proportion of the population, whilst 17.1% indicated they had been homeless for more than six months but less than a

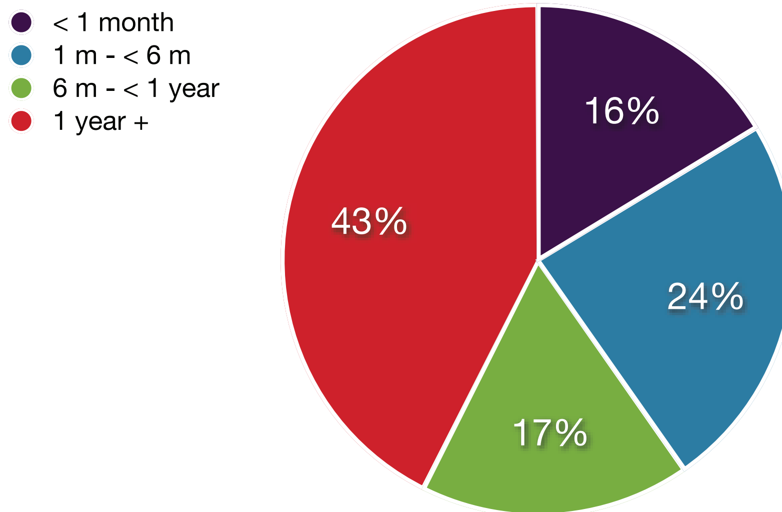
[2] Number does not add up to 151 as respondents could check off more than one option.

year, 24.0% for more than a month but no longer than six months, and 16.3% for less than a month (see Table 2).

TABLE 2: Duration of Homelessness

Duration	2014n	2014%
less than 1 month	21	16.3
1 month - < 6 months	31	24
6 months - < 1 year	22	17.1
1 year +	55	42.6
Total Response	129	100
No Response	22	
Total	151	

GRAPH 2: Duration of Homelessness



Based on the above, it is apparent that a substantial number of persons who live homeless in Abbotsford (42.6% or 55 individuals) are experiencing relative long-term or chronic homelessness.

2.4 Health Problems

Survey respondents were asked to report on their health problems; 20.6% of responses were registered for having a medical condition, 15.9% for having a physical disability, 41.3% for living with an addiction, and 22.5% with a mental illness. In addition, 28 respondents indicated that they live with an addiction and a mental illness (see Table 11 below). The phenomenon of people living with both mental health and addictions issues is also referred to as concurrent disorders.

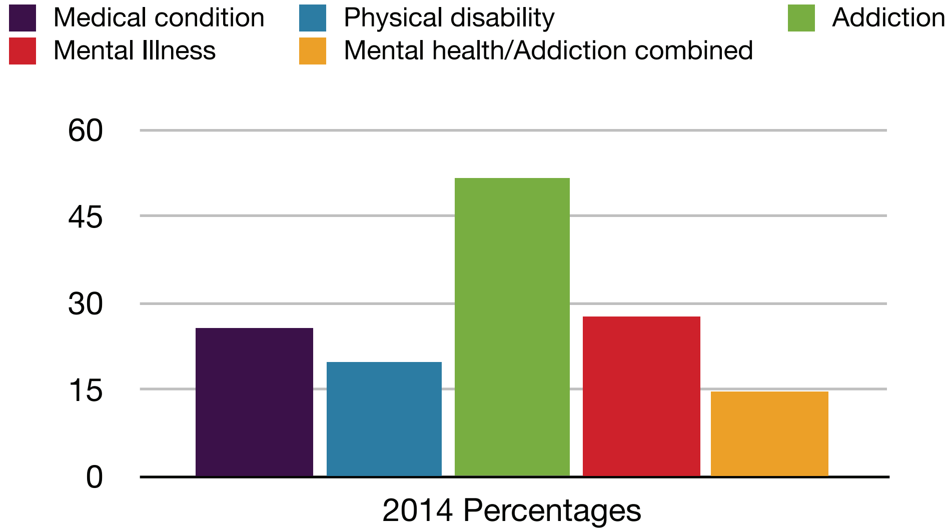
It is reasonable to argue that chronic emotional and mental illness complicates daily existence, and can mask acute illnesses or prevent people from accessing services and receiving much needed medical care and therefore remains trapped in chronic homelessness. Based on the former, it is reasonable to assert that homeless persons in Abbotsford suffer from a variety of chronic and acute illnesses that are aggravated by life on the streets.

TABLE 3: Reported Health Problems[3]

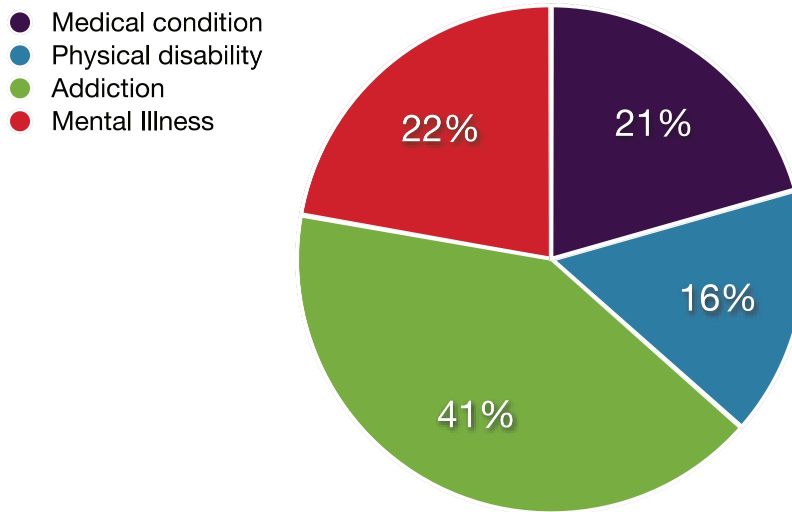
Health Issue	2014n	2014%
Medical condition	39	20.6
Physical disability	30	15.9
Addiction	78	41.3
Mental illness	42	22.2
Total Responses	189	100
No Responses	43	
Total	232	
Addiction and mental illness combined	28	

[3] The number does not add up because respondents could check off more than one option.

GRAPH 3: Percentage of Homeless Individuals with Reported Health Issues



GRAPH 4: Health Issues Percentages



Given the duration of homelessness (see Table 2) above and the reported health issues prevalent among homeless persons in Abbotsford (see Table 3) above, it is safe to assert that there are people who are chronically homeless in Abbotsford. The ***chronically homeless*** includes people who live on the periphery of society and who often face problems of drug or alcohol abuse or mental illness. It is estimated that this subgroup constitutes about 10–15% of the homeless population in a given locale. These are the so-called hard to house, but this label is

problematic; perhaps it is rather a case of current housing provisions not being geared to provide support to high-needs clients.

In the case of Abbotsford this category or subgroup is estimated to be higher than the conventional 15 – 20% range within Canadian based jurisdiction specific homeless populations. Based on “length of homelessness”, (Table 2 above) and the prevalence of mental health and addictions issues as reported by homeless persons (Table 3 above) the range of people who live chronically homeless in Abbotsford could conservatively be estimated in the 30% range or 45 to 50 people.

2.5 “Sheltered” and “Unsheltered” Homeless Persons

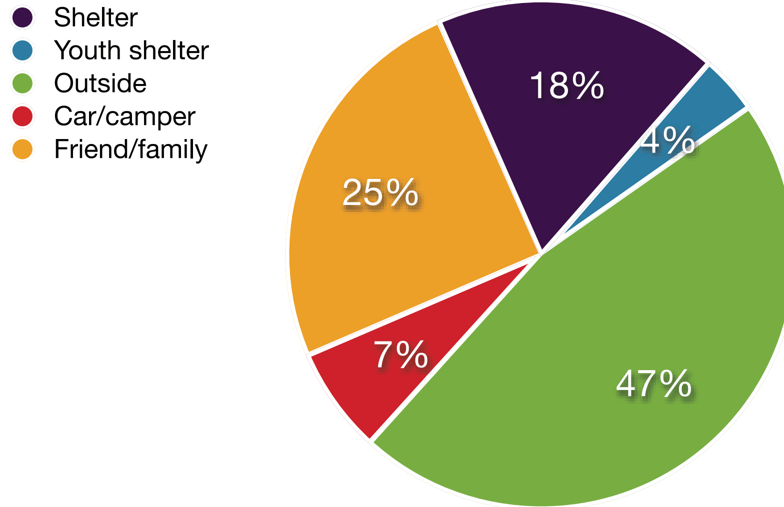
The number of homeless persons surveyed in official shelters was 24.6% and those surveyed who did not use shelter accommodation totaled 75.3%, including those who reported that they were sleeping at the homes of friends/family, so-called couch surfers (23.9%). Of this category 19.5% or 8 individuals were youth, defined as 18 years of age or younger. From this it is clear that couch surfing is not restricted to youth but is also used significantly by adults as a way to find places to overnight.

The number of homeless people surveyed outside, i.e. not in shelters and not couch surfing constitutes the biggest proportion namely (51.4%) if you combine “outside” with having slept in a “car/camper” (see Table 3).

TABLE 4: Accommodation on Night of Survey

Place Stayed	2014n	2014%
Transition house	5	3.6
Shelter	24	17.4
Youth shelter	5	3.6
Outside	62	44.9
Car/camper	9	6.5
Friend/Family’s place	33	24
Total Response	138	100
No Response	13	
Total	151	

GRAPH 5: Accommodation on Night of Survey



The respondents were asked to state their main reasons for not having used a transition house or a shelter the previous night. The biggest proportion falls into the category "dislike" of shelter (48.6%). Reasons given for disliking the shelter include "too many rules"; "feels too much like an institution"; don't like the curfew"; "do not feel safe", the latter response is in reference to having to share accommodation with "lunatics"' "drug addicts" and "crazy people" as stated by respondents. The proportion of those who cited "turned away" as the reason for not having stayed in a shelter is 20.3%. The category "turned away" includes reasons such as the shelter was full, they had used up their allotted days, their gender was inappropriate, etc. (see Table 5).

TABLE 5: Reasons for Not Using Shelter/Transition House

Reason	2014n	2014%
Turned away	15	20.3
Stayed with friend/family	14	14.9
Dislike	36	48.6
Did not know about shelter	0	0.0
Could not get to shelter	0	0.0
Slept in car/camper	0	0.0
No shelter in community	0	0.0
Other	12	16.2
Total Response	74	100
No Response	41	
Total	151	

2.6 What Will End Homelessness for You?

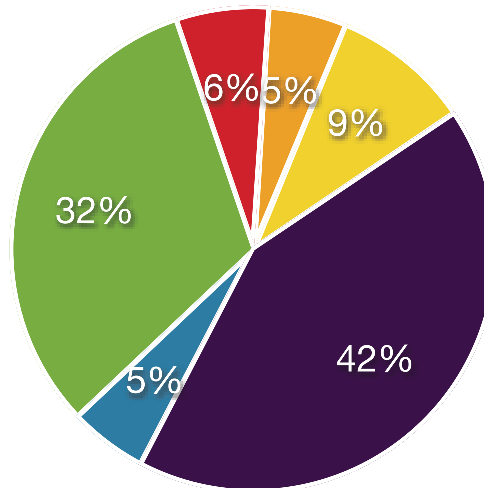
When asked what would end their homelessness, respondents indicated that access to more affordable housing was the most common barrier (42.3%) to overcome in finding a home, followed by a need for “higher income” at 32.0% (see Table 6).

TABLE 6: What Will End Homelessness for You?

Response	2014n	2014%
Affordable housing	41	42.3
Employment	5	5.2
Higher income	31	32.0
Overcoming addiction	4	6.2
Support/advocacy	5	5.2
Other	9	9.3
Total Response	97	100
No Response	54	
Total	151	

GRAPH 6: What Will End Homelessness for You?

- Affordable housing
- Employment
- Higher income
- Overcoming addiction
- Support/advocacy
- Other



2.7 Shelter and Transition Beds in Abbotsford

The total number of shelter beds in Abbotsford in 2014 is 35; 25 emergency shelter beds plus 10 extreme weather beds. According to the Salvation Army in Abbotsford, Coordinator of Extreme Weather beds, the total number of beds available varies depending on the time of the fall/ winter season.

Thus, Abbotsford has available in 2014/15 a maximum of 40 adult and 10 youth extreme weather beds to a minimum of 30 adult beds and 10 youth beds. The Salvation Army has 20 available from November 1 to March 31; Seven Oaks Alliance Church has 20 available (male only) during March; Cyrus Centre has 10 youth beds available in February; Ross Road Community Church (male only) has 10 beds available in January; Abbotsford Pentecostal Church has 20 beds available in November; and Abbotsford Community Services (male only) has 10 beds available in December. The total number of beds in the Abbotsford Transition House is 12.[4] It is important to note that there are limits on the number of days people can stay at these facilities.

There is a view among some scholars and some practitioners that "sheltering" people, does not facilitate either the complicated "road" toward self-sufficiency or linking someone to an integrated arrangement for wrap around support services that can over time facilitate a pathway out of homelessness. The desired outcome of making a break from living homeless cannot be achieved overnight and is dependent on long-term supports. The past 20 years have seen an increasing awareness and practice of integrated treatment for psychiatric and substance use issues in individuals experiencing concurrent disorders.

[4] This refers only to transition houses providing safe shelter and support to women who have left abusive relationships.

3. Profile of People Living Homeless in Abbotsford

People living homeless in Canada at any given time will be comprised of several groups, including, but not limited to, persons with severe addictions and/or mental illness, families, seniors, children, youth, persons with disabilities and aboriginals. Single men constitute the majority of the visible homeless, a fact confirmed by four surveys in the FVRD since 2004. People who live homeless in Abbotsford include people with addictions and/or mental illness, older individuals, youth, persons with disabilities and persons who self-identify as Aboriginal.

Based on information obtained from respondents during the 2014 homelessness survey, the following can be reported regarding a profile of homeless people in Abbotsford.

3.1 Gender

The gender distribution of homeless people surveyed in Abbotsford in 2014 breaks down into almost 60% males and almost 35% females. This gender breakdown corresponds well with available data regarding homelessness in Canada according to which women constitutes one third to one half of the homeless population in major urban areas across Canada.

TABLE 7: Gender of Surveyed Respondents

Gender	2014n	2014%
Male	90	59.6
Female	52	34.4
Unknown	9	6.0
Total		100

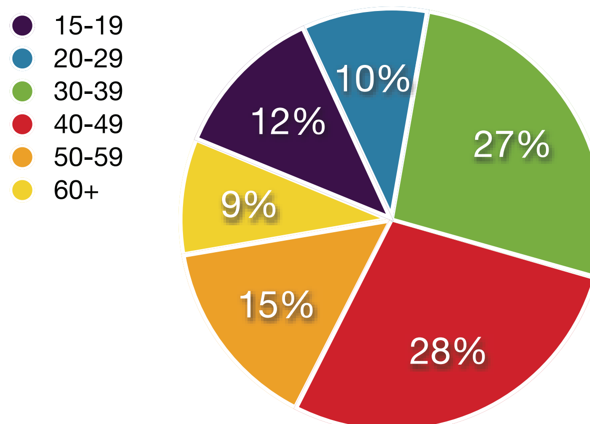
3.2 Age

Similar to previous homelessness surveys in the Fraser Valley (Van Wyk & Van Wyk, 2004, 2008 and 2011), the biggest proportion, just more than half of homeless respondents (54.8%) in 2014 fell in the 30–49 year age group. The second largest proportion (23.7%) or almost a quarter was those 50+ followed by those 19 and younger (11.9%).

TABLE 8: Age of Surveyed Respondents

Age	2014n	2014%
Under 15	0	0.0
15-19	16	11.9
20-29	13	9.6
30-39	36	26.7
40-49	38	28.1
50-59	20	14.8
60-69	9	6.7
70+	3	2.2
Total Response	135	100
No Response	16	
Total	151	

GRAPH 7: Age of Surveyed Respondents



Homelessness affects health and life expectancy in significant ways. Homeless Canadians are more likely to die younger and to suffer more illnesses than the general Canadian population. Many factors contribute to the lower life expectancy of homeless people, including lack of social support networks, education, unemployment, living conditions, personal health practices, biology and genetic endowment, lack of availability of health services, etc.

3.3 Aboriginal Presence

The respondents were asked to indicate whether they self-identify as Aboriginal. Thirty two respondents or 21.2% self-identified as Aboriginal in Abbotsford compared to 14 in 2011, thus a doubling of this sub-group within the homeless population in Abbotsford.

The literature indicates that the Aboriginal homeless have special needs that must be considered—e.g., cultural appropriateness, self-determination, and traditional healing techniques. It fell outside the scope of this survey to make further determinations in this regard. Suffice to say that the notion of providing culturally appropriate services for Aboriginal persons likely remains valid and requires further analysis.

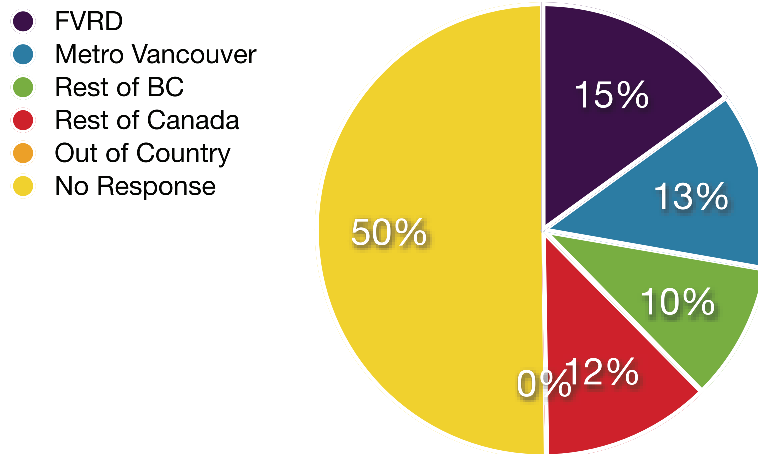
3.4 Community of Last Residence

Respondents were asked which community they moved from to Abbotsford. The biggest proportion (29.9%) indicated that they are from FVRD communities with a quarter (25.3%) stating that they formerly lived in Metro Vancouver communities. However, it is important to note that in response to the question: “How long have you been living in Abbotsford that just over half of the respondents (51.8%) have lived in Abbotsford for 11 years or longer. Those who lived here for 6 – 10 years constitute 11.6%. Thus, 63.4% of the respondents lived in Abbotsford for 6 years or longer.

TABLE 9: Where Did You Move Here From?

Place	2014n	2014%
FVRD	26	29.9
Metro Vancouver	22	25.3
Rest of BC	17	19.5
Rest of Canada	21	24.1
Out of Country	1	1.1
Total Response	87	100
No Response	64	
Total	151	

GRAPH 8: Where Did You Move Here From?

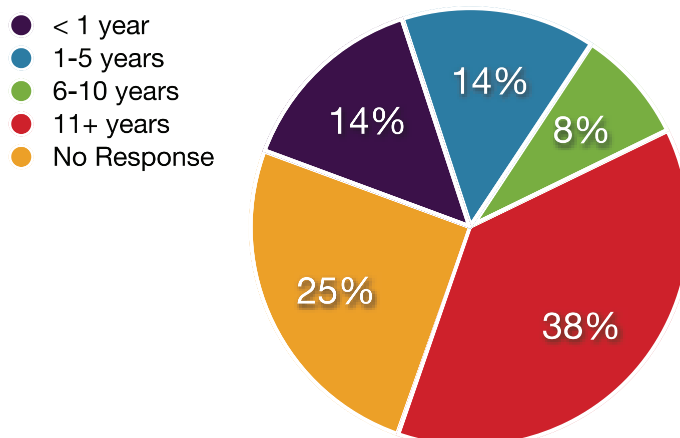


3.5 Length of Residency

TABLE 10: How Long Have You Been Living in Abbotsford?

Length of Residency	2014n	2014%
Less than 6 months	15	13.4
6-11 months	7	6.3
1 year - 23 months	6	5.4
2-5 years	13	11.6
6-10 years	13	11.6
11+ years	58	51.8
Total Response	112	100
No Response	39	
Total	151	

GRAPH 9: How Long Have You Been Living in Abbotsford?



3.6 Source of Income

"Welfare" as a source of income represents 26.8% of the responses followed by "disability allowance" at 11.8%. The percentage of responses in the category "employment" as source of income is 5.9%. Responses associated with "binning" and "panhandling" total 17.5%. Homeless persons typically hold unskilled, seasonal, and lower-paying jobs. The level of income associated with this type of employment makes it challenging to save money for emergencies, such as periodic or seasonal unemployment, or to secure the kind of economic stability that would prevent homelessness (van Wyk & van Wyk, 2005, p. 26). A significant proportion (11.8%) of responses fall in the category "no source of income".

TABLE 11: Source of Income

Source	2014n	2014%
Welfare	41	26.8
Disability benefit	18	11.8
Employment	9	5.9
EI/CPP/WCB/OAS/GIS	5	3.3
Binning/panhandle	27	17.5
Family/Friends	11	7.2
Other	24	15.7
No income	18	11.8
Total Response	153	100
No Response	38	
Total	191	

3.7 Usage of Services

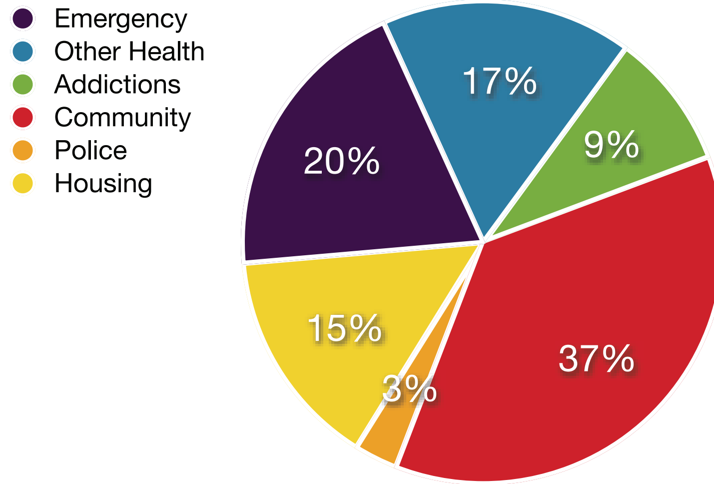
Table 12 indicates the extent to which services are being used by people who live homeless in Abbotsford. For example, 50% of the respondents indicated that they have accessed meal programs the past year, followed by outreach services at 43%, drop-in services 42%, emergency room 36%, food bank 35% extreme weather 32%, etc.

TABLE 12: Usage of Services Last 12 Months[5]

Service	2014n	2014%
Ambulance	26	17
Emergency room	54	36
Hospital (non-emergency)	42	28
Dental clinic or dentist	20	13
Mental health services	23	15
Addiction services	33	22
Extreme weather shelter	49	32
Employment/Job help services	23	15
Probation/Parole services	19	13
Drop-in Services	64	42
Food Bank	53	35
Meal Programs/Soup Kitchens	75	50
Health clinic	26	17
Newcomer services	2	1
Transitional housing	17	11
Housing help/Eviction prevention	15	10
Needle exchange	27	18
Outreach	65	43
Legal	21	14
Budgeting/Trusteeship	2	1

[5] Number does not add up to 151 as respondents could check off more than one option. Percentages are of service usage in relation to total number of respondents.

GRAPH 10: Usage of Services Last 12 Months[6]



Respondents were also asked whether they have been affected by a change or withdrawal in services. Twenty six or 28.0% answered in the affirmative and 67 or 72.0% answered "no" (see Table 13)

TABLE 12: Affected by Change or Withdrawal in Services

Affected by change/withdrawal	2014n	2014%
Yes	26	28
No	67	72
Total Response	93	100
No Response	58	
Total	151	

[6] Emergency-based services category includes Extreme Weather shelter, and Housing services category includes Outreach.

4. Summary of Findings

The following summarizes the main findings of this survey:

- In comparison to 2011, the number of homeless people interviewed in Abbotsford has increased from 117 to 151 (29% increase).
- Homelessness is a result of inadequate income (poverty), unaffordable rental rates, relational breakdown, and the impact of mental health issues and/or addiction to substance use, as well as a concomitant lack of adequate medical care and support at the community level.
- Lack of affordable housing is directly related to low wages, erosion of the social safety net, insufficient social housing inventory, especially lack of “housing first” options and increased rental accommodation cost.
- Chronic homeless people are conservatively estimated to be in the 30% range or 45 to 50 people. This is higher than the 15 - 20% that is conventionally seen as the percentage of homeless people in Canadian jurisdiction specific homeless populations.
- 43% of respondents or 55 individuals experience long-term homelessness (one year or longer).
- 51% of respondents live outside in makeshift shelters or other outdoor places.
- Almost half or 49% of those who live outside indicated a dislike in the emergency shelters as a reason for not accessing emergency shelters. Reasons for “dislike” include “too many rules”; “I don’t like the rules”; “feels too much like an institution”; “I don’t want to be with addicts and crazy people”, etc.
- Males constitute the majority of homeless persons i.e. 60%.
- 55% of homeless persons are in the age category 30-49 years and 23% are 50 years or older.
- 21% of Abbotsford homeless persons self-identify as Aboriginal.
- 63% of the homeless persons live in Abbotsford for 6 years or longer.
- Welfare and disability benefits are the source of income for 39% of the homeless persons.
- 41% of the population lives with an addiction to substance use and 22% live with a mental health issue while 12% indicated that they live with both an addiction to substance use and mental health issue, also referred to as concurrent disorders.
- 28% indicated that they have been impacted by service change or withdrawal. Most common examples cited are “refused welfare” or “being cut off welfare”.

5. Conclusions

1. There remains a need for permanent supportive housing based on the housing first approach for those who live with mental illness and/or addiction to substance use; transition (second-stage) housing for those coming out of treatment and those released from incarceration.
2. Homeless people are subject to stress because of the factors that made them homeless and because of the experience of being homeless. Poor diet, stress, cold and damp, along with inadequate sleeping arrangements, sanitation and hygiene, increase the risk of health problems and decrease life expectancy.
3. Homelessness in itself is an “agent of disease". As such homeless people are more exposed to and more likely to develop health problems than the general population, as living conditions predispose them to be particularly at risk of developing ill health.
4. People in Abbotsford who live chronically homeless suffer from a variety of chronic and acute illnesses that are aggravated by life on the streets.
5. Chronic emotional and mental illness complicates daily existence and can mask acute illnesses or prevent people from accessing services and receiving much needed medical care and therefore remains trapped in chronic homelessness.
6. Chronically homeless persons are people who cannot function in housing that assumes independent living without support. They are unable to fit into independent housing, and thus get evicted. What this population, also recognized by the term “concurrent disorders”, requires is housing that can respond adequately to their needs e.g. Housing First Approach.
7. Professional medical attention and community relationships are two key elements of care in relation to people who live homeless. People are more willing to think about treatment and other solutions if they feel trusted and understood. A relationship based on empathy creates a sense of belonging and is critical for people’s well-being. It makes them feel they are worthwhile and can play an active role in their own treatment.
8. In addition to a paradigm shift in the delivery of mental health care, it is also necessary to provide more than surface support, such as food, clothing, emergency shelter, soup kitchens, etc. High-need clients, such as those living with concurrent disorders and who are chronically homeless, require a full integration of mental health and addiction services in addition to health care and housing. Evidence suggests that the current system of care picks and chooses instead of offering the whole set of services needed, so clients

with the most complex needs get no care and drop out of the system. This reality aggravates the problem of inadequate care for those who live homeless.

9. Inclusion of homelessness has to be a main focus in mental health intake. It is necessary to mandate that an individual's basic needs must be met first.

10. It is not adequate care for a person with mental and/or substance abuse challenges to be housed without supportive service or to receive services without housing.

11. Housing needs to be inclusive of everything, from housing to medical care to psychiatric treatment to provision of food.

12. Supportive housing, inclusive of psychosocial rehabilitation, is seen as a leading practice in providing services and housing more effectively and efficiently to homeless persons.

13. Housing models must meet the needs of the whole person, with involvement in day-to-day support. It is imperative that participants not be constrained by exit deadlines.

14. A fully integrated system that makes "any door the right door"— means that people with concurrent disorders experiencing homelessness can enter the service system through any service door, be assessed, and have access to the full range of comprehensive services and support.

15. The following service strategies or approaches lead to improvements in mental health and substance use disorders among homeless individuals with concurrent disorders:
    - client choice in treatment decision-making
    - positive interpersonal relationships between clients and providers
    - assertive community treatment approaches
    - supportive housing
    - non-restrictive program approaches

16. Supportive case management is indispensable to successful service delivery to people living homeless.

17. Emergency shelters do not seem to be the most effective and efficient way to deal with chronic homeless persons who live with mental health issues or substance use addiction, or both. This subpopulation needs long-term or permanent supportive housing or housing with professional wrap around supports.

18. Housing-first models are predicated on the assumption that all individuals, regardless of substance misuse, are entitled to a safe place to live. They are also predicated on the assumption that addiction recovery is more likely to be successful when secure housing is met. Housing-first models encourage clients to seek addiction treatment, but do not make it mandatory before housing is provided.

6. Recommendations

1. Include the housing-first approach in policies and practices addressing homelessness in Abbotsford. It is imperative that this is implemented in Abbotsford in order to provide good care and make progress with homelessness reduction.
2. Take immediate steps to move toward the creation of a more adequate housing spectrum in Abbotsford through housing first provisioning and more comprehensive and farther in reach mental health and addictions services.
3. Provide a 50 – 60 unit housing facility based on the principles of housing first to provide housing and care to chronically homeless persons in Abbotsford.
4. Implement an Assertive Community Treatment (ACT) Team that facilitates an integrated model of care embracing empathetic therapeutic relationship building.
5. Establish a community housing resource and connect centre that will act as a hub where homeless persons or persons at risk of homelessness can access services and receive counseling and support.
6. Focus community care efforts on establishing a coherent and comprehensive intervention to implement housing and care.
7. Partner with existing community agencies to further extend the reach of housing first options through a scattered site approach (e.g. Raven's Moon Society's Model).

END NOTE

See Main Regional Homeless Report for more detailed analysis of homelessness in FVRD communities and a more expanded list of findings, conclusions and recommendations and also a list of references undergirding the analysis and recommendations in the main report.

APPENDIX 5

FRASER VALLEY REGIONAL DISTRICT 2014 HOMELESSNESS SURVEY

Findings, Conclusions and Recommendations

City of Chilliwack

Ron van Wyk, Mennonite Central Committee, BC
Anita van Wyk, Social, Culture and Media Studies, University of the Fraser Valley

To be read in conjunction with primary 2014 Homelessness Survey Report

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- Ann Davis Transition Society
- Chilliwack Community Services Society
- Fraser Valley Regional District
- GT Consulting
- Ministry of Children and Family Development
- Pacific Community Resources Society
- Ruth and Naomi's Mission Society
- Salvation Army, Chilliwack

A special word of thanks goes to the volunteer community survey coordinators, Kim Lloyd and Steve Esau of Pacific Community Resources Society, for the work that they have done with their teams of volunteers to plan logistics and conduct the survey in Chilliwack. Thank you also to the volunteers in Chilliwack who stepped forward and conducted the interviews. Without their work this survey would not have been a success. A big thank you is extended to homeless persons who participated in the survey by patiently answering our questions. Last but not least an acknowledgement of the financial and in-kind support by the FVRD to make this survey possible.

1. Introduction

1.1 Report Background

Homelessness in Chilliwack has been empirically confirmed in 2004, 2008, 2011 and again now in 2014 through a survey[1] of people who live homeless (van Wyk & van Wyk, 2005, 2008, 2011).

Following on these previous surveys, the 2014 homelessness survey in Chilliwack was conducted in collaboration with the following organizations:

- Ann Davis Transition Society
- Chilliwack Community Services Society
- Fraser Valley Regional District, Strategic Planning and Initiatives Department
- Pacific Community Resources Society - Chilliwack
- Ruth and Naomi's Mission
- Salvation Army Chilliwack

[1] As has been the practice since 2004 and in conjunction with the organizers of the Metro Vancouver tri-annual homeless count the survey is limited in the number of questions asked in order to keep it manageable given the overall methodological nature of this type of survey.

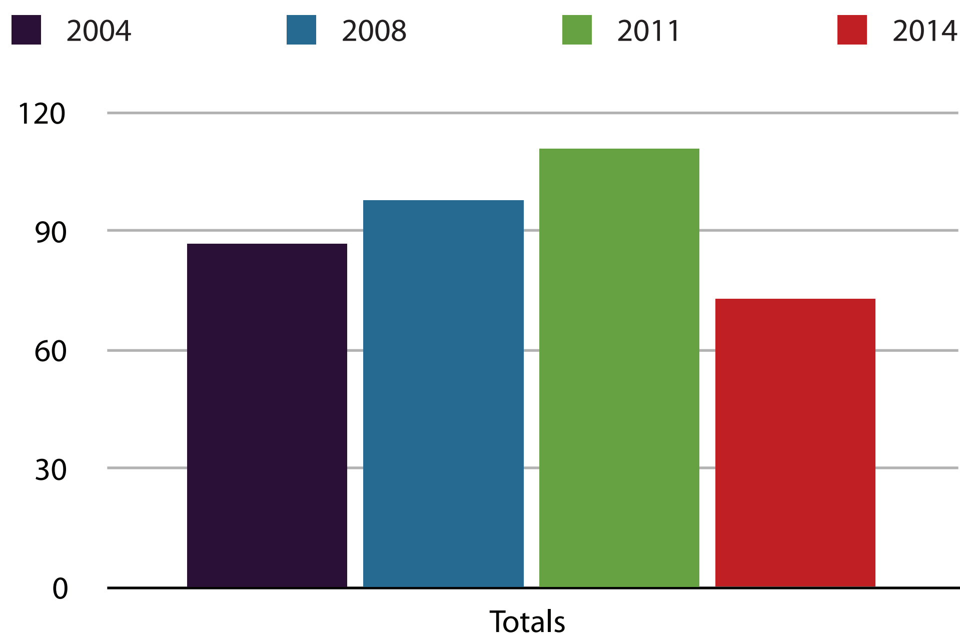
2. Extent of Homelessness in Chilliwack 2014

2.1 Number of Homeless People Interviewed in Chilliwack During the 24-Hour Survey Period

Seventy three (73) homeless people were surveyed during the 24-hour period, March 11 and 12, 2014, in Chilliwack.

Comparing this result with the 2011 survey indicates that the overall number of homeless persons surveyed in 2014 in Chilliwack (73) is down by 34% since 2011 when the number was 111. The number in 2008 was 98 and in 2004 it was 87.

CHART 1: Chilliwack Homeless Survey Totals 2004 - 2014



2.2 Reasons for Homelessness

Every homeless person has an individual story of his or her path into homelessness. Although research in the past has explored the personal dynamics that contribute to homelessness (including addiction and mental illness), Canadian studies have in addition started to include and reflect on understanding the structural/systemic factors that contribute to homelessness.

The reasons for being homeless cited by respondents in this survey are reflected in Table 1.

TABLE 1: Reasons for Being Homeless[2]

Reason Given	2014n	2014%
Inadequate income	59	26.9
Rent too high	30	13.7
Family breakdown/abuse/conflict	31	14.2
Evicted	15	6.8
Health/Disability	16	7.3
Addictions	40	18.3
Criminal history	18	8.3
Poor housing conditions	6	2.7
Pets	4	1.8
Other	0	0.0
Total Response	219	100.0
No Response	8	
Total	227	

A substantial proportion (40%) of the responses relate to lack of affordability i.e. inadequate income and unaffordable rent as the reason for homelessness, which is an example of a structural cause. A further 18% relate to addictions as the reason for homelessness with 14% of responses relating to family breakdown/abuse/conflict as the reason for homelessness. Health/disability reasons represent 7% of the responses and 6% relate to eviction.

It is evident from the survey results that while personal issues may precipitate homelessness in Chilliwack, it is further compounded by systemic structural factors. Research has shown that there are often precipitating factors including job loss, loss of permanent housing due to eviction, family breakdown, or illness. Homelessness can result when precipitating factors are compounded by structural and systemic factors such as shifting provincial or federal policy. Based on an interpretation of the growing body of knowledge on homelessness in Canada, it is safe to

[2] The total number is higher than 73 as respondents could check off more than one response.

assert that homelessness is indeed a complex phenomenon and that a variety of factors, in various combinations, contribute to homelessness. This applies to Chilliwack as well.

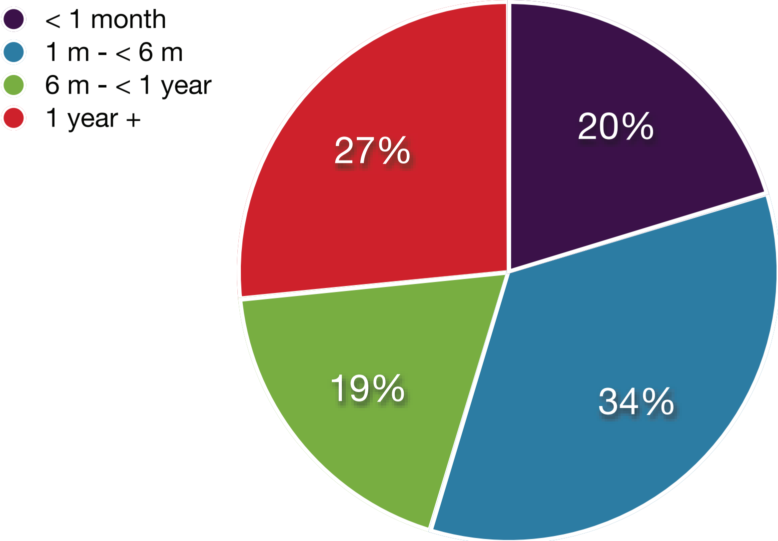
2.3 Duration of Homelessness

The respondents were asked to indicate how long they had been homeless. Those who had been homeless for a year or longer constituted 26%, just more than a quarter of the population, whilst 18% indicated they had been homeless for more than six months but less than a year, 34% for more than a month but no longer than six months, and 20% for less than a month (see Table 2).

TABLE 2: Duration of Homelessness

Duration	2014n	2014%
less than 1 month	13	20.3
1 month - less than 6 months	22	34.4
6 months - less than 1 year	12	18.7
1 year +	17	26.6
Total Response	64	100.0
No Response	9	
Total	73	

GRAPH 2: Duration of Homelessness



Based on the above, it is apparent that a significant proportion of persons (just more than a quarter) who live homeless in Chilliwack (26%) are experiencing relative long-term or chronic homelessness.

2.4 Health Problems

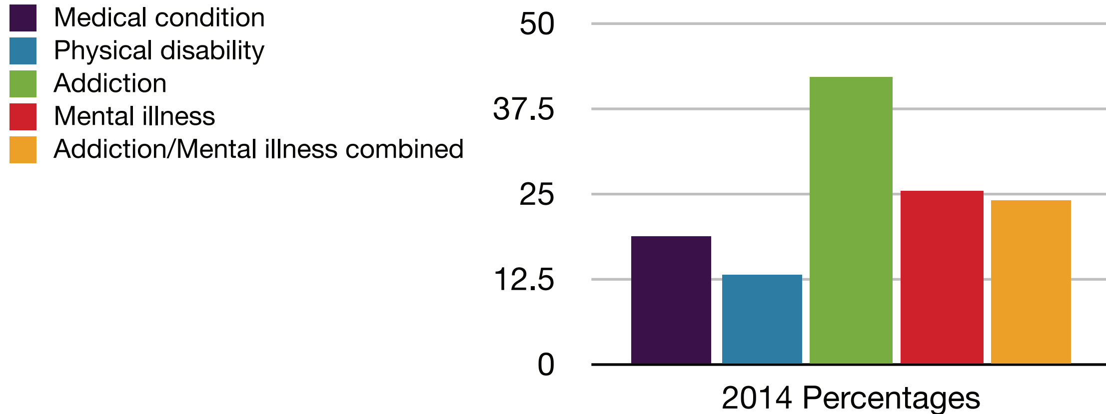
Survey respondents were asked to report on their health problems; 18% of responses were registered for having a medical condition, 13% for having a physical disability, 42% for living with an addiction, and 25% with a mental illness. In addition, 28 respondents indicated that they live with an addiction and a mental illness (see Table 11 below). The phenomenon of people living with both mental health and addictions issues is also referred to as concurrent disorders. It is reasonable to argue that chronic emotional and mental illness complicates daily existence, and can mask acute illnesses or prevent people from accessing services and receiving much needed medical care and therefore remains trapped in chronic homelessness. Based on the former, it is reasonable to assert that homeless persons suffer from a variety of chronic and acute illnesses that are aggravated by life on the streets.

TABLE 3: Reported Health Problems[3]

Health Issue	2014n	2014%
Medical condition	20	18.8
Physical disability	14	13.2
Addiction	45	42.5
Mental illness	27	25.5
Total Responses	106	100
No Responses	10	
Total	116	
Addiction/Mental Illness combined	28	

[3] The total number is higher than 73 as respondents could check off more than one response

CHART 2: Reported Health Problems



Furthermore, homeless people are subject to stress because of the factors that made them homeless and because of the experience of being homeless. Poor diet, stress, cold and damp living conditions, along with inadequate sleeping arrangements, sanitation and hygiene, increase the risk of health problems and decrease life expectancy.

Given the duration of homelessness (see Table 2) above and the reported health issues prevalent among homeless persons in Chilliwack (see Table 3) above, it is safe to assert that there are people who are chronically homeless in Chilliwack. The ***chronically homeless*** includes people who live on the periphery of society and who often face problems of drug or alcohol abuse or mental illness. It is estimated that this subgroup constitutes about 10–15% of the homeless population in a given locale. These are the so-called hard to house, but this label is problematic; perhaps it is rather a case of current housing provisions not being geared to provide support to high-needs clients.

In the case of Chilliwack, this category or subgroup of chronically homeless is estimated to be higher than the conventional 15 – 20% range within Canadian based jurisdiction specific homeless populations. Based on “length of homelessness”, (Table 2 above) and the prevalence of mental health and addictions issues as reported by homeless persons (Table 3 above) the range of people who live chronically homeless in Chilliwack could conservatively be estimated in the 25-35% range or 20 to 30 people.

2.5 “Sheltered” and “Unsheltered” Homeless People

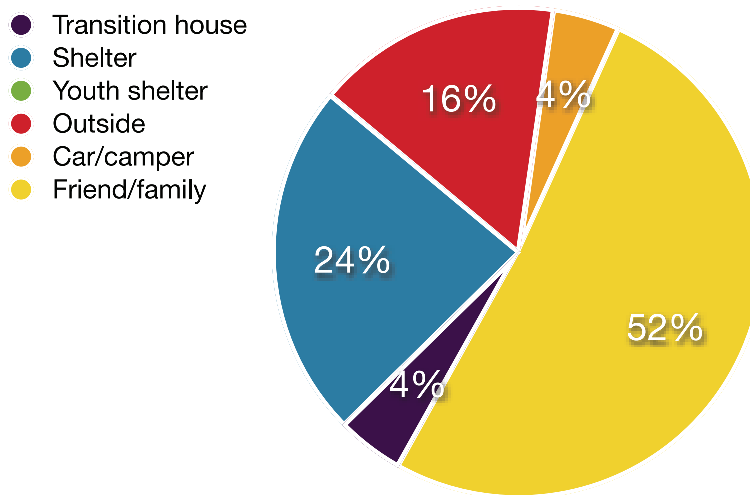
The number of homeless persons surveyed in official shelters was 27% and those surveyed who did not use shelter accommodation totaled 72%, including those who reported that they were sleeping at the homes of friends/family, so-called couch surfers (51%). Of this category the majority (24 out of 35 individuals) or 69% were youth, defined as 18 years of age or younger.

The number of homeless people surveyed outside, i.e. not in shelters and not couch surfing constitutes (20%) if you combine “outside” with having slept in a “car/camper” (see Table 4).

TABLE 4: Accommodation on Night of Survey

Place Stayed	2014n	2014%
Transition house	3	4.4
Shelter	16	23.5
Youth shelter	0	0.0
Outside	11	16.2
Car/camper	3	4.4
Friend/Family's place	35	51.5
Total response	68	100.0
No Response	5	
Total	73	

GRAPH 3: Accommodation on Night of Survey



The respondents were asked to state their main reasons for not having used a transition house or a shelter the previous night. The biggest proportion falls into the category "stayed with friend/ family" (24%). The category "turned away" (6%) includes reasons such as the shelter was full, they had used up their allotted days, their gender was inappropriate, etc. Reasons given for disliking the shelter (6%) include "too many rules"; "feels too much like an institution"; don't like the curfew"; "do not feel safe", the latter response is in reference to having to share accommodation, as some respondents have put it, with "lunatics"' "drug addicts" and "crazy people" (see Table 5).

TABLE 5: Reasons for Not Staying in Shelter/Transition House

Reason Given	2014n	2014%
Turned away	3	6.5
Stayed with Friend/Family	11	24.0
Dislike	3	6.5
Did not know about shelter	0	0.0
Couldn't get to shelter	7	15.2
Slept in car/camper	1	2.2
No shelter in community	0	0.0
Other	21	45.6
Total Response	46	100.0
No Response	7	
Total	53	

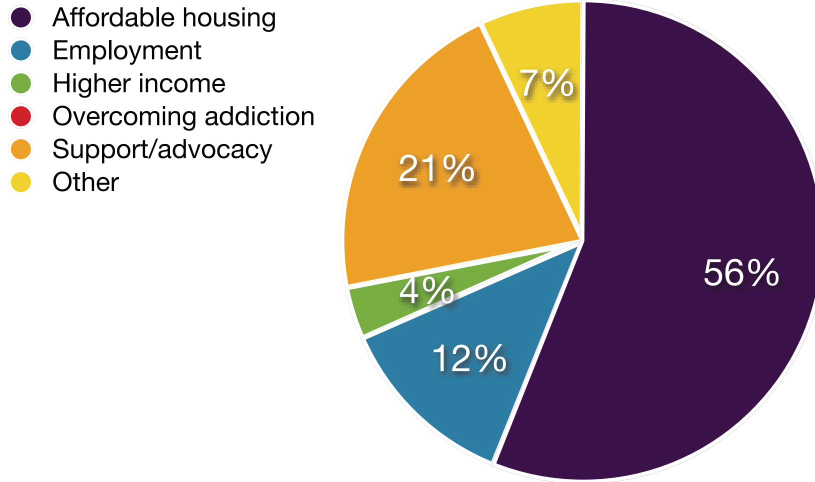
2.6 What Will End Homelessness for You?

When asked what would end their homelessness, respondents indicated that access to more affordable housing was the most common barrier (42.3%) to overcome in finding a home, followed by a need for "higher income" at 32.0% (see Table 6).

TABLE 6: What Will End Homelessness for You?

Response	2014n	2014%
Affordable housing	32	56.1
Employment	7	12.3
Higher income	2	3.5
Overcoming addiction	0	0.0
Support/Advocacy	12	21.1
Other	4	7.0
Total response	57	
No response	16	
Total	73	

GRAPH 4: What Will End Homelessness for You?



2.7 Shelter and Transition Beds in Chilliwack

The total number of emergency shelter and transition house beds in Chilliwack in 2014 is 104, made up of 57 shelter beds (Salvation Army and Ruth and Naomi's Mission), 31 Transition House beds (Ann Davis 12 and Xolhemet 19) and 16 youth shelter beds at the newly opened Cyrus Centre in Chilliwack.[4] It is important to note that there are limits on the number of days people can stay at these facilities.

There is also a view among some scholars and some practitioners that "sheltering" people does not facilitate either the complicated "road" toward self-sufficiency or linking someone to an integrated arrangement for wrap around support services that can over time facilitate a pathway out of homelessness. The desired outcome of making a break from living homeless cannot be achieved overnight and is dependent on long-term supports. The past 20 years have seen an increasing awareness and practice of integrated treatment for psychiatric and substance use issues in individuals experiencing concurrent disorders.

[4] Cyrus Centre in Chilliwack opened later in 2014 after the completion of the 2014 survey. Additional shelter beds, including extreme weather beds, were allocated to the Salvation Army and Ruth and Naomi's Mission at the beginning of December 2014, thus after the completion of the 2014 survey.

3. Profile of People Living Homeless in Chilliwack

People living homeless in Canada at any given time will be comprised of several groups, including, but not limited to, persons with severe addictions and/or mental illness, families, seniors, children, youth, persons with disabilities, and aboriginals. Single men constitute the majority of the visible homeless, according to the National Homeless Initiative, a fact confirmed by four surveys in the FVRD since 2004. As will be seen from the presentation that follows below, people who live homeless in Chilliwack include men and women, older individuals, youth, and persons who self-identify as Aboriginal.

Based on information obtained from respondents during the 2014 homelessness survey, the following can be reported regarding a profile of homeless people in Chilliwack.

3.1 Gender

The gender distribution of homeless people surveyed in Chilliwack in 2014 breaks down into 64% males and 34% females. This gender breakdown corresponds well with available data regarding homelessness in Canada according to which women constitutes one third to one half of the homeless population in major urban areas across Canada.

TABLE 7: Gender of Surveyed Respondents

Gender	2014n	2014%
Male	47	64.4
Female	25	34.2
Unknown	1	1.4
Total	73	100

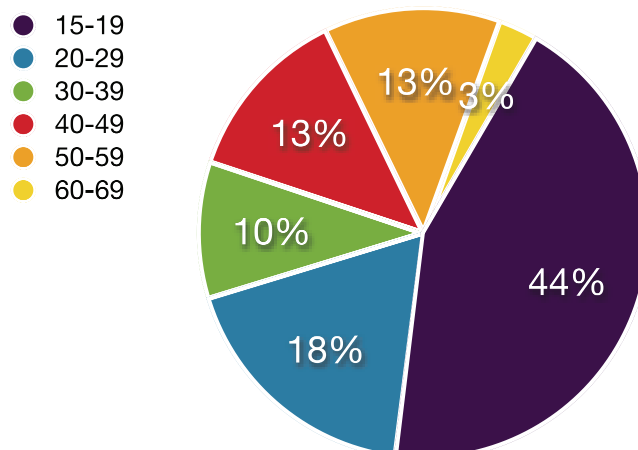
3.2 Age

The single biggest proportion, (43%) of homeless respondents in 2014, fell in the age category 19 years and younger. This high proportion of homeless youth is unique to Chilliwack in the context of FVRD communities included in this survey. The second largest proportion (18%) was those 20-29 years of age. Those 40 to 59 years of age make up a quarter (25%) of the homeless population in Chilliwack.

TABLE 8: Age of Surveyed Respondents

Age	2014n	2014%
Under 15	0	0.0
15-19	31	43.7
20-29	13	18.3
30-39	7	9.8
40-49	9	12.7
50-59	9	12.7
60-69	2	2.8
70+	0	0.0
Total Response	71	100
No Response	2	
Total	73	

GRAPH 5: Age of Surveyed Respondents



3.3 Aboriginal Presence

The respondents were asked to indicate whether they self-identify as Aboriginal. Twenty five respondents or 34% self-identified as Aboriginal in Chilliwack compared to 15 in 2011.

The literature indicates that the Aboriginal homeless have special needs that must be considered—e.g., cultural appropriateness, self-determination, and traditional healing techniques. It fell outside the scope of this survey to make further determinations in this regard. Suffice to say that the notion of providing culturally appropriate services for Aboriginal persons likely remains valid and requires further analysis.

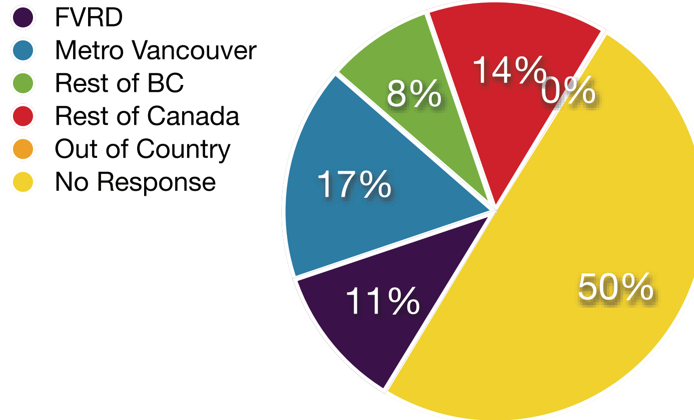
3.4 Community of Last Residence

Respondents were asked which community they moved from to Chilliwack. The biggest proportion (32%) indicated that they moved here from Metro Vancouver while 27% indicated that they came here from the "Rest of Canada", 16% came from "Rest of BC" and 21% are from FVRD communities. However, it is important to note that in response to the question: "How long have you been living in Chilliwack that 32% (almost a third) live in Chilliwack for 11 years or longer. Those who lived here for 6 – 10 years constitute 8%. Thus, 38% of the respondents lived in Abbotsford for 6 years or longer. Those living homeless for 2-5 years make up 21% and those living homeless less than six months constitute 27% (see Table 10).

TABLE 9: Where Did You Move Here From?

Place	2014n	2014%
FVRD	8	21.6
Metro Vancouver	12	32.4
Rest of BC	6	16.3
Rest of Canada	10	27.0
Out of Country	1	2.7
Total Response	37	100
No Response	36	
Total	73	

GRAPH 6: Where Did You Move Here From?



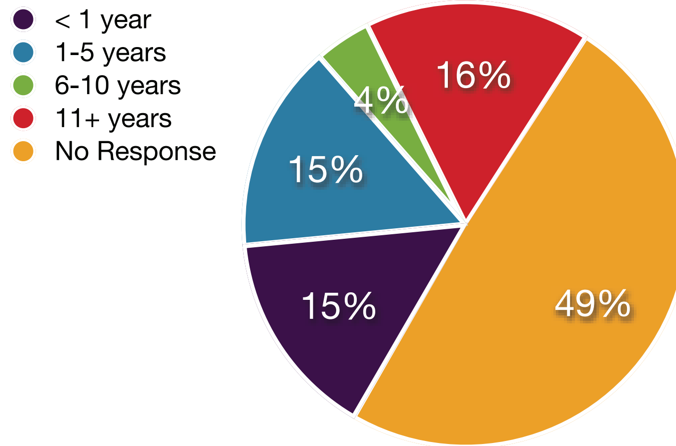
3.5 Length of Residence

Respondents were also asked how long they had been living in Chilliwack. The biggest proportion (32%) have lived in Chilliwack for 11 years or longer. Another significant number (27%) have lived in Chilliwack less than six months, and the third largest proportion (nearly 22%) have lived in Chilliwack 2-5 years. It must be noted that these percentages do not include the nearly 50% of respondents who did not respond to this question (see Graph 7 below).

TABLE 10: How Long Have You Been Living in Chilliwack?

Length of Residency	2014n	2014%
Less than 6 months	10	27.0
6-11 months	1	2.7
1 year - 23 months	3	8.1
2-5 years	8	21.7
6-10 years	3	8.1
11+ years	12	32.5
Total Response	37	
No Response	36	
Total	73	

GRAPH 7: How Long Have You Been Living in Chilliwack?



3.6 Source of Income

“Welfare” as a source of income represents 20% of the responses followed by “disability allowance” at 12%. The percentage of responses in the category “employment” as source of income is 11%. Responses associated with “binning” and “panhandling” total 17%. Thirteen percent (13%) of responses are linked to “family/friends” as source of income (see Table 11).

TABLE 11: Source of Income[5]

Source	2014n	2014%
Welfare	21	20.7
Disability benefit	13	12.7
Employment	12	11.8
EI/CPP/WCB/OAS/GIS	4	3.9
Binning/Panhandle	18	17.6
Family/Friends	14	13.7
Other	17	16.7
No Income	3	2.9
Total Responses	102	100
No Responses	5	
Total	107	

[5] The number is higher than 73 as respondents could check off more than one source of income.

3.7 Usage of Services

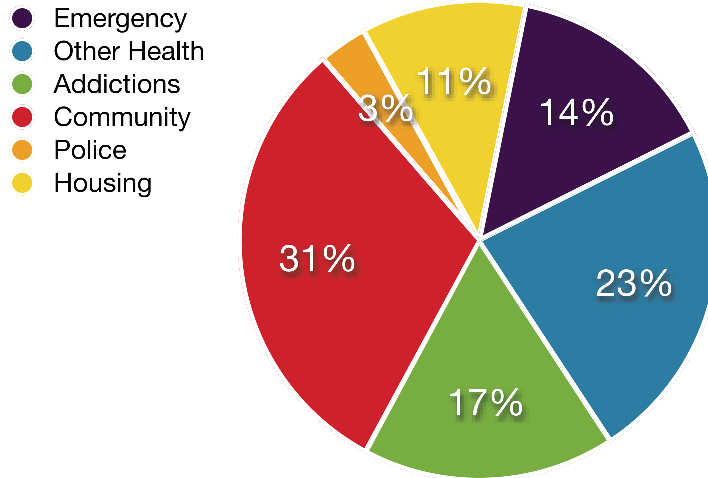
Table 12 indicates the extent to which services are being used by persons who live homeless in Chilliwack. For example 63% of respondents indicated that they used addiction services the past year, followed by 44% for emergency room; 41% meal programs; 38% mental health services; 34% health clinic, etc.

TABLE 12: Usage of Services in the Last 12 Months[6]

Service	2014n	2014%
Ambulance	12	16
Emergency room	32	44
Hospital (non-emergency)	14	19
Dental clinic or dentist	10	13
Mental health services	28	38
Addiction services	46	63
Extreme weather shelter	4	6
Employment/Job help services	24	33
Probation/Parole services	11	15
Drop-in services	17	23
Food bank	21	29
Meal programs/Soup kitchens	30	41
Health clinic	25	34
Newcomer services	0	0
Transitional housing	4	6
Housing help/Eviction prevention	3	4
Needle exchange	11	15
Outreach	30	41
Legal	11	15
Budgeting/Trusteeship	0	0

[6] Number is higher than 73 as respondents could check off more than one service. Percentages are of service usage in relation to total number of respondents.

GRAPH 8: Service Use Percentages in the Last 12 Months[7]



Respondents were also asked whether they have been affected by a change or withdrawal in services. Sixteen or 28.0% answered in the affirmative and 48 or 75% answered “no” (see Table 13).

TABLE 13: Affected by Change or Withdrawal of Services

Affected by Change or Withdrawal	2014n	2014%
Yes	16	25.0
No	48	75.0
Total Response	64	100.0
No Response	9	
Total	73	

[7] Emergency-based services category includes Extreme Weather shelter, and Housing services category includes Outreach.

4. Summary of Survey Findings Chilliwack

The following summarizes the main findings of this survey:

1. In comparison to 2011, the number of homeless people interviewed in Chilliwack has decreased from 111 to 73 (34% decrease).
2. Homelessness is a result of inadequate income (poverty), unaffordable rental rates, addiction to substance use, relational/family breakdown and mental health issues.
3. Lack of affordable housing is directly related to low wages, erosion of the social safety net, insufficient social housing inventory, especially lack of "housing first" options and increased rental accommodation cost.
4. Chronic homeless people are conservatively estimated to be in the 25-35% range or 20 to 30 people. This is higher than the 15 - 20% that is conventionally seen as the percentage of homeless people in Canadian jurisdiction specific homeless populations.
5. 26% of respondents experience long-term homelessness (one year or longer). However, the majority of respondents indicated that they are living homeless for less than six months.
6. 20% of respondents live outside in makeshift shelters or other outdoor places and just more than half (51%) spent the night of the survey at a place of "family/friends".
7. Males constitute the majority of homeless persons i.e. 64%. Females constitute 34%.
8. A very significant proportion of those who live homeless (43%) is 19 years of age or younger. If combined with those 20-29 years of age (18%) the percentage increases to 50%. Thus, Chilliwack has a significant proportion of younger homeless persons compared to other FVRD communities.
9. 34% (15 persons) of Chilliwack homeless people self-identify as Aboriginal.
10. 62% of the homeless persons live in Chilliwack for 2 years or longer.
11. Welfare and disability benefits are the source of income for one third (33%) of the homeless persons.
12. 13% of the Chilliwack homeless population lives with a physical disability, 25% with a mental health issue and 42% with an addiction to substance use.
13. Three quarters or 75% of respondents indicated that they have not been affected by service change or withdrawal. Those that have been affected cited "refused welfare" or "being cut off welfare" as examples of how they have been affected.

5. Conclusions

1. There remains a need for permanent supportive housing based on the housing first approach for those who live with mental illness and/or addiction to substance use those coming out of treatment and those released from incarceration.
2. Housing-first models are predicated on the assumption that all individuals, regardless of substance misuse, are entitled to a safe place to live. They are also predicated on the assumption that addiction recovery is more likely to be successful when secure housing is met. Housing-first models encourage clients to seek addiction treatment, but do not make it mandatory before housing is provided.
3. Homeless people are subject to stress because of the factors that made them homeless and because of the experience of being homeless. Poor diet, stress, cold and damp, along with inadequate sleeping arrangements, sanitation and hygiene, increase the risk of health problems and decrease life expectancy.
4. Homelessness in itself is an “agent of disease". As such homeless people are more exposed to and more likely to develop health problems than the general population, as living conditions predispose them to be particularly at risk of developing ill health.
5. Chronic emotional and mental illness complicates daily existence and can mask acute illnesses or prevent people from accessing services and receiving much needed medical care and therefore remains trapped in chronic homelessness.
6. Chronically homeless persons are people who cannot function in housing that assumes independent living without support. They are unable to fit into independent housing, and thus get evicted. What this population, also recognized by the term “concurrent disorders”, requires is housing that can respond adequately to their needs e.g. Housing First Approach.
7. Professional medical attention and community relationships are two key elements of care in relation to people who live homeless. People are more willing to think about treatment and other solutions if they feel trusted and understood.
8. In addition to a paradigm shift in the delivery of mental health care, it is also necessary to provide more than surface support, such as food, clothing, emergency shelter, soup kitchens, etc. High-need clients, such as those living with concurrent disorders and who are chronically homeless, require a full integration of mental health and addiction services in addition to health care and housing. Evidence suggests that the current system of care picks and chooses instead of offering the whole set of services needed, so clients with the most complex needs get no care and drop out of the system. This reality aggravates the problem of inadequate care for those who live homeless.

9. It is not adequate care or good use of resources for a person with mental and/or substance abuse challenges to be housed without supportive service or to receive services without housing. Housing needs to be inclusive of everything, from housing to medical care to psychiatric treatment to provision of food.

10. Housing models must meet the needs of the whole person, with involvement in day-to-day support. It is imperative that participants not be constrained by exit deadlines.

11. A fully integrated system that makes “any door the right door”— means that people with concurrent disorders experiencing homelessness can enter the service system through any service door, be assessed, and have access to the full range of comprehensive services and support.

12. Supportive case management is indispensable to successful service delivery to people living homeless.

6. Recommendations

1. Include the housing-first approach in policies and practices addressing homelessness in Chilliwack. It is imperative that this is expanded in Chilliwack in order to provide good care and make progress with homelessness reduction.
2. Take immediate steps to move toward the creation of a more adequate housing spectrum in Chilliwack through housing first provisioning and more comprehensive and farther in reach mental health and addictions services.
3. Provide a 30 – 40 unit housing facility based on the principles of housing first to provide housing and care to chronically homeless persons in Chilliwack.
4. Implement an Assertive Community Treatment (ACT) Team that facilitates an integrated model of care embracing empathetic therapeutic relationship building.
5. Focus community care efforts on establishing a coherent and comprehensive intervention to implement housing and care.
6. Partner with existing community agencies to further extend the reach of housing first options through a scattered site approach (e.g. Raven's Moon Society's Model in Abbotsford).

END NOTE

See Main Regional Homeless Report for more detailed analysis of homelessness in FVRD communities and a more expanded list of findings, conclusions and recommendations and also a list of references undergirding the analysis and recommendations in the main report.

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APPENDIX 5

FRASER VALLEY REGIONAL DISTRICT 2014 HOMELESSNESS SURVEY

Findings, Conclusions and Recommendations

District of Mission

Ron van Wyk, Mennonite Central Committee, BC
Anita van Wyk, Social, Culture and Media Studies, University of the Fraser Valley

To be read in conjunction with primary 2014 Homelessness Survey Report

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- Alison Stewart, Fraser Valley Regional District
- Dorothy Henneveld, Women's Resource Society of the Fraser Valley
- Kirsten Hargreaves – District of Mission
- Michele Lylyk, Mission Friendship Centre

Thank you also to the volunteers in Mission who stepped forward and conducted the interviews. Without their work this survey would not have been a success. Last, but certainly not least, a big thank you is extended to homeless persons who participated in the survey by patiently answering questions.

1. Introduction

1.1 Report Background

Homelessness in Mission has been empirically confirmed in 2004, 2008, 2011 and again now in 2014 through a survey[1] of people who live homeless (van Wyk & van Wyk, 2005, 2008, 2011)

Following on these previous surveys, the 2014 homelessness survey in Mission was conducted in collaboration with the following organizations:

- Women's Resource Society of the Fraser Valley
- Mission Friendship Centre
- District of Mission, Social Development and Planning
- Mission Community Services Society
- Youth Unlimited, Mission

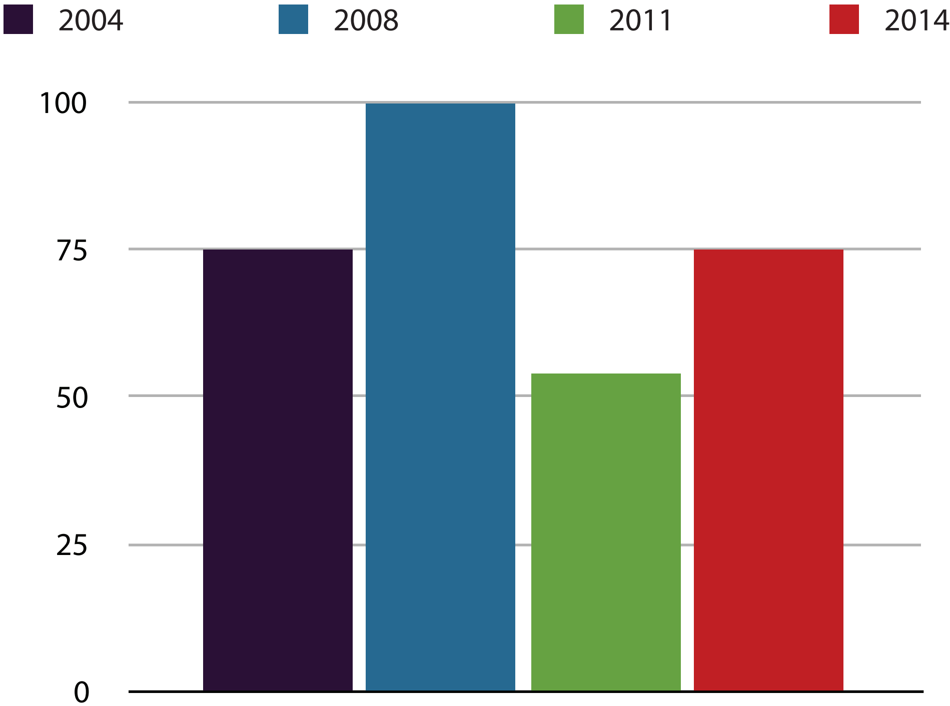
[1] As has been the practice since 2004 and in conjunction with the organizers of the Metro Vancouver tri-annual homeless count the survey is limited in the number of questions asked in order to keep it manageable given the purpose of this type of survey and the associated methodological challenges.

2. Extent of Homelessness in Mission 2014

2.1 Number of Homeless People Interviewed in Mission in Survey Period

Seventy five (75) homeless people were surveyed during the 24-hour period, March 11 and 12, 2014, in Mission. Comparing this result with the 2011 survey indicates that the number of homeless persons surveyed in Mission is up by 39% since 2011. However, the number is lower than the 100 homeless persons interviewed in 2008 and the same (75) as the number of homeless persons interviewed in 2004.

CHART 1: Mission Homeless Survey Totals 2004-2014



2.2 Reasons for Homelessness

Every homeless person has an individual story of his or her path into homelessness. Although research in the past has explored the personal dynamics that contribute to homelessness (including addiction and mental illness), Canadian studies have in addition started to include and reflect on understanding the structural/systemic factors that contribute to homelessness.

The reasons for being homeless cited by respondents to this survey in Mission are reflected in Table 1.

TABLE 1: Reasons for Being Homeless[2]

Reason Given	2014n	2014%
Inadequate income	46	25.7
Rent too high	34	19.0
Family breakdown/abuse/conflict	19	10.6
Evicted	11	6.1
Health/Disability	19	10.6
Addictions	29	16.2
Criminal history	10	5.6
Poor housing conditions	9	5.1
Pets	2	1.1
Other	0	0.0
Total Response	179	100.0
No Response	8	
Total	187	

Forty four percent (44%) of the respondents claimed that the reason for homelessness related to the issue of affordability, i.e., inadequate income and unaffordable rent, which is an example of a structural cause. A further 16% cited addictions as the reason for homelessness with 10% of respondents citing family breakdown/abuse/conflict as the reason. Health/disability reasons were cited by 10% and 6% said they were evicted.

It is evident from the survey results that while personal issues may precipitate homelessness it is further compounded by systemic structural factors. Research has shown that there are often precipitating factors including job loss, loss of permanent housing due to eviction, family breakdown, or illness. Homelessness can result when precipitating factors are compounded by structural and systemic factors such as shifting provincial or federal policy. Based on an interpretation of the growing body of knowledge on homelessness in Canada, it is safe to assert that

[2] The total number is higher than 75 as respondents could check off more than one reason for being homeless.

homelessness is indeed a complex phenomenon and that a variety of factors, in various combinations, contribute to homelessness; this applies to Mission as well.

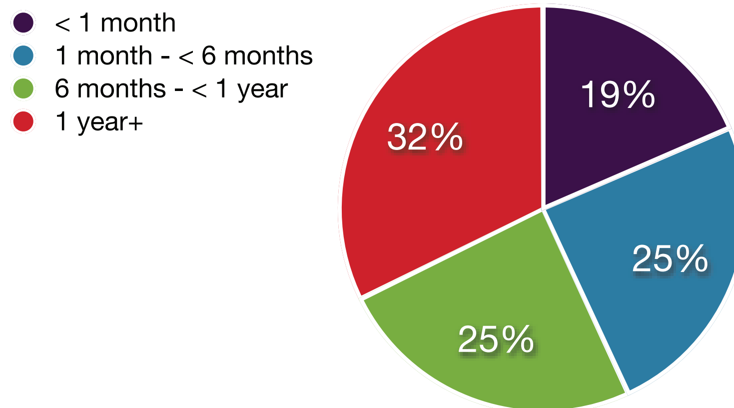
2.3 Duration of Homemessness

The respondents were asked to indicate how long they had been homeless. Those who had been homeless for a year or longer constituted 32%, a substantial proportion of the population, whilst 24% indicated they had been homeless for more than six months but less than a year, 24.0% for more than a month but no longer than six months, and 18% for less than a month (see Table 2).

TABLE 2: Duration of Homelessness

Duration	2014n	2014%
less than 1 month	12	18.5
1 month - less than 6 months	16	24.6
6 months - less than 1 year	16	24.6
1 year +	21	32.3
Total Response	65	100.0
No Response	10	
Total	75	

GRAPH 1: Duration of Homelessness



Based on the above, it is apparent that almost one third of the persons who live homeless in Mission (32% or 21 individuals) are experiencing relative long-term (one year or longer) or chronic homelessness.

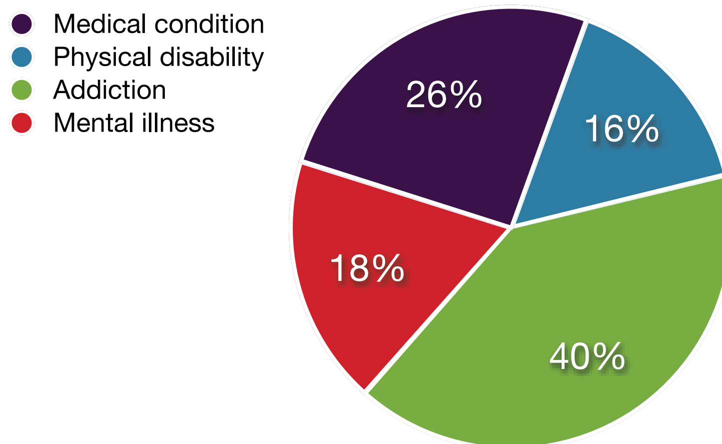
2.4 Health Problems

Survey respondents were asked to report on their health problems; 25% of responses were registered for having a medical condition, 15% for having a physical disability, 40% for living with an addiction, and 18% living with a mental illness. It is reasonable to argue that chronic emotional and mental illness complicates daily existence, and can mask acute illnesses or prevent people from accessing services and receiving much needed medical care and therefore prone to become chronically homeless. Based on the former, it is reasonable to assert that homeless persons suffer from a variety of chronic and acute illnesses that are aggravated by life on the streets.

TABLE 3: Reported Health Problems

Health Issue	2014n	2014%
Medical condition	28	25.7
Physical disability	17	15.6
Addiction	44	40.4
Mental illness	20	18.3
Total Responses	109	100
No Responses	15	
Total	124	

GRAPH 2: Percentages of Homeless Individuals with Reported Health Issues



Homeless people are more exposed to and more likely to develop health problems than the general population, as living conditions predispose them to be particularly at risk of developing ill health. Furthermore, homeless people are subject to stress because of the factors that made them homeless and because of the experience of being homeless. Poor diet, stress, cold and damp, along with inadequate sleeping arrangements, sanitation and hygiene, increase the risk of health problems and decrease life expectancy.

Given the duration of homelessness (see Table 2) above and the reported health issues prevalent among homeless persons in Mission (see Table 3) above, it is safe to assert that there are people who are chronically homeless in Mission. ***Chronically homeless*** people include those who live on the periphery of society and who often face problems of drug or alcohol abuse or mental illness. It is estimated that this subgroup constitutes about 10–15% of the homeless population in a given locale. These are the so-called hard to house persons, but this label is problematic; perhaps it is rather a case of current housing provisions not being geared to provide support to high-needs clients.

In the case of Mission this category or subgroup is estimated to be higher than the conventional 10 – 15% range within Canadian based jurisdiction specific homeless populations. Based on "length of homelessness", (Table 2 above) and the prevalence of mental health and addictions issues as reported by homeless persons (Table 3 above) the range of people who live chronically homeless in Mission could conservatively be estimated in the 20%-25% range or 15 to 20 people.

2.5 "Sheltered" and "Unsheltered" Homeless Persons

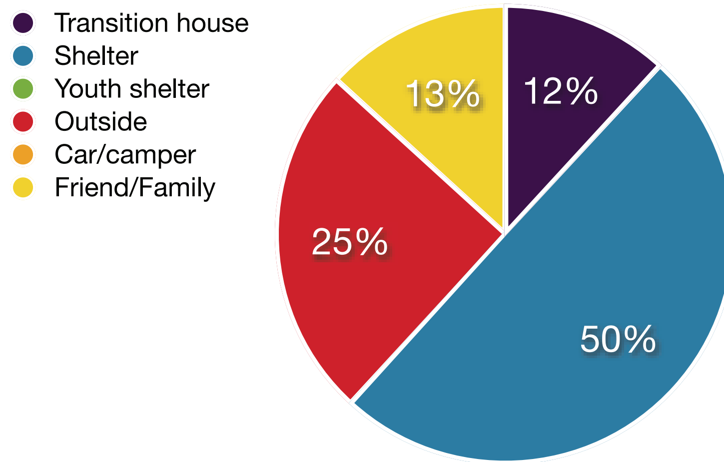
The number of homeless persons surveyed in official shelters was 61% and those surveyed who did not use shelter accommodation totaled 38%, including those who reported that they were sleeping at the homes of friends/family, so-called couch surfers (13%).

The number of homeless people surveyed outside, i.e. not in shelters and not couch surfing constitutes one quarter (25%) of the people who live homeless in Mission (see Table 4).

TABLE 4: Accommodation on Night of Survey

Places Stayed	2014n	2014%
Transition house	8	11.8
Shelter	34	50.0
Youth shelter	0	0.0
Outside	17	25.0
Car/camper	0	0.0
Friend/Family's place	9	13.2
Total Response	68	100
No Response	7	
Total	75	

GRAPH 3: Accommodation on Night of Survey



The respondents were asked to state their main reasons for not having used a transition house or a shelter the previous night (see Table 5 below). The biggest proportion falls into the category "turned away" (37%). The category "turned away" includes reasons such as the shelter was full, they had used up their allotted days, their gender was inappropriate, etc. This is followed by 22% stating that they have spent the night with friends/family. The category of those who indicated a "dislike" in shelter constitutes 11%. Reasons given for disliking the shelter include "too many rules"; "feels too much like an institution"; don't like the curfew"; "do not feel safe", the latter response is in reference to having to share accommodation with "lunatics"' "drug addicts" and "crazy people" as stated by respondents.

TABLE 5: Reasons for Not Staying in Shelter/Transition House

Reason	2014n	2014%
Turned away	10	37.0
Stayed with friend/family	6	22.2
Dislike	3	11.2
Did not know about shelter	0	0.0
Couldn't get to shelter	2	7.4
Slept in car/camper	0	0.0
No shelter in community	0	0.0
Other	6	22.2
Total Response	27	100.0
No Response	48	
Total	75	

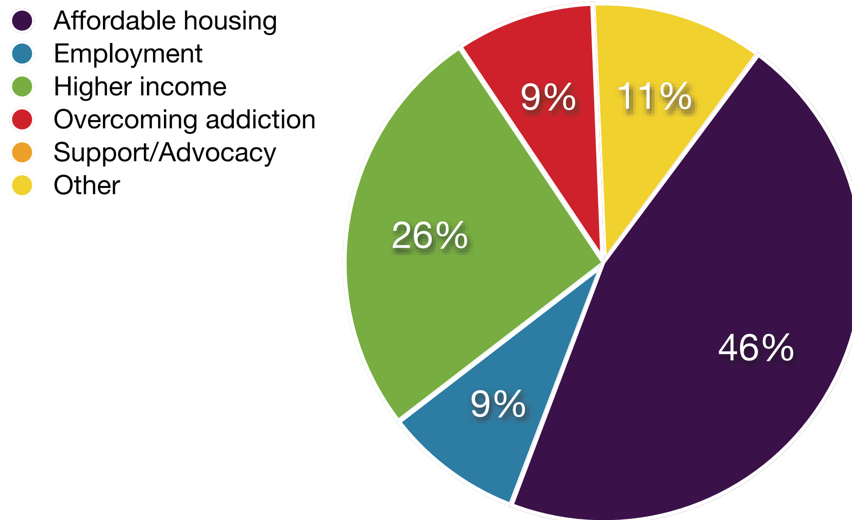
2.6 What Will End Homelessness for You?

When asked what would end their homelessness, respondents indicated that access to more affordable housing was the most common barrier (45%) to overcome in finding a home, followed by a need for “higher income” at 26% (see Table 6).

TABLE 6: What Will End Homelessness for You?

Response	2014n	2014%
Affordable housing	21	45.7
Employment	4	8.7
Higher income	12	26.1
Overcoming addiction	4	8.7
Support/Advocacy	0	0.0
Other	5	10.8
Total Response	46	100
No Response	29	
Total	75	

GRAPH 4: What Will End Homelessness for You?



2.7 Shelter and Transition Beds in Mission

The total number of emergency shelter beds in Mission in 2014 is 24, made up of 20 beds at Haven in Hollow Shelter and 4 extreme weather beds. The total number of beds in the Mission Transition House is 10. It is important to note that there are limits on the number of days people can stay at these facilities.

There is a view among some scholars and some practitioners that “sheltering” people, does not facilitate either the complicated “road” toward self-sufficiency or linking someone to an integrated arrangement for wrap around support services that can over time facilitate a pathway out of homelessness. The desired outcome of making a break from living homeless cannot be achieved overnight and is dependent on long-term relationships and supports. The past 20 years have seen an increasing awareness and practice of integrated treatment for psychiatric and substance use issues in individuals experiencing concurrent disorders.

3. A Profile of People Living Homeless in Mission

People living homeless in Canada at any given time will be comprised of several groups, including, but not limited to, persons with severe addictions and/or mental illness, families, seniors, children, youth, persons with disabilities, and aboriginals. Single men constitute the majority of the visible homeless, according to the National Homeless Initiative, a fact confirmed by four surveys in the FVRD since 2004. As will be seen from the presentation that follows below, people who live homeless in Mission include people with addictions and/or mental illness, older individuals, youth, persons with disabilities and persons who self-identify as Aboriginal.

Based on information obtained from respondents during the 2014 homelessness survey, the following can be reported regarding a profile of homeless people in Mission.

3.1 Gender

The gender distribution of homeless people surveyed in Mission in 2014 breaks down into almost 60% males and almost 35% females. This gender breakdown corresponds well with available data regarding homelessness in Canada according to which women constitutes one third to one half of the homeless population in major urban areas across Canada.

TABLE 7: Gender of Surveyed Respondents

Gender	2014n	2014%
Male	44	58.6
Female	24	32.0
Unknown	7	9.3
Total	75	100

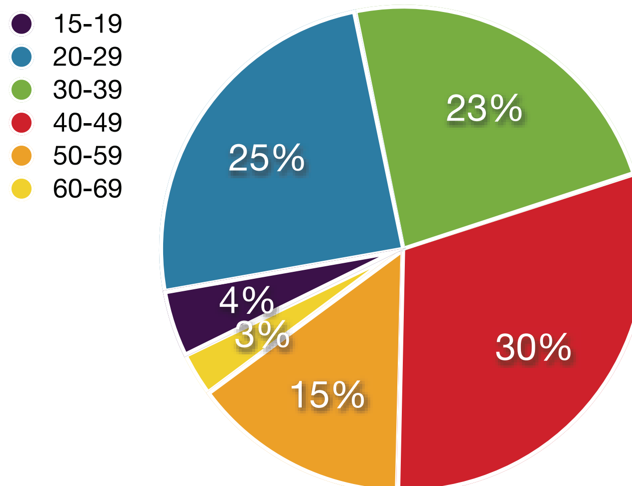
3.2 Age

Similar to previous homelessness surveys in the Fraser Valley (Van Wyk & Van Wyk, 2004, 2008 and 2011), the biggest proportion, just more than half of homeless respondents (53%) in 2014 fell in the 30–49 year age group. The second largest proportion (29%) is made up of those 29 years of age or younger. Those 50 years of age or older constitute 17% of the people who live homeless in Mission.

TABLE 8: Age of Surveyed Respondents

Age	2014n	2014%
Under 15	0	0.0
15-19	3	4.4
20-29	17	24.6
30-39	16	23.2
40-49	21	30.4
50-59	10	14.5
60-69	2	2.9
70+	0	0.0
Total Response	69	100
No Response	6	
Total	75	

GRAPH 5: Age of Surveyed Respondents



Homelessness affects health and life expectancy in significant ways. Homeless Canadians are more likely to die younger and to suffer more illnesses than the general Canadian population. Many factors contribute to the lower life expectancy of homeless people, including lack of social support networks, education, unemployment, living conditions, personal health practices, biology and genetic endowment, lack of availability of health services, etc.

3.3 Aboriginal Presence

The respondents were asked to indicate whether they self-identify as Aboriginal. Eighteen respondents or 24.0% self-identified as Aboriginal in Mission compared to 5 individuals or 7% in 2011.

The literature indicates that the Aboriginal homeless persons have special needs that must be considered—e.g., cultural appropriateness, self-determination, and traditional healing techniques. It fell outside the scope of this survey to make further determinations in this regard. Suffice to say that the notion of providing culturally appropriate services for Aboriginal persons likely remains valid and requires further analysis.

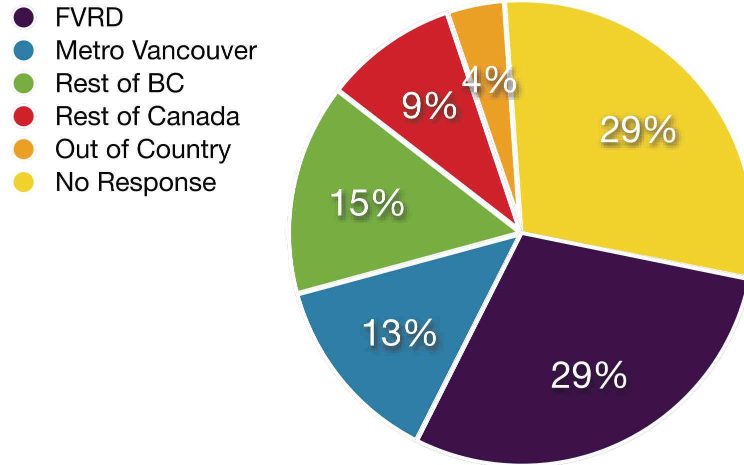
3.4 Community of Last Residence

Respondents were asked which community they moved from to Mission. The biggest proportion (20%) indicated that they are from other parts of BC than the FVRD and Metro Vancouver with a significant proportion (18%) from Metro Vancouver (see Table 9 below). However, it is important to note that in response to the question: “How long have you been living in Mission that more than a third (37%) have lived in Mission for 11 years or longer with other third (33%) having lived in Mission between 2 and 10 years (see Table 9 below).

TABLE 9: Where Did You Move Here From

Where From	2014n	2014%
FVRD	22	41.5
Metro Vancouver	10	18.9
Rest of BC	11	20.8
Rest of Canada	7	13.2
Out of Country	3	5.7
Total Response	53	100
No Response	22	
Total	75	

GRAPH 6: Where Did You Move Here From?

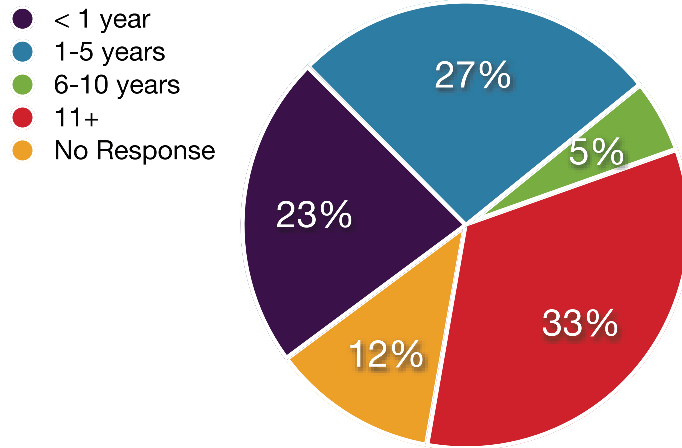


3.5 Length of Residency

TABLE 10: How Long Have You Lived in Mission?

Length of Residency	2014n	2014%
Less than 6 months	13	19.7
6-11 months	4	6.1
1 year - 23 months	2	3
2-5 years	18	27.3
6-10 years	4	6.1
11+ years	25	37.8
Total Response	66	100
No Response	9	
Total	75	

GRAPH 6: How Long Have You Been Living in Mission?



3.6 Source of Income

"Welfare" as a source of income is mentioned by 41% of the responses followed by "disability allowance" at 15%. The percentage of responses in the category "employment" as source of income is 4%. Responses associated with "binning" and "panhandling" make up 14% of the population (see Table 11 below).

TABLE 11: Source of Income[3]

Source	2014n	2014%
Welfare	40	41.3
Disability benefit	15	15.5
Employment	4	4.1
EI/CPP/WCB/OAS/GIS	4	4.1
Binning/Panhandle	14	14.4
Family/Friends	7	7.2
Other	7	7.2
No Income	6	6.2
Total Response	97	100
No Response	8	
Total	105	

[3] Number does not add up to 75 as respondents could check off more than one source of income.

3.7 Usage of Services

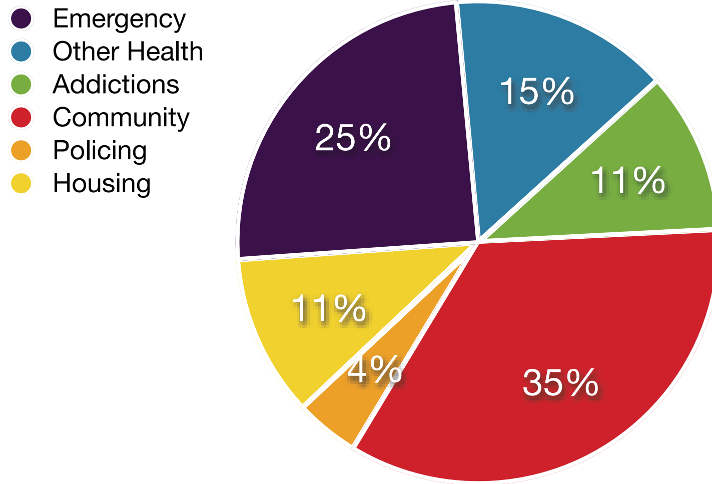
Table 12 indicates the extent to which services are being accessed by people who live homeless in Mission. For example, 53% accessed the emergency room over the past year followed by 51% who used the food bank, 45% meal programs, 44% drop-in services, 43% ambulance service, 39% addiction services, 37% outreach services, 36% extreme weather shelter, 33% hospital, etc.

TABLE 12: Usage of Services Last 12 Months[4]

Service	2014n	2014%
Ambulance	32	43
Emergency room	40	53
Hospital (non-emergency)	25	33
Dental clinic or dentist	19	25
Mental health services	15	20
Addiction services	29	39
Extreme weather shelter	27	36
Employment/Job help services	16	21
Probation/Parole services	17	23
Drop-in services	33	44
Food bank	38	51
Meal programs/Soup kitchens	34	45
Newcomer services	1	1
Transitional housing	13	17
Housing help/Eviction prevention	3	4
Needle exchange	15	20
Outreach	28	37
Legal	14	19

[4] Number does not add up to 75 as respondents could choose more than one service. Percentages are service usage in relation to total number of respondents.

GRAPH 7: Usage of Services[5]



Respondents were also asked whether they have been affected by a change or withdrawal in services. Fifteen or 29% answered in the affirmative and 26 or 70% answered "no" (see Table 13 below).

TABLE 13: Affected by Change or Withdrawal in Services

Affected by Change/Withdrawal	2014n	2014%
Yes	15	29.4
No	26	70.6
Total Response	51	100.0
No Response	24	
Total	75	

[5] Emergency-based services category includes Extreme Weather shelter, and Housing services category includes Outreach.

4. Summary of Survey Findings

The following summarizes the main findings of this survey:

- In comparison to 2011, the number of homeless people interviewed in Mission has increased from 54 to 75 (39% increase).
- Homelessness is a result of inadequate income (poverty), unaffordable rental rates, relational breakdown, and the impact of mental health issues and/or addiction to substance use, as well as a concomitant lack of adequate medical care and support at the community level.
- Lack of affordable housing is directly related to low wages, erosion of the social safety net, insufficient social housing inventory, especially lack of "housing first" options and increased rental accommodation cost.
- Chronic homeless people are conservatively estimated to be in the 20%-25% range or 15 to 20 people. This is slightly higher than the 15 - 20% that is conventionally seen as the percentage of homeless people in Canadian jurisdiction specific homeless populations.
- 32% of respondents experience long-term homelessness (one year or longer).
- 25% of respondents live outside in makeshift shelters or other outdoor places.
- Males constitute the majority of homeless persons i.e. 58%.
- 53% of homeless persons are in the age category 30-49 years and 17% are 50 years or older.
- 24% of Mission homeless persons self-identify as Aboriginal.
- 43% of the homeless persons live in Mission for 6 years or longer.
- Welfare and disability benefits are the source of income for more than half (56%) of the homeless persons.
- 40% of the population lives with an addiction to substance use and 18% live with a mental health issue.
- 29% indicated that they have been affected by service change or withdrawal. Most common examples cited are "refused welfare" or "being cut off welfare".

5. Conclusions

1. There remains a need for permanent supportive housing based on the housing first approach for those who live with mental illness and/or addiction to substance use those coming out of treatment and those released from incarceration.
2. Housing-first models are predicated on the assumption that all individuals, regardless of substance misuse, are entitled to a safe place to live. They are also predicated on the assumption that addiction recovery is more likely to be successful when secure housing is met. Housing-first models encourage clients to seek addiction treatment, but do not make it mandatory before housing is provided.
3. Homeless people are subject to stress because of the factors that made them homeless and because of the experience of being homeless. Poor diet, stress, cold and damp, along with inadequate sleeping arrangements, sanitation and hygiene, increase the risk of health problems and decrease life expectancy.
4. Homelessness in itself is an “agent of disease". As such homeless people are more exposed to and more likely to develop health problems than the general population, as living conditions predispose them to be particularly at risk of developing ill health.
5. Chronic emotional and mental illness complicates daily existence and can mask acute illnesses or prevent people from accessing services and receiving much needed medical care and therefore remains trapped in chronic homelessness.
6. Chronically homeless persons are people who cannot function in housing that assumes independent living without support. They are unable to fit into independent housing, and thus get evicted. What this population, also recognized by the term “concurrent disorders”, requires is housing that can respond adequately to their needs e.g. Housing First Approach.
7. Professional medical attention and community relationships are two key elements of care in relation to people who live homeless. People are more willing to think about treatment and other solutions if they feel trusted and understood.
8. In addition to a paradigm shift in the delivery of mental health care, it is also necessary to provide more than surface support, such as food, clothing, emergency shelter, soup kitchens, etc. High-need clients, such as those living with concurrent disorders and who are chronically homeless, require a full integration of mental health and addiction services in addition to health care and housing. Evidence suggests that the current system of care picks and chooses instead of offering the whole set of services needed, so clients with the most complex needs get no care and drop out of the system. This reality aggravates the problem of inadequate care for those who live homeless.

9. It is not adequate care or good use of resources for a person with mental and/or substance abuse challenges to be housed without supportive service or to receive services without housing. Housing needs to be inclusive of everything, from housing to medical care to psychiatric treatment to provision of food.

10. Housing models must meet the needs of the whole person, with involvement in day-to-day support. It is imperative that participants not be constrained by exit deadlines.

11. A fully integrated system that makes “any door the right door”— means that people with concurrent disorders experiencing homelessness can enter the service system through any service door, be assessed, and have access to the full range of comprehensive services and support.

12. Supportive case management is indispensable to successful service delivery to people living homeless.

6. Recommendations

1. Include the housing-first approach in policies and practices addressing homelessness in Mission. It is imperative that this be expanded in Mission in order to provide good care and make progress with homelessness reduction.
2. Take immediate steps to move toward the creation of a more adequate housing spectrum in Mission through housing first provisioning and more comprehensive and farther in reach mental health and addictions services.
3. Provide a 30 – 40 unit housing facility based on the principles of housing first to provide housing and care to chronically homeless persons in Mission.
4. Implement an Assertive Community Treatment (ACT) Team that facilitates an integrated model of care embracing empathetic therapeutic relationship building.
5. Focus community care efforts on establishing a coherent and comprehensive intervention to implement housing and care.
6. Partner with existing community agencies to further extend the reach of housing first options through a scattered site approach (e.g. Raven's Moon Society's Model in Abbotsford).

END NOTE

See Main Regional Homeless Report for more detailed analysis of homelessness in FVRD communities and a more expanded list of findings, conclusions and recommendations and also a list of references undergirding the analysis and recommendations in the main report.

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APPENDIX 5

FRASER VALLEY REGIONAL DISTRICT
2014 HOMELESSNESS SURVEY

Findings, Conclusions and Recommendations

Districts of Hope and Kent*

Ron van Wyk, Mennonite Central Committee, BC
Anita van Wyk, Social, Culture and Media Studies, University of the Fraser Valley

To be read in conjunction with primary 2014 Homelessness Survey Report

* Consolidates the District of Hope, District of Kent, Village of Harrison Hot Springs, and Boston Bar

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- Alison Stewart - Fraser Valley Regional District
- Grace Admiraal – Agassiz-Harrison Community Services Society
- Nancy Carmichael– Boston Bar Enhancement Society
- Paul Keller – Hope and Area Transition Society
- Wendy Coleman - Fraser-Cascade School District 78

Thank you also to the volunteers in Hope, Boston Bar and Agassiz who stepped forward and conducted the interviews. Without their work this survey would not have been a success. Last, but certainly not least, a big thank you is extended to homeless persons who participated in the survey by patiently answering questions.

1. Introduction

1.1 Report Background

Homelessness in Hope and Agassiz-Harrison (HAH) has been empirically confirmed in 2004, 2008, 2011 and again now in 2014 through a survey[1] of people who live homeless (van Wyk & van Wyk, 2005, 2008, 2011).

Following on these previous surveys, the 2014 homelessness survey in Mission was conducted in collaboration with the following organizations:

- Fraser-Cascade School District 78
- Agassiz-Harrison Community Services Society
- Hope and Area Transition Society
- Boston Bar Enhancement Society

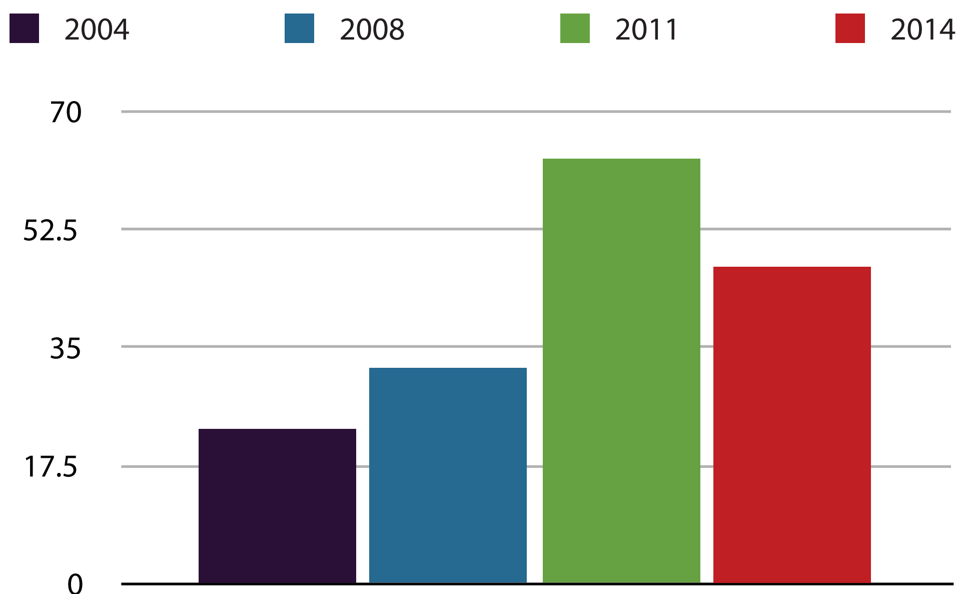
[1] As has been the practice since 2004 and in conjunction with the organizers of the Metro Vancouver tri-annual homeless count, the survey is limited in the number of questions asked in order to keep it manageable given the purpose of this type of survey and the associated methodological challenges.

2. Extent of Homelessness in Hope and Kent 2014

2.1 Number of Homeless People Interviewed During 24 Hour Survey

Forty seven (47) homeless people were surveyed during the 24-hour period, March 11 and 12, 2014. Comparing this result with the 2011 survey indicates that the number of homeless persons surveyed is up down by 25% since 2011 when 63 persons were interviewed.

CHART 1: Hope and Agassiz-Harrison Homeless Survey Totals 2004-2014



2.2 Reasons for Homelessness

Every homeless person has an individual story of his or her path into homelessness. Although research in the past has explored the personal dynamics that contribute to homelessness (including addiction and mental illness), Canadian studies have in addition started to include and reflect on understanding the structural/systemic factors that contribute to homelessness.

The reasons for being homeless cited by respondents to this survey in HAH are reflected in Table 1.

TABLE 1: Reasons for Homelessness[2]

Reason	2014n	2014%
Inadequate income	36	24.8
Rent too high	18	12.4
Family breakdown/abuse/conflict	17	11.7
Evicted	11	7.6
Health/Disability	13	8.9
Addictions	21	14.5
Criminal history	5	3.4
Poor housing conditions	6	4.1
Pets	0	0.0
Other	0	0.0
Total Response	145	100.0
No Response	1	
Total	146	

Thirty-seven percent (37%) of the respondents claimed that the reason for homelessness related to the issue of affordability, i.e., inadequate income and unaffordable rent, which is an example of a structural cause. A further 14% cited addictions as the reason for homelessness with 11% of respondents citing family breakdown/abuse/conflict as the reason. Health/disability reasons were cited by 8% and 7% said they were evicted.

It is evident from the survey results that while personal issues may precipitate homelessness it is further compounded by systemic structural factors. Research has shown that there are often precipitating factors including job loss, loss of permanent housing due to eviction, family breakdown, or illness. Homelessness can result when precipitating factors are compounded by structural and systemic factors such as shifting provincial or federal policy. Based on an interpretation of the growing body of knowledge on homelessness in Canada, it is safe to assert that

[2] Total number is higher than 47 as respondents could check off more than one reason for homelessness.

homelessness is indeed a complex phenomenon and that a variety of factors, in various combinations, contribute to homelessness; this applies to HAH as well.

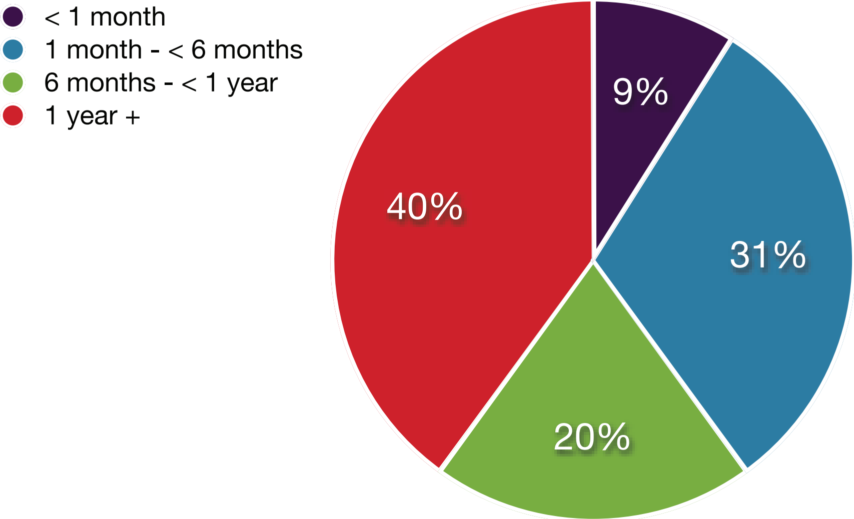
2.3 Duration of Homelessness

The respondents were asked to indicate how long they had been homeless. Those who had been homeless for a year or longer constituted 40%, a substantial proportion of the population, whilst 20% indicated they had been homeless for more than six months but less than a year, 31.0% for more than a month but no longer than six months, and 8% for less than a month (see Table 2).

TABLE 2: Duration of Homelessness

Duration	2014n	47
less than 1 month	4	8.9
1 month - less than 6 months	14	31.1
6 months - less than 1 year	9	20.0
1 year +	18	40.0
Total Response	45	100.0
No Response	2	
Total	47	

GRAPH 1: Duration of Homelessness



Based on the above, it is apparent that more than a third of the persons who live homeless (40% or 18 individuals) are experiencing relative long-term (one year or longer) or chronic homelessness.

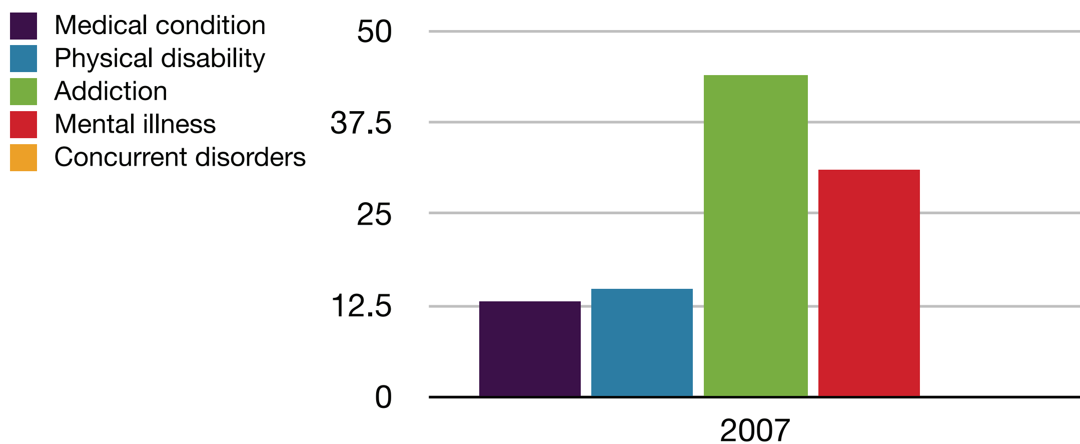
2.4 Health Problems

Survey respondents were asked to report on their health problems; 13.% of responses were registered for having a medical condition, 14% for having a physical disability, 44% for living with an addiction, and 31% living with a mental illness. It is reasonable to argue that chronic emotional and mental illness complicates daily existence, and can mask acute illnesses or prevent people from accessing services and receiving much needed medical care and therefore prone to become chronically homeless. Based on the former, it is reasonable to assert that homeless persons suffer from a variety of chronic and acute illnesses that are aggravated by life on the streets.

TABLE 3: Reported Health Problems[3]

Health Issue	2014n	2014%
Medical condition	8	13.1
Physical disability	9	14.8
Addiction	25	44.0
Mental illness	19	31.1
Total Responses	61	100.0
No Responses	11	
Total	72	
Concurrent disorders		

CHART 2: Reported Health Problem Percentages



[3] Total number is higher than 47 as respondents could check off more than one health issue.

Homeless people are more exposed to and more likely to develop health problems than the general population, as living conditions predispose them to be particularly at risk of developing ill health. Furthermore, homeless people are subject to stress because of the factors that made them homeless and because of the experience of being homeless. Poor diet, stress, cold and damp, along with inadequate sleeping arrangements, sanitation and hygiene, increase the risk of health problems and decrease life expectancy.

Given the duration of homelessness (see Table 2) above and the reported health issues prevalent among homeless persons (see Table 3) above, it is safe to assert that there are people who are chronically homeless. **C*hronically homeless*** people include those who live on the periphery of society and who often face problems of drug or alcohol abuse or mental illness. It is estimated that this subgroup constitutes about 10–15% of the homeless population in a given locale. These are the so-called hard to house persons, but this label is problematic; perhaps it is rather a case of current housing provisions not being geared to provide support to high-needs clients.

In the case of HAH this category or subgroup is estimated to be higher than the conventional 10 – 15% range within Canadian based jurisdiction specific homeless populations. Based on "length of homelessness", (Table 2 above) and the prevalence of mental health and addictions issues as reported by homeless persons (Table 3 above) the range of people who live chronically homeless in Mission could conservatively be estimated in the 30%-40% range or 15 to 20 people.

2.5 "Sheltered" and "Unsheltered" Homeless Persons

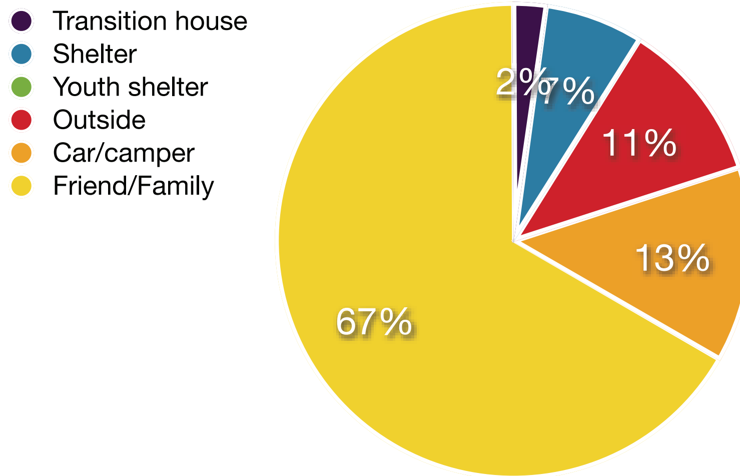
The number of homeless persons surveyed in official shelters was 9% and those surveyed who did not use shelter accommodation totaled 91%, including those who reported that they were sleeping at the homes of friends/family, so-called couch surfers (66%).

The number of homeless people surveyed outside, i.e. not in shelters and not couch surfing constitutes almost one quarter (24%) of the people who live homeless (see Table 4).

TABLE 4: Accommodation on Night of Survey

Place Stayed	2014n	2014%
Transition house	1	2.2
Shelter	3	6.7
Youth shelter	0	0.0
Outside	5	11.1
Car/camper	6	13.3
Friend/Family's place	30	66.7
Total Response	45	100.0
No Response	2	
Total	47	

GRAPH 2: Accommodation on Night of Survey



The respondents were asked to state their main reasons for not having used a transition house or a shelter the previous night (see Table 5 below). The biggest proportion falls into the category "stayed with friend/family" (55%). This is followed by 20% stating that there is no shelter in the community; indeed the situation in Agassiz-Harrison and Boston Bar.

TABLE 5: Reasons for Not Staying in Shelter/Transition House

Reason	2014n	2014%
Turned away	1	2.5
Stayed with friend/family	22	55.0
Dislike	3	7.5
Did not know about shelter	4	10.0
Couldn't get to shelter	1	2.5
Slept in car/camper	0	0.0
No shelter in community	8	20.0
Other	1	2.5
Total Response	40	100.0
No Response	7	
Total	47	

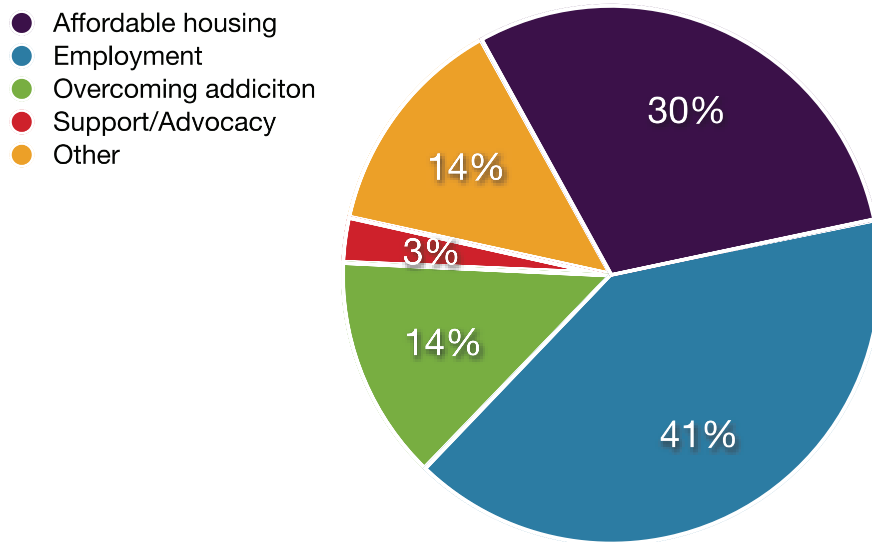
2.6 What Will End Homelessness for You?

When asked what would end their homelessness, respondents indicated that access to paid employment was the most common barrier (40%) to overcome in finding a home, followed by a need for “affordable housing” at 29% and both “higher income” and “support/advocacy” at 13% (see Table 6).

TABLE 6: What Will End Homelessness for You?

Response	2014n	2014%
Affordable housing	11	29.8
Employment	15	40.5
Higher income	5	13.5
Overcoming addiction	1	2.7
Support/advocacy	5	13.5
Other	0	0.0
Total Response	37	100.0
No Response	10	
Total	47	

GRAPH 3: What Will End Homelessness for You?



2.7 Shelter and Transition Beds in Hope and Agassiz-Harrison

The total number of emergency shelter beds in Hope[4] in 2014 is 14, made up of 4 emergency shelter and 10 extreme weather beds. The total number of Transition House beds in Hope[5] is 8. It is important to note that there are limits on the number of days people can stay at these facilities.

There is a view among some scholars and some practitioners that "sheltering" people, does not facilitate either the complicated "road" toward self-sufficiency or linking someone to an integrated arrangement for wrap around support services that can over time facilitate a pathway out of homelessness. The desired outcome of making a break from living homeless cannot be achieved overnight and is dependent on long-term relationships and supports. The past 20 years have seen an increasing awareness and practice of integrated treatment for psychiatric and substance use issues in individuals experiencing concurrent disorders.

[4] There are no official shelter beds available in Agassiz-Harrison or Boston Bar.

[5] The only transition house for women is located in Hope, serving also Boston Bar. Agassiz-Harrison clients make use mostly of the transition house in Chilliwack.

3. Profile of People Living in the Districts of Hope and Kent

People living homeless in Canada at any given time will be comprised of several groups, including, but not limited to, persons with severe addictions and/or mental illness, families, seniors, children, youth, persons with disabilities, and aboriginals. Single men constitute the majority of the visible homeless, according to the National Homeless Initiative, a fact confirmed by four surveys in the FVRD since 2004. As will be seen from the presentation that follows below, people who live homeless in Mission include people with addictions and/or mental illness, older individuals, youth, persons with disabilities and persons who self-identify as Aboriginal.

Based on information obtained from respondents during the 2014 homelessness survey, the following can be reported regarding a profile of homeless people in the districts of Hope and Kent.

3.1 Gender

The gender distribution of homeless people surveyed breaks down into almost two thirds (61%) males and one third (34%) females. This gender breakdown corresponds well with available data regarding homelessness in Canada according to which women constitutes one third to one half of the homeless population in major urban areas across Canada.

TABLE 7: Gender of Surveyed Respondents

Gender	2014n	2014%
Male	29	61.7
Female	16	34.0
Unknown	2	4.3
Total	47	100.0

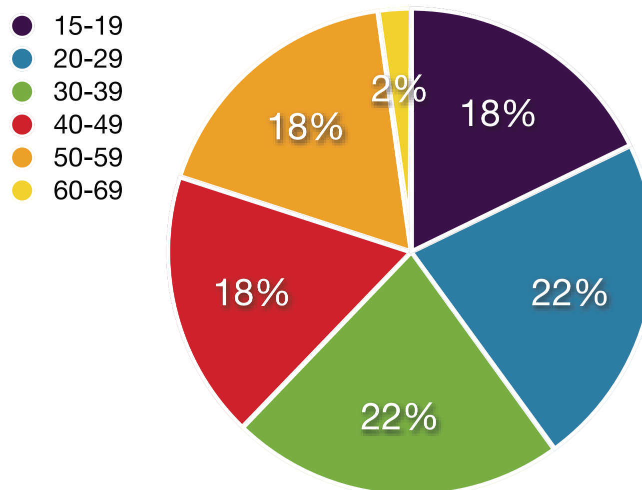
3.2 Age

Forty percent of respondents are younger than 30 years of age. A similar proportion, (40%) falls in the age category 30 – 49 years while those 50 years and older make up 20% and those 19 years of age and younger constitute 17 percent.

TABLE 8: Age of Surveyed Respondents

Age	2014n	2014%
Under 15	0	0.0
15-19	8	17.8
20-29	10	22.2
30-39	10	22.2
40-49	8	17.8
50-59	8	17.8
60-69	1	2.2
70+	0	0.0
Total Response	45	100.0
No Response	2	
Total	47	

GRAPH 4: Age of Surveyed Respondents



3.3 Aboriginal Presence

The respondents were asked to indicate whether they self-identify as Aboriginal. Eight out of 47 respondents or 17% self-identified as Aboriginal compared to 19 out of 63 individuals or 30% in 2011.

The literature indicates that the Aboriginal homeless persons have special needs that must be considered—e.g., cultural appropriateness, self-determination, and traditional healing techniques. It fell outside the scope of this survey to make further determinations in this regard. Suffice to say that the notion of providing culturally appropriate services for Aboriginal persons likely remains valid and requires further analysis.

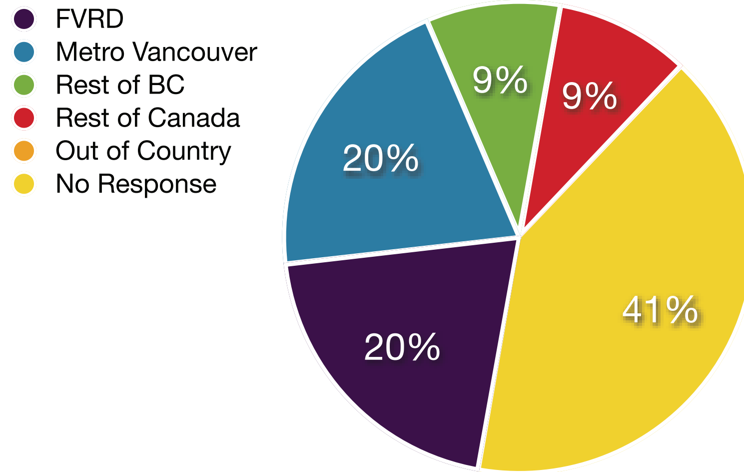
3.4 Community of Last Residence

Respondents were asked which community they moved from to the Districts of Kent and Hope. Equal proportions (34% each) indicated that they are from Metro Vancouver and FVRD communities. Those from the "rest of BC" and "rest of Canada" constitute 15% each (see Table 9 below). However, it is important to note that in response to the question: "How long have you been living in either the district of Kent or the district of Hope, that almost one quarter (24%) have lived in Kent and Hope for 11 years or longer and 43% having lived in Hope and Kent between 2 and 10 years (see Table 10 below).

TABLE 9: Where Did You Move Here From?

Where From	2014n	2014%
FVRD	11	34.4
Metro Vancouver	11	34.4
Rest of BC	5	15.6
Rest of Canada	5	15.6
Out of Country	0	0.0
Total Response	32	100
No Response	15	
Total	47	

GRAPH 5: Where Did You Move Here From?

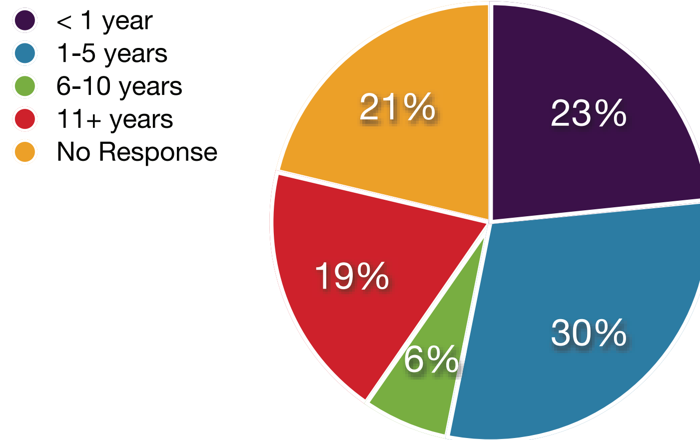


3.5 Duration of Residence

TABLE 10: How Long Have You Been Living in Districts of Hope and Kent?

Length of Residency	2014n	2014%
Less than 6 months	9	24.3
6-11 months	2	5.4
1 year - 23 months	1	2.7
2-5 years	13	35.2
6-10 years	3	8.1
11+ years	9	24.3
Total Response	37	100.0
No Response	10	
Total	47	

GRAPH 6: How Long Have You Been Living in Districts of Hope and Kent?



3.6 Source of Income

"Welfare" as a source of income is mentioned by 36% of the responses followed by "disability benefit" at 12%. The percentage of responses in the category "employment" as source of income is significant at 14%. Responses associated with "binning" and "panhandling" and "support from family/friends" make up respectively 7% and 12% of the population (see Table 11 below).

TABLE 11: Source of Income[6]

Source	2014n	2014%
Welfare	23	36.5
Disability benefit	8	12.7
Employment	9	14.3
EI/CPP/WCB/OAS/GIS	1	1.6
Binning/Panhandle	5	7.9
Family/Friends	8	12.7
Other	0	0.0
No Income	9	14.3
Total Response	63	100.0
No Response	3	
Total	66	

[6] Numbers add up to more than 47 as respondents could check off more than one source of income.

3.7 Use of Services

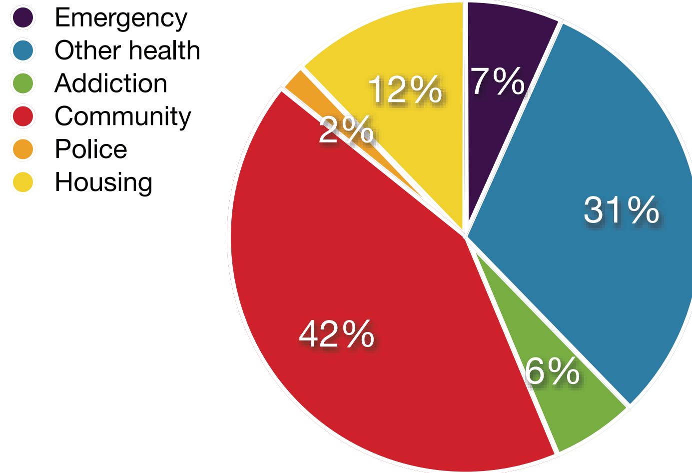
Table 12 indicates the extent to which services are being accessed by people who live homeless in the Districts of Kent and Hope. For example, 69% have accessed the food bank, followed by 56% for both other meal programs and drop-in services over the past year. Twenty nine percent (29%) have accessed employment programs and addiction services with 24% having accessed mental health services.

TABLE 12: Use of Services[7]

Service	2014n	2014%
Ambulance	5	11
Emergency room	7	16
Hospital (non-emergency)	11	24
Health clinic	10	22
Dental health clinic or dentist	4	9
Mental health services	11	24
Addiction services	13	29
Extreme weather shelter	4	9
Employment/Job help services	13	29
Probation/Parole services	5	11
Drop-in services	25	56
Food bank	31	69
Meal programs/soup kitchens	25	56
Newcomer services	0	0
Transitional housing	5	11
Housing help/eviction prevention	2	4
Needle exchange	1	2
Outreach	23	51
Legal	4	8

[7] Total number is more than 47 as respondents could check off more than one service. Percentages are in relation to service used by the total number of respondents.

GRAPH 7: Percentages of Service Usage[8]



Respondents were also asked whether they have been affected by a change or withdrawal in services. Sixteen or 25.0% answered in the affirmative, and 48 or 75% answered "no" (see Table 13).

TABLE 13: Affected by Change or Withdrawal in Service

Affected by Change or Withdrawal	2014n	2014%
Yes	16	25.0
No	48	75.0
Total Response	64	100.0
No Response	9	
Total	73	

[8] Emergency-based services category includes Extreme Weather shelter, and Housing services category includes Outreach.

4. Summary of Survey Findings Districts of Kent and Hope

The following summarizes the main findings of this survey:

- In comparison to 2011, the number of homeless people interviewed in the Districts of Kent and Hope has decreased from 63 to 47 (25% decrease).
- Homelessness is a result of inadequate income (poverty), unaffordable rental rates, relational breakdown, and the impact of mental health issues and/or addiction to substance use, as well as a concomitant lack of adequate medical care and support at the community level.
- Lack of affordable housing is directly related to low wages, erosion of the social safety net, insufficient social housing inventory, especially lack of “housing first” options and increased rental accommodation cost.
- Chronic homeless people are conservatively estimated to be in the 30%-40% range, or 15 to 20 people. This is higher than the 15 - 20% that is conventionally seen as the percentage of homeless people in Canadian jurisdiction specific homeless populations.
- 40% of respondents experience long-term homelessness (one year or longer).
- 24% of respondents live outside in makeshift shelters or other outdoor places.
- Males constitute the majority of homeless persons i.e. 61%.
- 40% of homeless persons are younger than 30 years and 40% are in the age category 30-49 years.
- 17% of homeless persons self-identify as Aboriginal.
- 32% of the homeless persons live in the Districts of Kent and Hope for 6 years or longer.
- Welfare and disability benefits are the sources of income for more than half (49%) of the homeless persons.
- 44% of the population lives with an addiction to substance use and 31% live with a mental health issue.

5. Conclusions

1. There remains a need for permanent supportive housing based on the housing first approach for those who live with mental illness and/or addiction to substance use those coming out of treatment and those released from incarceration.
2. Housing-first models are predicated on the assumption that all individuals, regardless of substance misuse, are entitled to a safe place to live. They are also predicated on the assumption that addiction recovery is more likely to be successful when secure housing is met. Housing-first models encourage clients to seek addiction treatment, but do not make it mandatory before housing is provided.
3. Homeless people are subject to stress because of the factors that made them homeless and because of the experience of being homeless. Poor diet, stress, cold and damp, along with inadequate sleeping arrangements, sanitation and hygiene, increase the risk of health problems and decrease life expectancy.
4. Homelessness in itself is an "agent of disease". As such homeless people are more exposed to and more likely to develop health problems than the general population, as living conditions predispose them to be particularly at risk of developing ill health.
5. Chronic emotional and mental illness complicates daily existence and can mask acute illnesses or prevent people from accessing services and receiving much needed medical care and therefore remains trapped in chronic homelessness.
6. Chronically homeless persons are people who cannot function in housing that assumes independent living without support. They are unable to fit into independent housing, and thus get evicted. What this population, also recognized by the term "concurrent disorders", requires is housing that can respond adequately to their needs e.g. Housing First Approach.
7. Professional medical attention and community relationships are two key elements of care in relation to people who live homeless. People are more willing to think about treatment and other solutions if they feel trusted and understood.
8. In addition to a paradigm shift in the delivery of mental health care, it is also necessary to provide more than surface support, such as food, clothing, emergency shelter, soup kitchens, etc. High-need clients, such as those living with concurrent disorders and who are chronically homeless, require a full integration of mental health and addiction services in addition to health care and housing. Evidence suggests that the current system of care picks and chooses instead of offering the whole set of services needed, so clients with the most complex needs get no care and drop out of the system. This reality aggravates the problem of inadequate care for those who live homeless.

9. It is not adequate care or good use of resources for a person with mental and/or substance abuse challenges to be housed without supportive service or to receive services without housing. Housing needs to be inclusive of everything, from housing to medical care to psychiatric treatment to provision of food.

10. Housing models must meet the needs of the whole person, with involvement in day-to-day support. It is imperative that participants not be constrained by exit deadlines.

11. A fully integrated system that makes “any door the right door”— means that people with concurrent disorders experiencing homelessness can enter the service system through any service door, be assessed, and have access to the full range of comprehensive services and support.

12. Supportive case management is indispensable to successful service delivery to people living homeless.

6. Recommendations

1. Include or expand the housing-first approach in policies and practices addressing homelessness in the Districts of Kent and Hope. It is imperative that this be expanded in order to provide good care and make progress with homelessness reduction.
2. Take immediate steps to move toward the creation of a more adequate housing spectrum through housing first provisioning and more comprehensive and farther in reach mental health and addictions services.
3. Provide a 30 – 40 unit housing facility based on the principles of housing first to provide housing and care to chronically homeless persons.
4. Implement an Assertive Community Treatment (ACT) Team that facilitates an integrated model of care embracing empathetic therapeutic relationship building.
5. Focus community care efforts on establishing a coherent and comprehensive intervention to implement housing and care.
6. Partner with existing community agencies to further extend the reach of housing first options through a scattered site approach (e.g. Raven's Moon Society's Model in Abbotsford).

END NOTE

See Main Regional Homeless Report for more detailed analysis of homelessness in FVRD communities and a more expanded list of findings, conclusions and recommendations and also a list of references undergirding the analysis and recommendations in the main report.

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