EXCERPT

This Municipal Summary has been prepared at the request of the City of Abbotsford to provide information to the Mayors' Taskforce on Homelessness. Material contained in this report formed part of the final FVRD Regional Report.

2014 FRASER VALLEY REGIONAL DISTRICT HOMELESSNESS SURVEY: FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

ABBOTSFORD - 2014

By

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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:

- Fraser Valley Regional District, Strategic Planning and Initiatives Department
- Abbotsford Community Services Society – Abbotsford Food Bank
- Cyrus Centre, Abbotsford
- Elizabeth Fry Society
- 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

In addition, this report also contains information on the context within which homelessness continues to unfold in the Lower Mainland of BC, the importance of housing with wrap around support as a solution to homelessness and the merits of the housing first approach and leading evidence based practices i.e. critical time interventions, assertive community treatment teams and therapeutic relationships in relation to homelessness.

[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.

1.2 Survey Objectives

The objectives of the survey were to:

- Determine whether homelessness is increasing or decreasing in Abbotsford;
- Provide reliable data to support the work by the FVRD, City of Abbotsford and Abbotsford Social Services Sector in addressing housing and homelessness in Abbotsford;
- Continue to increase awareness and understanding of homelessness and the services and approaches to services that are needed 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 support services in Abbotsford.

1.4 Defining Homelessness

A precursor to quantifying the extent of homelessness is defining what it means to be "homeless". For the purpose of this study, two major factors were considered in defining homelessness: the importance of maintaining consistency with similar research in Metro Vancouver so that useful comparisons could be made, 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.

1.5 Methodology and Ethical Considerations

A 24-hour snapshot survey method was used to enumerate as accurately as possible the number of homeless people in Abbotsford. 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.

1.6 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. 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 Abbotsford than the number determined by this survey.

Enumerating homeless persons poses longstanding difficulties. A major challenge associated with surveying of homeless people, even those who live rough in outside locations, is that the single most important survival tactic is being invisible. For example, it is difficult to measure the extent of homelessness in certain subpopulations, such as women with children, who are often invisible homeless persons since safety concerns affect 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 exact enumeration difficult.

The homeless estimate that was arrived at through 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 Abbotsford, it nevertheless does provide a guideline 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) where available. 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.

1.5.4 Ethical considerations

In keeping with the principles of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, it is recognized 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, the following approach was applied 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 the homeless community, an awareness of the realities contributing to homelessness, empathy for persons in this situation, and ease in relating to homeless persons.

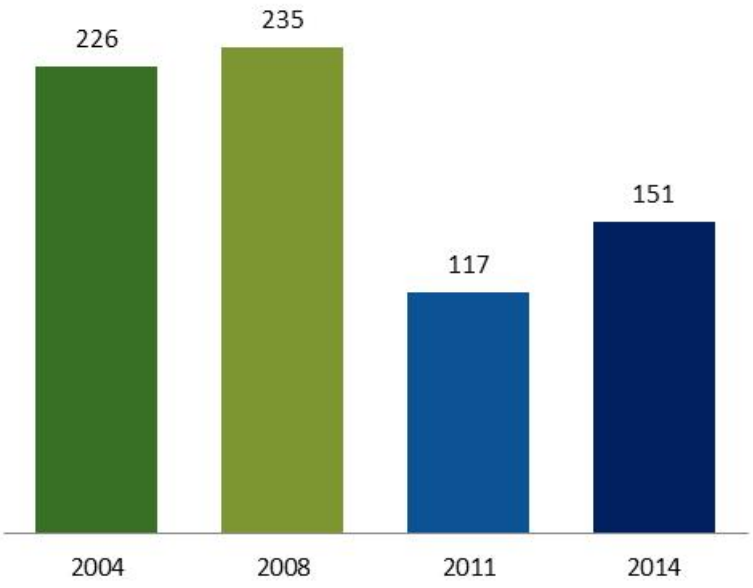
2. EXTENT OF HOMELESSNESS IN ABBOTSFORD IN 2014

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

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.

CHART 1: Abbotsford Homeless Count 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.

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 politics, economics, and social issues have all played a role in the dramatic increase in homelessness over the past two decades in Canadian cities in general, including Abbotsford. **(See Appendix 1 for more detailed analysis of the socio-political, socio-economic and socio-cultural context within which homelessness has taken root in BC.)**

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

TABLE 1: Reasons for Being Homeless

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	100.0
No Response	25	
Total	**282**	

Just over fourty percent of the respondents (41.7%) 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 17.5% cited addictions as the reason for homelessness with 8.6% of respondents citing family breakdown/abuse/conflict as the reason for homelessness. Health reasons were cited by 7.8% and 7.2% said they were evicted, most of them probably for non-payment of rent. “Other” reasons were checked off by 7.5%.

It is evident from the survey results that while personal issues may precipitate homelessness in Abbotsford 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 (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. Based on an interpretation of the growing body of knowledge on homelessness in Canada, it is safe to assert that homelessness is indeed a complex phenomenon and that a variety of factors, in various combinations, contribute to homelessness. This applies to Abbotsford as well.

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.

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 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	2014 n	2014 %
less than 1 month	21	16.3
1 month – less than 6 months	31	24.0
6 months – less than 1 year	22	17.1
1 year +	55	42.6
Total Response	129	100.0
No Response	22	
Total	**151**	

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. (**See Appendix 2 for more detailed discussion about concurrent disorders in relation to homelessness.)**

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

Health Issue	2014 n	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	

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 (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 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 Abbotsford (see Table 3) above, it is safe to assert that there are people who are chronically homeless in Abbotsford. The notion of chronic homelessness is in line with the assertion of Begin et al. (1999) that the duration of homelessness is a contributing factor in the continuum of homelessness, characterized by the following three subgroups.

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.

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 lose 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.

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 4).

TABLE 4: Accommodation on Night of Survey

Place Stayed	2014 n	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's/Family's place	33	24.0
Total Response	138	100
No Response	13	
Total	**151**	

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 staying in 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
Couldn't 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	**115**	

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	2014 n	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**	

2.7. Shelter and Transition Beds in Abbotsford

The total number of emergency shelter beds in Abbotsford in 2014 is 28, made up of 24 beds at William Booth Shelter and 4 youth beds at the Cyrus Centre. The total number of beds in the Abbotsford Transition House is 12. 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.

2.8. Housing First and Integrated Models of Care

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).

Leading practices in housing and care provisioning include the Housing First Approach undergirded by Assertive Community Treatment Teams and Critical Time Interventions based on empathetic therapeutic relationships that combined result in a Comprehensive, Continuous, Integrated, system of Care.

The literature is clear that effective treatment for homeless people with concurrent disorders requires comprehensive, highly integrated, client-centred 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.

(See Appendix 3 for a more detailed discussion of leading housing practices, including Housing First, Assertive Community Treatment Teams, etc.)

3. A 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 (Patterson et al., 2008), families (CMHC, 2003b), seniors, children, youth, and 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. As will be seen from the presentation that follows below 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 (Lenon, 2000, p. 1; Neal, 2004, p. 1; Wove, Serge, Beetle, & Brown, 2002, p. 9).

TABLE 7: Gender of Surveyed Respondents

Gender	2014 n	2014 %
Male	90	59.6
Female	52	34.4
Unknown	9	6.0
Total	151	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 (11.95).

TABLE 8: Age of Surveyed Respondents

Age	2014 n	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	

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 (Beavis, Klos, Carter, & Douchant, 1997). 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?

	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	

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

Length of Residency	2014 n	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	

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	2014 n	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 contains the total of responses from people who live homeless with regard to usage of service available in the community. The meal programs are frequented most (11.4%), followed by visits to Outreach Services (9.9%), Drop-In Services (9.7%), the Emergency Room (8.2%) and the Food Bank (8.1%).

TABLE 12: Usage of Services Last 12 Months

Service	2014 n	2014%
Ambulance	26	3.9
Emergency room	54	8.2

Hospital (non-emergency)	42	6.4
Dental clinic or dentist	20	3.0
Mental health services	23	3.4
Addiction services	33	5.0
Extreme Weather Shelter	49	7.5
Employment/Job help services	23	3.4
Probation/ Parole services	19	2.9
Drop-in services	64	9.7
Food bank	53	8.1
Meal programs/Soup kitchens	75	11.4
Health clinic	26	3.9
Newcomer services	2	0.3
Transitional housing	17	2.6
Housing help/Eviction prevention	15	2.3
Needle Exchange	27	4.0
Outreach	65	9.9
Legal	21	3.2
Budgeting/Trusteeship	2	0.3
Other	4	0.6
Total Responses	657	100
None/No Response	41	
Total	698	

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 13: Affected by change or withdrawal in services

Affected by service change or withdrawal	2014 n	2014%
Yes	26	28.0
No	67	72.0
Total Response	93	100.0
Non-response	58	
Total	151	

4. SUMMARY OF SURVEY FINDINGS (ABBOTSFORD)

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”.
- 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.

1. 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.

2. 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.

3. People in Abbotsford who live chronically homeless suffer from a variety of chronic and acute illnesses that are aggravated by life on the streets.

4. 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.

5. 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.

6. 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 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.

7. 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.

8. 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.

9. 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.

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

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

12. 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.

13. 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.

14. 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
15. Supportive case management is indispensable to successful service delivery to people living homeless.
16. 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.
17. 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.

7, 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).

APPENDIX 1 - THE SOCIO-POLITICAL, SOCIO-ECONOMIC AND SOCIO-CULTURAL CONTEXT WITHIN WHICH HOMELESSNESS 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[2].

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[3] 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[4] 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 addiction, and their concomitant needs.

In terms of British Columbia housing policy prior to 2000, affordable[5] 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

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

[3] 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.

[4] 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.

[5] 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.

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.

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,[6] 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.

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.

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[6] 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.

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 – 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 factors 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 Housing

The literature is clear that effective treatment for homeless people with concurrent disorders requires comprehensive, highly integrated, client-centred 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.

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