Regional Homelessness Plan for Greater Vancouver

DRAFT

Draft Plan

February 6, 2001

Prepared for the Regional Steering Committee on Homelessness

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1 Introduction

1.1 Homelessness in Greater Vancouver

There are many people living on our streets. Their lives are bleak, often isolated from family and friends. They are cold, wet and hungry, and some are suffering from serious physical and mental health conditions. Substance misuse affects a significant share of the homeless. Many of these individuals can be found in doorways, alleyways, in parks and under bridges. There are also the invisible homeless, people who move from friend to friend, or sleep in accommodation that is unsafe or insecure. There is a growing sense that the situation is worsening, particularly among those individuals with serious, and often multiple, health issues. Positive steps are being taken to reduce homelessness, yet growing numbers of people in need are turned away from emergency shelters around the region every day. Developing additional shelter space in the winter months has helped somewhat to meet needs, but more is required.

Why has this happened? There are several reasons. Very little new private rental housing has been built for years because it is uneconomical to do so. The existing stock of affordable housing (SRO hotels, rooming houses, and others) is being lost. The region is known for its high housing costs and low vacancy rates so low incomes place many people in a vulnerable position. People working for low wages or receiving income assistance cannot afford to pay for the average market rental unit. The federal government has withdrawn from building new social housing. The provincial government continues to build some new social housing, but it is not enough to meet the need. Waiting lists for affordable social housing have grown to the point where there are over 13,000 people waiting for independent and supportive housing in the Lower Mainland. Other reasons often cited as contributing to homelessness are family breakdown, lack of social supports, the changing labour market, deinstitutionalization and gentrification.

> *"Because we are an affluent community without an identifiable 'inner city', we are largely unaware that there are many people who 'live' on the North Shore without a home."* **Homelessness on the North Shore, 2000. North Shore Homeless Task Force.**

Homelessness has been an issue since the mid-1980s, mainly in the central area of Vancouver. Now it is emerging as a regional issue – there are homeless people in Surrey, New Westminster, Richmond and the North Shore. And while the homeless have traditionally been thought of as single older males, they are also young, female, families and members of the Aboriginal community and a diverse range of cultural groups.

If we do not take steps to prevent homelessness it will likely become worse. Over 65,000 Greater Vancouver renter households are at risk of becoming homeless because they pay more than half of their income for rent. This works out to about one-quarter of all renter households who have insufficient incomes to meet their daily needs. A small setback can plunge them into life on the streets.

Many municipalities in the Vancouver region recognizing the gravity of the situation have joined their counterparts elsewhere in Canada in declaring homelessness a national disaster. They have also worked with the Federation of Canadian Municipalities to put forward a proposal to the federal government to solve this nation-wide crisis.

1.2 Why do we need a regional homelessness plan?

For over a decade, many groups in Greater Vancouver have been working to support people who are homeless or to prevent homelessness for persons at risk. This has resulted in a remarkable array of services and facilities for homeless people and those at risk of homelessness, including some innovative and nationally recognized approaches. Developing new, permanent, affordable housing has been the favoured strategy for many years of those involved in the day to day needs of homeless people in the Lower Mainland. The provincial government's social housing supply program, HOMES BC, has facilitated this approach. In addition, providers in the region have led the way in developing full service shelters that offer a range of services necessary to help people live stable lives in the community. There are, however, serious outstanding issues and needs that remain to be addressed.

To date, efforts to address homelessness have not occurred within a coordinated strategy to provide solutions across the region. Because it is essential that homeless people do not 'fall through the cracks' coordination in the planning and delivery of services for homeless people is essential. This planning process is an effort to build on the work already done by individual agencies and providers in communities around the region, enable people to share ideas and expertise, and to create a collective, region-wide plan to prevent and alleviate homelessness.

The December 1999 federal government announcement of $753 million in funding over three years to address homelessness across Canada included $305 million for a new program, *Supporting Community Partnership Initiatives (SCPI)*, which is administered by Human Resources Development Canada. The SCPI program is targeted at absolute homelessness. Greater Vancouver was identified as one of ten Canadian centres that has a homeless problem and will receive funding under this program in the amount of approximately $25 million over 3 years. With new resources in place it is critical that service providers, individuals who are homeless or at risk, community groups and different levels of government move immediately to identify urgent priorities for services in Greater Vancouver.

1.3 The Regional Steering Committee on Homelessness

In March 2000, a Steering Committee formed to facilitate a community driven process to create a plan to alleviate, as well as prevent, homelessness in Greater Vancouver. It consists of representative stakeholders from government, community organizations, agencies and service providers from across Greater Vancouver. The main purpose of this Steering Committee is to develop a regional plan on homelessness that will provide a more formal framework for the planning, co-ordination and development of housing, services and facilities across Greater Vancouver. Appendix A contains a list of Steering Committee members and terms of reference for the committee. The same committee acted as an interim governance body for the first year of SCPI funding and is has made recommendations regarding the funding of initiatives for the first year of the Supporting Community Partnership Initiatives Program (SCPI). A community entity is yet to be identified to act as the governance body for years two and three of the SCPI program.

1.4 What will the regional plan do?

The purpose of the regional plan is to identify policies and actions that can be implemented throughout the region by all levels of government and the private and non-profit sectors to prevent and alleviate homelessness in Greater Vancouver.

The specific goals of the plan are to:

1) Enhance the continuum of housing and support;
2) Create and maintain a continuum of housing;
3) Ensure households have adequate income;
4) Deliver support services; and
5) Support sub-regions to meet local needs.

The plan is to be used to provide a region-wide framework for community based programs and services that address homelessness and its root causes. It sets out broad policy directions for the region, as well as setting out recommendations about needs for services and facilities. It looks at capacity and how existing delivery systems can be improved. It focuses on what is needed and how best to achieve it. An implementation plan will outline specific time horizons and major actors and partners. The plan will also be used to guide spending decisions under the new federal SCPI program.

The plan is intended to guide future actions of major stakeholders in the Vancouver region with respect to homelessness. However, compliance with the plan would be entirely voluntary. Community groups, service providers, federal, provincial and local governments and health authorities would be expected to turn to this plan for direction when issues related to homelessness arise in the course of day to day business, in developing longer term plans for action or when funding decisions are being made. For example, the plan should be considered by service providers and funders when new services or facilities are under consideration. Local governments revising their Official Community Plans or developing housing policies could turn to the plan to identify policies and strategies that would help reduce or prevent homelessness.

The plan considers the diversity of the homeless population across the region, including youth, single men and women, families with children, immigrants and refugees, urban Aboriginal people, seniors, low income urban singles and people with special needs (due to disability, or needs associated with substance use or mental health problems).

This plan addresses urgent priorities for the 2000/2001 fiscal year and medium term (one to three years) and long term priorities (three or more years) as well.

1.4 Geographic scope

The focus of the plan is the Greater Vancouver region. The region is made up of 21 municipalities of different sizes, each with a different history, demographic composition, local issues and needs. What they have in common is a significant number of households at risk of homelessness and, in some municipalities, absolute homelessness. The plan first takes a regional perspective in identifying issues, policies and strategies for preventing and alleviating homelessness. Secondly, the plan adopts a sub-regional perspective. Where possible, it provides recommendations for supporting sub-regions and communities within sub-regions to meet local needs. Six sub-regions were identified at the outset of the planning process as follows:

(Insert map here)

Vancouver – Vancouver and UEL
Inner municipalities – Richmond, Burnaby, New Westminster
North Shore – City of North Vancouver, District of North Vancouver and West Vancouver
South of Fraser – Surrey, White Rock, Delta, City of Langley, Township of Langley
North East Sector – Coquitlam, Port Coquitlam, Port Moody
Ridge Meadows – Maple Ridge, Pitt Meadows

The following table depicts the current population distribution according to the sub-regions that make up the Greater Vancouver Regional District (for the purposes of this planning project).

Table 1: Distribution of population by sub-region

1999 population	Number	Share
Vancouver	558,232	28%
Inner Municipalities	408,458	21%
North Shore	172,690	9%
South of Fraser	567,372	29%
Northeast Sector	188,368	10%
Ridge Meadows	76,726	4%
Region wide	1,971,846	100%

Source: GVRD. Greater Vancouver Key Facts, 1999.

1.5 What do we mean by homelessness?

The plan addresses the needs of homeless people who are living with no physical shelter - on the street, in doorways, in parkades, in parks and on beaches as well as people living temporarily in emergency shelters or transition houses for women fleeing violence. Some people who are homeless use emergency shelters some of the time, and sleep outside the rest of the time. An individual may move indoors or outdoors depending upon the weather, how long they can stay in an emergency shelter or for some other reason. Others living 'rough' never use emergency shelters. However, at any one time, there are homeless people living rough and homeless people in emergency shelters.

The plan will also address the needs of individuals 'at risk of homelessness'. This includes people living in spaces that do not meet basic health and safety standards, do not provide for security of tenure or personal safety and are not affordable. This also includes people considered as the invisible homeless, such as individuals who are 'couch surfing' or staying temporarily with family and friends.

1.6 Developing this community plan

The plan is intended to set region wide priorities for addressing homelessness over the next three years. The process for developing this plan has involved:

- Developing guiding principles for the plan and ratifying them;
- Holding a stakeholder working session to elicit community feedback on urgent, short term and long term priorities;
- Creating an inventory of existing services and facilities serving homeless people in the region;

- Identifying gaps in services and facilities serving the homeless;
- Obtaining preliminary evidence of need through a review of existing reports and studies, and contacts with key informants in each sub-region; and
- Identifying critical issues and developing policies and strategies to address these issues.

A working session with over 140 participants including homeless individuals was held by the Regional Steering Committee on June 28, 2000. The purpose of the session was to begin crafting the plan, with a particular emphasis on identifying *urgent need priorities* in addressing homelessness in Greater Vancouver. Detailed workshop proceedings are available in a separate document entitled *Summary of Proceedings: Regional Working Session on Reducing Homelessness June 28, 2000.* Workshop participants identified nine key areas as requiring immediate action. Since that time the remaining elements of the continuum of housing and support have been incorporated to form a draft plan.

At the same time, Aboriginal and youth groups in the Lower Mainland are working to develop separate plans to address their specific needs. It is intended that this plan will reflect the priorities identified through those planning processes, when they are completed.

A regular newsletter is intended to inform stakeholders about the status and content of the plan as it develops, as well as to inform them about upcoming events. The first newsletter was sent to invitees following the June 28, 2000 workshop and another is being distributed together with the draft plan.

1.7 Next steps

The draft plan is being distributed to stakeholders for comment. A second stakeholder workshop is planned for February 2001. The purpose of the session will be to obtain feedback on the draft plan from interested parties. A final plan will plan be completed in spring 2001. Following the workshop, the Steering Committee will:

- Refine the information and conclusions in the draft plan;
- Determine how the plan will be implemented;
- Determine how the plan will be monitored and specific projects evaluated, and
- Involve stakeholders to endorse the plan.

2 Principles guiding development of the plan

The purpose of the plan is to identify policies and actions that can be implemented by all levels of government and the private and non-profit sectors to prevent and alleviate homelessness in Greater Vancouver.

The following principles will guide the development of the plan.

1) Solutions to homelessness require a coordinated community response. The plan must be developed jointly by homeless individuals, housing groups, advocacy groups, service providers, community organizations, labour, the private sector, local governments within the GVRD, provincial ministries and federal government departments.

2) The plan will address the needs of people who are living with no physical shelter - on the street, in doorways, parkades, in parks, on beaches - or people living in emergency shelters. It will also address the needs of individuals 'at risk of homelessness' living in spaces that do not meet basic health and safety standards, provide security of tenure or personal safety, and are not affordable.

3) Preventing and alleviating homelessness requires flexible and coordinated responses that recognize the diversity of homeless people and their needs. These needs can be met through a "continuum of housing and support" that consists of:

   Housing continuum
   - emergency shelters
   - transition houses
   - supportive and second stage housing
   - independent housing

   Adequate income
   - employment
   - employment insurance
   - income assistance

   Support services
   - outreach
   - drop-in centres
   - health services
   - mental health services
   - prevention services
   - substance misuse services

4) Homeless households must have access to all components of the "continuum of housing and support" according to need and distributed in communities throughout each of Greater Vancouver's sub-regions.

5) The plan must identify actions (including education and communication) that could be initiated or implemented to address homelessness within the time frame of HRDC funding and beyond, specifically:
   - urgently (by Fall 2000);
   - in the medium term (1-3 years); and
   - in the long term (3 or more years).

3 The continuum of housing and support

The plan adopts a model for addressing homelessness called the 'continuum of housing and support'. It sets out the essential components of what is needed to address homelessness in this region. This framework was developed by refining the U. S. Department of Housing and Urban Development (HUD) 'continuum of care' model to suit the unique characteristics and needs of the Greater Vancouver region.

The continuum consists of three major elements – housing, income and support - each of which has several sub-elements. All are critical for preventing and alleviating homelessness. Addressing homelessness therefore requires actions in all three areas. The continuum espouses a strong prevention approach by focusing on housing and income as solutions to homelessness, while recognizing the importance of support (personal support and community services). The continuum serves as a framework for organizing the plan and all its elements, including the inventory of services and facilities and recommendations.

A wide variety of housing, income and support services are available in the Greater Vancouver region. These are summarized in the *Inventory of Facilities and Services* prepared as part of this plan and available under separate cover. The following describes the specific elements of the continuum.

3.1 Housing continuum

The housing continuum refers to both the creation of new housing through the construction of new social or affordable market housing and maintaining the existing stock of affordable housing through a variety of approaches. The following types of housing form the housing continuum.

- **emergency shelters** - provide single or shared bedrooms or dorm type sleeping arrangements with accommodation for up to one month. Some shelters offer a higher level of support to individuals. This is accomplished with additional sources of funding, either through other government agencies or fund raising. Families with children are served through emergency shelters, motels or similar accommodations. Youth under age 19 are sheltered in safe houses. Emergency shelters may also be referred to as hostels.
- **transition houses** - provide temporary housing in a safe, secure environment for women and their children leaving abusive relationships or persons leaving addictions treatment. This form of housing usually includes support services.
- **supportive and second stage housing** – includes supportive, second stage and transitional housing. This type of housing may assist individuals in making the transition between emergency shelters and permanent housing. It provides affordable, independent accommodation, sometimes in a purpose-designed building or in scattered site apartments. Added support services may include those that provide skills, training and support with housekeeping, meal preparation, banking support and access to medical care, counseling, referrals, crisis response and intervention.
- **independent housing** – permanent affordable housing for individuals who can live independently. This involves creating new housing, as well as maintaining the existing stock of affordable housing.

3.2 Adequate income

Obtaining an adequate income to enable one to live in adequate housing may be accomplished in a number of ways, either privately in the marketplace or through public assistance of some kind. Only employment assistance programs are documented in the inventory, due to time limitations. All are important components of the continuum of housing and support.

- **employment** – policies to ensure adequate income from employment and promote employment through employment assistance
- **employment insurance** - refer to employment insurance eligibility, practices and benefits are included.
- **income assistance** – refers to BC Benefits eligibility, practises and benefits.

3.3 Support services

Support services that are essential to the continuum of housing and support for homeless persons or those at risk of homelessness are described below. While the emphasis is on programs and services, it is recognized that individual and personal support, such as that offered by family and friends, is also important.

- **outreach**– a service focused on finding homeless people who might not use services with the goal of establishing rapport and eventually engaging them in a service they need. Outreach workers often have the first contact with a homeless person.
- **drop-in centres** –offer homeless people the ability to come in off the street, have a coffee, a meal, use a washroom, shower, wash clothes, and obtain counseling and referral to other services etc. Drop-in centres can provide activities and/or programs to build life skills or simply increase quality of life.
- **health services** – includes hospital emergency wards, general health clinics, targeted clinics, mobile clinics and dental care. Services may be delivered in conjunction with other services such as mental health or addictions.
- **mental health services** - includes assessment, counseling, treatment, rehab, referrals, crisis response, case management, and medication management.
- **prevention services** - help keep people from becoming homeless. These include: programs that offer direct assistance to households to prevent evictions (e.g. mediation and rent banks), support stable tenancies, and find affordable housing (e.g. housing registries); advocacy work aimed at addressing housing and poverty issues; and social programs designed to support the family. The latter type of prevention is not included in the inventory, due to time and space limitations.
- **substance misuse services** – include sobering centres, detoxification, residential treatment, supportive recovery homes, counseling, methadone treatment, needle exchange and medium and long-term permanent supportive housing, some of which provide alcohol and drug free environments

4 The plan

This section of the plan identifies components of the plan requiring action in the fiscal year 2000/2001. They were identified through feedback obtained at the stakeholders' workshop and analysis of the regional inventory of services and facilities for gaps in service. A summary of existing services and facilities by sub-region and target group precedes each section.

4.1 Enhance the continuum of housing and support

A broad network of services and facilities are necessary to ensure that homeless individuals do not 'fall through the cracks'. While the region as a whole possesses a fairly significant array of services and facilities addressing the needs of people who are homeless and at risk of homelessness, there are certain elements of the continuum that are not as well developed. Access to all components of the continuum is necessary for each component to work effectively. For example, without adequate affordable supportive housing, an individual who has successfully completed detox and addiction treatment, can afford to live only in SRO accommodation in the Downtown Eastside and is vulnerable to renewed substance misuse. Ensuring that the continuum is well developed and without gaps requires an overall perspective to the provision of homeless services and facilities, and high levels of coordination and planning.

In addition, while a service or facility may be available within the region, it is unrealistic to assume that a homeless person can travel across the region, by public transit, late at night, to access this service. The inventory has identified sub-regions that face gaps in a particular element of the continuum of housing and support services. In some cases, further work is necessary to determine if needs exist in those sub-regions.

Issue

There are gaps and insufficient capacity in the continuum of housing and support services for homeless individuals and households at risk of homelessness region-wide and in communities around the region.

Policy Statement

1. All elements of the continuum of housing and support should be available in communities throughout Greater Vancouver based on need.

Strategies

a) Determine the number of people who are homeless and at risk of homelessness, their characteristics and indicators of need in each sub-region and region-wide.
b) Create or designate an organization responsible for monitoring the implementation of this plan, evaluating regional homelessness initiatives, and updating the Inventory of Services and Facilities and plan on an ongoing basis.
c) Support communities in each sub-region to address local homeless needs.

4.2 Create and maintain a continuum of housing

The planning process identified as urgent priorities emergency shelters, supportive/second stage housing and independent housing. The other element of the housing continuum, transition houses for women fleeing violence, will be addressed in the final plan.

4.2.1 Minimal barrier emergency shelters

Emergency shelters are used as accommodation of last resort for those individuals who have no other housing options. They may have been evicted from an apartment, released from hospital or a criminal justice institution, separated from a spouse, or for a number of other reasons have no alternatives and require shelter. The role of emergency shelter is to prevent people from ending up on the street, and to provide an exit from the street. Emergency shelters in B.C. have tended to focus on providing more than '3 hots and a cot', referring to the enhanced role of support services and referral in many emergency shelters. Emergency shelters are often viewed as the first step off the street, or the 'entrance' to the housing continuum.

There are currently 23 emergency shelters in Greater Vancouver with 528 permanent shelter beds. These consist of emergency shelters, youth safe houses and ongoing Ministry of Social Development and Economic Security funded beds in private SRO hotels. Accommodation in most of these shelters is restricted to individuals who are eligible for BC Benefits. With the addition of cold-wet weather beds in the winter months, the number of available beds climbs to between 682 and 737. BC Benefits eligibility is not required for these low barrier beds.

Table 2: Emergency shelters in Greater Vancouver

Sub-region	Permanent Facilities	Permanent Beds	% permanent beds	Cold-wet weather beds*	Total beds
Vancouver	15	447	85%	112-167	559-614
South of Fraser	3	40	8%	36	76
Inner Municipalities	5	41	8%	6	47
North Shore	0	0	0	0	0
Northeast Sector	0	0	0	0	0
Ridge Meadows	0	0	0	0	0
Region wide	23	528	100%	154-209	682-737

Source: Inventory of Facilities and Services, Sept. 29, 2000.
*The number of cold-wet beds fluctuates depending upon funding.

The vast majority of permanent emergency shelter beds, 85%, are located in Vancouver. South of Fraser has approximately 8% of emergency shelter beds in the region and the Inner Municipalities have 8%.

Table 3: Emergency shelters in Greater Vancouver by target group

Target group	# Permanent Beds	% of permanent beds
Youth	42	8%
Women (and families with children)	84	16%
Refugees	70	13%
Urban Aboriginal People	0	0
Seniors	0	0
Low Income Urban Singles – men and women	45	9%
People with Special Needs	80	15%
Adult males	207	39%
Total	528	100%

The largest number of permanent beds is for adult men (207 or 39%). There are 84 beds for women and children and 42 for youth region-wide. Some of the beds are for youth under the age of majority (19), others only for youth age 19 years and older. All youth facilities are located in Vancouver. One facility with 70 beds is targeted specifically for refugees, and there are 80 spaces for men and women with special needs such as substance misuse, mental illness and dual diagnosis. There are two Aboriginal-run youth safe houses with a total of 15 beds. These are included in the youth category.

Since 1998, the Lower Mainland Cold–Wet Weather Strategy has been working to increase winter emergency shelter capacity across the region. It is a partnership among service providers, community agencies, health boards and municipal and provincial governments. It accomplishes this by opening winter-only shelters and creating temporary beds or mats during extreme weather. In the winter of 1999/2000 between 154 and 209 temporary beds were added in Vancouver, the Inner Municipalities and South of Fraser sub-regions. High occupancy rates were reported by at least two of the major temporary shelter providers (92% and 100%). The Strategy is currently seeking coordinated and sustainable funding to support its efforts.

After many years of operating independently and with little coordination, emergency shelter providers in BC have recently come together to form Shelter Net BC. Shelter Net BC is an umbrella network for shelter/hostel providers in the province. By coordinating and supporting the efforts of BC shelter providers, the organization has a mandate to a) provide shelter for the diversity of those in need in all areas and b) obtain more support dollars to meet the more complex needs of clients. The organization is also working towards the development of a best practice approach to providing emergency shelter.

The planning process identified 24 hour, minimal barrier emergency shelters as an urgent priority. Some specific priorities included shelter and short stay shelter for youth, shelter for women and families, and better access for seniors and refugees. Some locations that were specifically identified include Langley, Surrey and New Westminster.

Several emergency shelters are proposed under the new multi-service housing initiative of HOMES BC. They will consist of combined short stay (emergency shelter), second stage housing and expandable capacity for cold-wet weather.

Inadequate capacity

After many years of limited growth in shelter capacity in Greater Vancouver, service providers agree that there is a growing shortage of spaces in emergency shelters. The growing number of people they are unable to serve provides evidence of this. Some emergency shelters record the number of 'turnaways' each night. Turnaways are people they are unable to serve either because the shelter is full or for other reasons. This suggests a need for more shelter spaces. Two Vancouver shelters, Lookout and Triage, who serve individuals with significant social and behavioural concerns, recorded an increase of over 85% in combined turnaway statistics in five years. There were over 3,600 turnaways in 1998/99.[1] Most of these occurred because there are no available beds or a lack of appropriate beds due to gender. Turnaways also occur in other shelters throughout the region and at shelters serving special groups such as women and youth.

Studies have confirmed the need for more emergency shelter beds for certain sub-groups and in certain areas throughout the region, specifically, more beds/facilities in Vancouver, New Westminster and Surrey.[2] A 1996 study, which included a survey of shelter providers, found that the vast majority of respondents (83%) indicated moderate to high need for additional emergency shelter capacity in Vancouver.[3] There is a generally accepted view that additional resources are required in Vancouver but outside the Downtown Eastside. In New Westminster, need has been identified for additional emergency shelter spaces during the winter months. Women, families, persons with physical disabilities or addictions and those who have been in conflict with providers are not well served by existing facilities.[4]

Residents of some communities travel to Vancouver to find emergency shelter when they become homeless. They do this because 85% of all emergency shelter beds are in Vancouver and because there are other related services, such as meal programs and drop-in centres, particularly in the Downtown Eastside. The remaining beds are in the South of Fraser and Inner Municipality sub-regions. If other sub-regions have none or few emergency beds, people requiring shelter from outside Vancouver will have to use existing facilities in Vancouver. The *Inventory of Facilities and Services* shows that there are no emergency shelter beds in three of six Greater Vancouver sub-regions – the North Shore, Northeast Sector and Ridge Meadows. There are no cold-wet weather temporary beds in these same sub-regions and very few in the Inner Municipalities. Vancouver shelters often serve clients from outside the city. For example, twenty five percent of clients at two Vancouver shelters were from the rest of the region, province and out of province in 1998/99.[5]

Evidence of need for emergency shelter beds has been demonstrated in some areas where there are currently no facilities. For example, the North Shore Homelessness Survey determined that there were at least 83 homeless people on the North Shore in a recent nine-month period. 81% of respondents indicated that they would use a shelter if one were available. In addition, 49 homeless youth were identified in the six-month period from September 1998 to February 1999.[6] While needs may exist in the Northeast Sector and Ridge Meadows, no studies that provide evidence of need were located. Some areas like New Westminster have identified a need for more shelter capacity.

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[1] GVMHSS, *Housing Services Report 1998/99*, October 1999.
[2] Queenswood Consulting, *The Review of Shelter Resources in Greater Vancouver: Moving Towards Resolution.* Feb. 1999.
[3] Western Management Consultants, *Proposal for an Emergency Shelter* 1996.
[4] *Alternative Emergency Shelter Options for New Westminster*, September 1999.
[5] GVMHSS. *Housing Services Report 1998/99*, October 1999.
[6] *Final Report on the North Shore Homeless Survey*, May 2000.

Issue

The current supply of emergency shelter beds in the Greater Vancouver region is inadequate to meet existing needs and homeless people in several communities have no access to shelter beds locally.

Policy Statements

2. Emergency shelters are a crisis response to homelessness and only part of the continuum of housing and support.
3. Permanent and cold-wet weather emergency shelter capacity should be increased throughout the region so individuals living in each community have access to suitable emergency shelter locally.
4. No one should be turned away from an emergency shelter because of a lack of suitable space.
5. Emergency shelters should have a mandate and resources to help clients obtain permanent affordable housing.
6. Emergency shelters should aim to provide service according to a best practices approach, which, at a minimum, means minimal barrier, responsive to need, and client-centred.
7. Community-based solutions are the most suitable.

Strategies

a) Investigate emergency shelter needs in all sub-regions and communities that do not have emergency shelter beds.
b) Expand shelter capacity where need has been demonstrated.
c) Improve existing shelter facilities to provide minimal barrier access and continue to provide needed services.
d) Support the work of the Cold-Wet Weather Strategy to meet crisis needs.
e) Support the work of Shelter Net BC as the coordinating body for emergency shelters in the region and the province, a repository for research and with responsibility for the development of a best practice approach to emergency shelter provision.

Emergency shelters unresponsive to unique needs

Many emergency shelters are adult male oriented and not suitable to meet the diverse needs of youth, women (with and without children), refugees, members of different cultural groups and Aboriginal people. This does not mean that there is an over supply of male shelter beds, or even an adequate supply. It simply means that little attention has been paid in the past to meeting the distinct needs of homeless people within the shelter system in favour of a one-size fits all approach. According to the inventory, there are few spaces region wide for youth, women and families with children, and refugees or members of cultural minorities. There are only a few spaces in Aboriginal run safehouses that meet the needs of Aboriginal youth. In some cases, adult male shelters can be shared (for example with women) and adapted to meet their unique needs, in others not.

Youth under age 19 are not permitted to stay in adult shelters. The law requires separate facilities. Child protection issues complicate the provision of emergency shelter for youth. Youth under the age of majority (19 years) are generally required to stay in safe houses or be taken into care. They are however, permitted to stay in an adult shelter for a maximum of 2 days if necessary. Shelters must obtain approval from the Ministry for Children and Families to house them for longer than 48 hours. This often results in youth leaving the safety of a shelter after this time period. Youth

age 19 to 23 years can stay at Covenant House in Vancouver. However, after only two years of operation, Covenant House turns away several youth each night.[7] Service providers have noted a lack of minimal barrier shelter space for youth so that when they are inebriated or high, they can find no place to stay.

Women and families with children are often considered the invisible homeless, as they tend to live in sub-standard accommodation or share with others rather than live on the street or use emergency shelters. Some adult shelters have dedicated beds for women, and there are several shelters solely for women with or without families. However, these often have to turn away women suggesting inadequate capacity.[8] Transition houses offer temporary (30 day) accommodation for women and their children fleeing violence. However, there is some evidence that women use transition houses for reasons unrelated to violence. And there are anecdotal reports of homeless women seeking shelter in transition houses. A 1996 survey of shelter providers in the Lower Mainland found that 44% felt that additional emergency shelter space for single women was a moderate to high need.[9]

Emergency shelters provide emergency accommodation to refugees. While not a large share of the homeless population, there can be a significant number at one time. Refugees tend to have large families that are difficult to accommodate in family shelter facilities. In BC, the Ministry of Social Development and Economic Security will temporarily house them in hotels. In addition, recent immigrants and members of cultural minorities require culturally appropriate services in shelters.

According to many studies, Aboriginal people are over represented in the homeless population, and tend to avoid traditional shelters.[10] However, there is little information on the characteristics or needs of the Aboriginal homeless in Greater Vancouver. Anecdotal evidence suggests that their needs are best met in Aboriginal run facilities where unique cultural issues can be addressed. Only one emergency shelter facility in the region, a safe house for youth, is run by an Aboriginal organization.

[7] Personal communication. Sandy Cooke. Covenant House.
[8] Personal communication. Powell Place for Women.
[9] Western Management Consultants, *Proposal for an Emergency Shelter.* 1996
[10] City of Toronto. *Taking Responsibility for Homelessness: An Action Plan for Toronto.* Report of the Mayors Homelessness Action Task Force. January 1999; Edmonton Task Force on Homelessness. *A Call to Action.* May 1999.

Issue

The emergency shelter system has insufficient resources to meet a wide range of needs among the diverse homeless and at risk population.

Policy Statement

8) Emergency shelters throughout the region should be responsive to the unique needs of all groups including youth, women (with and without children), refugees, members of different cultural groups, and Aboriginal people.

Strategies

a) Expand emergency shelter capacity that meets the needs of groups that are currently under-served including youth, women (with and without children) and Aboriginal people.
b) Develop the ability to meet the needs of different cultural groups within existing shelters.

Growing number of clients with serious physical and mental health concerns

Many emergency shelters report an increase in the number of clients they see with mental illness, addictions and/or serious physical, social and behavioural concerns. This trend is evident throughout the shelter system.[11] Shelters like Lookout and Triage, both of which are funded to meet special needs, are at capacity and turn away many people each night. It is felt that emergency shelters are serving clients that should be elsewhere, such as in detox facilities or supportive housing. However, many shelters do not have the resources, mandate or skills to adequately serve this clientele. Behavioural concerns or inebriation are reasons for service refusal.

A survey of shelter providers by Western Management Consultants found that the majority of respondents (61%) felt there was a moderate to high need for additional shelter capacity for men and women with multiple problems, including mental illness and substance misuse issues. It concluded that there is a strong need for additional permanent emergency shelter capacity in Vancouver, outside the Downtown Eastside, to accommodate persons with significant social and behavioural concerns.[12] Inability to obtain immediate access to detox facilities in the Lower Mainland and lengthy waiting lists for supportive housing mean that people with special needs are unable to obtain suitable accommodation and services, and can end up on the street or in emergency shelters.

There are two ways to address this issue – either by developing shelters that specifically target this population with suitable staff levels and training and/or increasing the ability of existing shelters to meet these needs, through the hiring of additional trained staff. Both approaches should be considered to increase the ability of emergency shelters to serve individuals with mental illness, addictions and/or serious physical, social and behavioural concerns.

[11] Eberle et al. *Profile, Policy Review and Analysis of Homelessness in BC.* BC Ministry of Social Development and Economic Security and BC Housing. Forthcoming.
[12] Western Management Consultants, *Proposal for an Emergency Shelter.* 1996.

Issue

Growing numbers of individuals with mental illness, addictions and/or serious physical, social and behavioural concerns are using emergency shelters. Emergency shelters are generally unequipped to provide an adequate level of service to this population.

Policy Statement

9) Individuals with mental illness, addictions and/or serious physical, social and behavioural concerns should receive treatment to meet their needs and be accommodated in suitable permanent supportive housing.
10) No homeless individual in Greater Vancouver with mental illness, addictions and/or serious physical, social and behavioural concerns should be turned away from an emergency shelter because of lack of shelter capacity or the services needed to accommodate them.

Strategies

a) Develop emergency shelter capacity for homeless individuals with mental illness, addictions and/or serious physical, social and behavioural concerns in Vancouver, outside the Downtown Eastside and elsewhere in the region.
b) Expand the ability of existing facilities in the region to meet the needs of individuals with mental illness, addictions and/or serious physical, social and behavioural concerns by hiring more staff and providing additional staff training.
c) Emphasize advocacy services to help shelter clients obtain needed treatment and suitable housing and support to successfully sustain them in that housing.
d) Develop more treatment facilities and supportive housing so that people may obtain appropriate treatment, accommodation and services to help them live independently in the community.

Inadequate access to emergency shelters

Unfortunately, everyone who needs emergency shelter is not eligible to stay in emergency shelters. Most emergency shelters can only provide access to Ministry of Social Development and Economic Security (MSDES) funded shelter beds for people who are receiving or are eligible for BC Benefits. Those who are ineligible for BC Benefits (such as some youth, people with other sources of income like Employment Insurance benefits and pensions, and until recently, people with outstanding warrants for arrest) either cannot stay in MSDES funded beds, or if the shelter accommodates that individual, it would not be reimbursed.

In addition, some people who are eligible for BC Benefits find it difficult to comply with the paperwork or other 'hoops' necessary for obtaining benefits. For example, attending orientation sessions and appointments are difficult when you are homeless and have no alarm clock. Waiving income assistance eligibility as a requirement for a shelter stay and reducing barriers to obtaining income assistance would improve access to the existing system. In the shorter term, creating minimal barrier shelters where individuals may access shelters regardless of eligibility for BC Benefits would address this issue. This is the context behind the drive for minimal barrier shelter. Cold-wet weather beds address the need for minimal barrier shelters because they are available based on need, regardless of income assistance eligibility.

When an emergency shelter is full and staff must turn away an individual seeking shelter, they have no way of knowing where to send this individual without telephoning several shelters. Computerized databases can keep track of shelter bed availability, providing up to date information to shelter staff in this situation. Development of a shelter bed registry with the capacity to be continually updated would improve this situation.

Physical barriers such as a distant location away from major transportation routes and lack of transportation limit access to emergency shelters. Shelters located outside the Downtown core, while much needed require individuals to travel, usually by public transit, or, may be inaccessible at night when transit shuts down. Facilitating mobility would improve access to emergency shelter beds. This could include providing transit tickets, taxi fare and safe ride vans.

Issue

Some homeless individuals are unable to access emergency shelters, because they are ineligible for BC Benefits, since eligibility requirements make it difficult for homeless people to obtain and maintain benefits, or because of the distance of shelters from major transportation routes.

Policy Statement

11) Emergency shelters should provide accommodation to people in need, regardless of eligibility for BC Benefits.
12) Minimal barrier emergency shelter space should be available in communities throughout the region.
13) Emergency shelters should be located close to services and major transportation routes to promote easy access for those in need.

Strategies

a) Request that the provincial government waive income assistance eligibility as a requirement for staying in an emergency shelter.
b) Request that the provincial government review the requirements that make it difficult to obtain and maintain benefits.
c) Support Shelter Net BC in its discussions with the provincial government on issues related to BC Benefits eligibility and other barriers to access.
d) Expand cold–wet weather capacity throughout the Lower Mainland with an emphasis on meeting needs in communities with little or no cold-wet weather capacity (North Shore, Northeast Sector, Ridge Meadows and the Inner Municipalities).
e) Develop a 24-hour emergency shelter bed registry to provide current information on shelter bed availability throughout the region.
f) Develop locational criteria to ensure that emergency shelters are suitably located adjacent to other support services and in close proximity to major transportation routes.
g) Facilitate transportation to shelters with available beds.

Little information about people who are homeless and at risk of homelessness

We do not know how many different homeless people use emergency shelters in the region over the course of one year or any other time period. Nor do we know much about who they are – their age, sex, family status, and reason for admission. The dearth of good information has made it difficult to develop policies and plans to address homelessness. While each individual shelter keeps its own records and some have fairly detailed statistics, there is no region-wide database of

unique individuals using all shelters. We know only the number of people who stay in shelters at any one time – essentially a measure of the capacity of the shelter system.

Comprehensive longitudinal data on each individual who stays in the shelter system in the Lower Mainland is needed. This would provide better information for understanding needs and for planning purposes. A Canada Mortgage and Housing Corporation (CMHC) sponsored and locally supported project to develop such a database, called the Homeless Individuals and Families Information System (HIFIS), is presently being tested at some Lower Mainland facilities. However, data will not likely be available until the 2002. The information will be maintained by BC Housing.

We know very little about people who are homeless and do not use emergency shelters and instead live 'rough' on the streets, in parks, parkades and elsewhere. A concerted effort to count and profile those not using emergency shelters is required. While challenging to undertake, it is not impossible. Many other jurisdictions have undertaken such work including Edmonton and Calgary. A regular update, for example, every two years, can be helpful in providing a benchmark for identifying changes over time and for monitoring the effectiveness of the plan.

Issue

There is little information about people who are homeless and at risk of homelessness in the Greater Vancouver region.

Policy Statement

14) Longitudinal information about the number of people living in emergency shelters, on the streets, and those who are at risk of homelessness and their characteristics is necessary for policy development and planning purposes.

Strategies

a) Support the development and maintenance of a database of information about people who use shelters. Continue to work with BC Housing in developing the Homeless Individuals and Families Information System (HIFIS) to ensure that it is inclusive of all groups of people who are homeless.
b) Encourage all Lower Mainland emergency shelters to participate in HIFIS.
c) Resources should be allocated to undertake a regular homeless count and develop a profile of people who do not use emergency shelters, but live rough or who are otherwise not housed adequately.
d) Develop and maintain estimates of the number of people who are at risk of becoming homeless in Greater Vancouver and in each sub-region.

4.2.2 Transition houses

Women fleeing abusive relationships may find themselves with nowhere to live. The process of leaving home to avoid abuse may result in homelessness if family or friends cannot offer a place to stay. North American and other studies have shown that a high proportion of homeless women

disclose domestic violence as a chronic feature of their family life or as a precipitating factor in their current homeless episode.[13]

Transition houses offer temporary housing in a safe, secure environment for women with and without children leaving abusive relationships. Funded by the BC Ministry of Women's Equality and operated by non-profit organizations, this form of housing usually includes support services. The maximum length of stay is generally up to 30 days.

At the present time, there are 194 beds in transition houses throughout Greater Vancouver. The largest share of these beds is located in Vancouver and South of Fraser.

Table 4: Number of beds in transition houses for women and children

Sub-region	# Beds for Women and Children	% facilities
Vancouver	62	32%
South of Fraser	62	32%
Inner Municipalities	30	15%
North Shore	18	9%
North East Sector and Ridge Meadows	22	11%
Total	194	100%

Source: Inventory of Facilities and Services, Sept 29, 2000 - updated

Ability of current supply of transition houses to meet needs

Table 5 below provides information on 11 of the 16 transition houses in Greater Vancouver. This table shows that there is great demand for transition house beds, and that transition houses are able to meet less than one third of this demand. Many women and children are turned away, more than 6,500 people over the course of a year. The ability of existing transition houses to meet needs varies by sub-region. In Vancouver, South of Fraser and the Inner Municipalities - only 13% to 38% of the demand by women was met. As can be seen in Table 5 below, most of the women were turned away because of lack of space. In some cases this means that the house was full. In other cases, families were turned away because the configuration of the rooms meant that the total family unit could not be accommodated.

[13] Chung, Donna et al. *Home Safe Home. The Link between Domestic and Family Violence and Women's Homelessness.* Australia Commonwealth Office of the Status of Women. November 2000. Research in Toronto for the Golden Task Force indicates that 8 percent of *all* households staying in emergency shelters are fleeing an abusive spouse. Figures for women not published. Springer, Mars and Dennison, 1998.

Table 5: Women and children served and turned away 1999-2000*

Sub-region	# Women & Children Served	# Women & Children Turned Away	Total Demand	% Served
Vancouver	209 (97 women/112 children) *(info from one of 4 houses)*	927 (643 women/284 children)	1,136 (740 women/396 children)	18% (13% women/28% children)
South of Fraser	1,652 (983 women/669 children)	3,772 (2,556 women/1,216 children)	5,434 (3,539 women/1,885 children)	30% (18% women/35% children)
Inner Municipalities	922 (513 women/409 children)	1,411 (845 women/566 children)	2,333 (1,358 women/975 children)	40% (38% women/42% children)
North Shore	438 (286 women/152 children)	281 (140 women/141 children)	719 (426 women/293 children)	61% (67% women/52% children)
North East Sector & Ridge Meadows	148 (78 women/70 children	109 women (info not available on children)	257 (187 women/ 70children)	42% women
Total	3,369 (1,957 women/1,412 children)	6,500 (4,293 women/2,207 children)	9,869 (6,250 women/ 3,619 children)	34% (31% women/39% children)

*All numbers are for a one year period, although some are for the calendar year and others are for the fiscal year.

Table 6: Number of women turned away and reasons why

Sub-region	Lack of Space*	Outside program mandate	Could not accommodate special needs[14]	Women did not arrive or chose not to use service at this time	Other	Total
Vancouver	443	152	44	4	0	643
South of Fraser**	1,850	194	71	29	120	2,264
Inner Municipalities***	566	0	0	0	0	566
North Shore	82	42	7	6	3	140
North East Sector and Ridge Meadows	10	57	22	20	0	109
Total	2,951	445	144	59	123	3,722
	79%	12%	4%	2%	3%	100%

*May also mean not sufficient space for whole family.
**For two homes, statistics are for the period Jan-Aug 2000
***Does not include information from one of the houses noted above

[14] Special needs may include mental health issues, substance use, physical accessibility etc.

Issue

There are not enough transition beds in Greater Vancouver to meet the needs of women with and without children fleeing abusive relationships.

Policy Statement

15) There should be enough transition house beds in communities throughout Greater Vancouver to meet the needs of women with and without children fleeing abusive relationships.

Strategy

a) Obtain a commitment from the BC Society of Transition Houses and the Ministry of Women's Equality, to develop additional beds to serve women with and without children fleeing abusive relationships.

Demand for services by persons outside the program mandate

Table 6 above shows that about 11% of women seeking accommodation in transition houses were turned away because their needs were outside the program mandate. Providers indicate that most of these women were turned away because although they needed a place to stay, they were not fleeing an abusive relationship. This situation may indicate a need for more emergency shelters that meet the needs of homeless women with and without children.

Issue

The fact that a significant number of homeless women contact transition houses when they are seeking a place to stay indicates a need for more emergency shelters that meet the needs of homeless women with and without children.

Policy Statement

16) Emergency shelter space that meets the needs of women with and without children should be available in communities throughout Greater Vancouver.

Strategy

a) Expand the shelter capacity throughout Greater Vancouver to meet the needs of homeless women with and without children.

4.2.3 Supportive and second stage housing

While some homeless people simply need affordable housing, others, particularly those who have been homeless for any length of time, require the additional services and supports offered by supportive housing. Supportive housing refers to affordable, independent accommodation, sometimes in a purpose designed building with added support services that provide skills, training and support with housekeeping, meal preparation, banking support and access to medical care, counseling, referrals, crisis response and intervention. It provides opportunities for individuals to stabilize their personal situation and re-establish connections with the community. Second stage

housing, also called transitional housing, is similar to supportive housing, except that it may be time limited. A resident may be expected to move to permanent housing upon stabilizing their living situation in second stage housing.

Supportive housing is viewed as the most desirable form of housing for many people with severe and persistent mental illness. A 1997 study undertaken by the Clarke Institute of Psychiatry found that controlled studies of individuals with severe mental illness, including homeless people, show they can be housed in the community when provided with assertive case management services.[15] Research has also shown that supportive housing is effective in reducing homelessness and the health care costs associated with homelessness.[16] Supportive housing is also an important part of the continuum of addiction treatment in Portland, Oregon.[17] Supportive or second stage housing for youth is also an essential component of a strategy to help youth who have been homeless or are at risk learn how to live independently.

Different types of supportive housing meet different needs. They can include supported apartments in which all tenants experience similar concerns, and the Supported Independent Living Program (SILP) units in which individuals receive support in apartment units scattered in the private market. A more recent model, the supported hotel, serves individuals with a broad range of specialized needs, including those who were formerly homeless. It is estimated that 40% of the residents in supported hotels have a mental health problem and most have some problems with substance misuse. In BC, the Homeless At Risk Housing (HARH) program was developed to specifically address this issue and to prevent people with difficult and challenging behaviours from 'falling through the cracks'. HARH units consist of supportive and second stage units. These may be similar to supported apartment blocks with services for individuals who were formerly homeless and at risk of homelessness. A community agency or non-profit organization generally manages these resources.

There are over 2,200 units of supportive housing in Greater. The following table illustrates the distribution of these units around the region. All the SILP and approximately half of the supported apartments are for mental health consumers. Many residents in supported hotels are also mental health clients. HARH units and some of the units in supported hotels serve people with diverse needs. People living with HIV require supportive housing and are eligible for subsidies as well.

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[15] *The Review of Best Practices in Mental Health Reform* and *Best Practices in Housing* one of seven mental health reports released in early 2000 by the BC Ministry of Health.

[16] Corporation for Supportive Housing. *Supportive Housing and its Impact on the Public Health Crisis of Homelessness*. Interim Report. May 2000.

[17] BC Ministry of Social Development and Economic Security. *Local Responses to Homelessness: A Guide for BC Communities*. October 2000.

Table 7: Supportive Housing in Greater Vancouver

Sub-region	SILP*	Supp. Apart-ments**	Sup. Hotels	HARH ***	HIV	Total	% of Total
Vancouver	289	415	301	455	196	1656	74%
South of Fraser	134	36	0	20		190	9%
Inner municipalities	202	24	0	28		254	11%
North Shore	49	0	0	0		49	2%
Northeast Sector & Ridge Meadows	82	0	0	0		82	4%
Total	756	475	301	503	196	2231	100%

Source: Inventory of Facilities and Services, Sept 29, 2000. Does not include second stage units.
* Includes forensic and youth SIL.
** Includes satellite apartments.
***Completed (175) and under development (328).

The majority of supportive housing units are located in Vancouver. Of the total 2,231 supportive units, 74% are in Vancouver. South of Fraser has 9% of the supportive units and the Inner Municipalities have 11%. The supported hotels and HARH units most directly serve people who have been homeless, and most of these units are located within Vancouver.

The planning process identified as an urgent and short-term priority the need to increase the number of supportive housing units across the region, particularly for seniors with mental illness, Aboriginal people, low income urban singles and people with special needs. It also identified the need for more second stage housing for youth (longer than 30 days) and people with special needs. Locations specified were the North Shore, Inner Municipalities and South of Fraser.

Inadequate supplies of supportive and second stage housing

There is an insufficient supply of supportive housing for all client groups including youth, persons with mental illness, HIV/AIDS and, people with addictions and those who are dually diagnosed with both mental illness and an addiction. There are over 3,800 individuals waiting for mental health supportive housing in the region and an additional 625 people waiting for HIV housing for a total of about 4,500 persons. The lack of supportive housing for people with addictions is noted as a particular problem by many in the field, which is addressed in Section 4.4.4. There is no waiting list for individuals with addictions who need supportive housing (as there is no housing targeted for this group). These figures also do not capture the needs of people who are transient, and who are not on any waiting list thus they underestimate the need for supportive housing.

Table 8: Supportive Housing in Greater Vancouver

Health Region	Mental Health Number of clients waiting	HIV Number of clients waiting	Total clients waiting
Vancouver	3,000	625	3625
Richmond	500 – 600		500 - 600
Simon Fraser Health Region (Burnaby, Tri-cities, New Westminster, Maple Ridge)	120		120
South Fraser Health Region	150		150
North Shore Health Region	34		34
Total	3,804-3,904	625	4,429-4,529

People with multiple issues, such as mental illness together with drug addiction, pose a particular challenge for a system where they may fall outside the mandate of individual program ministries. Their needs are not well served in an environment where only one challenging behaviour is treated. These people, who may have experienced chronic homelessness, need the supports offered by supportive housing. Responding to the multi-faceted needs of these individuals requires a large degree of flexibility and coordination in the provision of housing and support services.

Youth have distinct needs for supportive or second stage housing after leaving an emergency shelter. Many young people can't move directly to independent housing either because it is unavailable to them (unaffordable or they are discriminated against) or they are unable to cope because they do not have the skills for independent living.

Seventy five percent of the existing supportive housing supply is located within Vancouver and most of the Homeless at Risk Housing projects is located in Vancouver. It is unclear to what extent this demand arises from residents from other Lower Mainland municipalities and how much of this is in response to the significant needs of Vancouver residents. However, increasingly, it is felt that despite the range of support services available in the Downtown Eastside, some people do not want to live there or are too vulnerable to the drug scene to permit them to live safely. Supportive housing needs to be developed in Vancouver outside the downtown core. In addition there is little supportive housing in the North Shore, Northeast Sector and Ridge Meadows and only a few units in the Inner Municipalities or South of Fraser. Waiting lists for supportive housing exist in most health regions that comprise the GVRD (Simon Fraser Health Region, South Fraser Health Region, North Shore Health Region as well as in Vancouver and Richmond.)

The Simon Fraser Health Region is planning to develop a supported apartment building for mental health clients in the next year and is actively participating in the proposed acquisition of a hotel in New Westminster. The South Fraser Health Region has also identified a need for more supported housing for mental health clients. It provided funding to develop a housing coalition to ensure the provision of a range of supported housing options for this target group.

Issue

There is an insufficient supply of supportive housing for all client groups, including youth, persons with mental illness, HIV/AIDS or addictions and individuals with dual diagnosis (both mental illness and addictions) or multiple diagnosis. Homeless people in several communities have no access to supportive housing units locally.

Policy Statement

17) The number and range of supportive housing units meeting the needs of all client groups with unique needs should be expanded so that wait times are reduced to a reasonable level.
18) Supportive housing should be distributed in all communities throughout the region based on need.

Strategies

a) Encourage federal, provincial and local governments to increase the supply of supportive and second stage housing along with an increase in support funding from relevant ministries and health authorities.
b) Develop short stay/second stage housing (longer than 30 days) for all group, and particularly youth.
c) Develop supportive housing in communities around the region where need has been demonstrated

Complexity of acquiring support funding

BC Housing, through the provincial housing program HOMES BC, provides capital and operating funding for supportive apartments and hotels. Supportive apartments for mental health consumers have dedicated support funds from the Ministry of Health, Adult Mental Health. The same is usually true for Homeless At Risk Housing (HARH). However, there is no dedicated source of funding for the support component of supported hotels and housing for persons with HIV. HOMES BC Low Income Urban Singles projects rarely have committed funding for support although they can house the same population. Nor is there dedicated funding for addictions support. The ministry considers each proposal for funding support on an individual basis. Often it is necessary for project proponents to seek funding from several program ministries making coordination and pre-project development work extremely onerous for sponsors.

In fact, some projects have been under construction before all support funds are committed, placing sponsors in a risky position. Some housing projects have opened their doors without adequate support services in place for their residents. This is a serious unresolved issue in the Vancouver region and throughout the province. Supportive housing projects for youth seem to have particular difficulty in obtaining funds to provide adequate support services for their residents.

Proponents receiving allocations from BC Housing are eligible for proposal development funding up to a certain limit. However, given the amount of time it takes to develop supportive housing, additional funds for capacity building, research, and coordination with funders would facilitate the creation of new multi-funded options for a diverse clientele as would simplifying and standardizing agreements for the support component of supportive housing.

Issue

It is often difficult for project sponsors to obtain adequate funding to provide necessary support services in supportive housing with the result that there is significant unmet need for supportive housing, particularly among certain groups with unique needs and in some communities around the region.

Policy Statements

19) Federal, provincial and local governments, regional health boards and others should act in a coordinated way to facilitate the development of new supportive housing for a range of client groups.
20) Funding sources should be in place and allocated for the support component of supportive housing for each client group.

Strategies

a) Develop a dedicated source of funding for the support component of supportive housing for persons recovering from addictions and for youth.
b) Implement needed support funding and programming for existing youth supportive and second stage housing facilities.
c) Simplify and standardize agreements for the support component of supportive housing.

Supportive housing allocations for mental health clients are not portable

Supportive housing subsidies for mental health clients are not portable when a resident wishes to move from one health region to another. Four health boards in the Greater Vancouver region administer mental health care. Mental health clients receiving a Supported Independent Living Program (SILP) subsidy or living in a supportive apartment block cannot take their subsidy with them when they move to another health region.

Issue

Residents with Supported Independent Living Program (SILP) subsidies who move between health regions lose their subsidy.

Policy Statement

21) Residents with Supported Independent Living Program (SILP) subsidies should be able to move between health regions without losing their subsidy.

Strategy

a) Develop reciprocal agreements among Lower Mainland health regions so that persons receiving SILP subsidies are able to maintain their housing subsidy when they move.

4.2.4 Independent housing

Affordable housing for low and moderate -income households helps to prevent and reduce homelessness. Two important strategies help to ensure an adequate supply of affordable housing: developing new affordable housing and maintaining the existing stock of affordable housing.

Both approaches are equally important. Provincial and municipal governments, community groups and service providers in the Vancouver region have consistently advocated permanent affordable housing as a solution to homelessness.

Rental vacancy rates in the Vancouver region have been consistently low throughout the 1990s, only rising above 3% in 1998. The private sector is producing few new rental units and, since 1993 the federal government has provided no ongoing funding for new social housing in BC. It is estimated that this has meant 11,000 fewer social housing units were built in the province, based on previous federal commitments.

The province delivers social housing through HOMES BC, a program which develops new affordable housing for seniors, families and low income urban singles. The provincial government has funded the development of about 4,800 units under this program, about 600 units per year. In June 1999, the government announced that it would double its funding over the next two years to provide 1,200 additional affordable units in 1999 and 2000. Partnerships with non-profit organizations, municipalities and private donors help to leverage additional units from a given allocation with the contribution of discounted land and equity.

Almost half the permanent social housing in the region (built under federal/provincial housing programs or provincial housing programs) is located in Vancouver. The remainder is distributed throughout the region, with the next largest share located in the Inner Municipalities (23%). This housing has traditionally been targeted mainly to families and seniors. The recently developed Low Income Urban Singles (LIUS) component of HOMES BC is for individuals at risk of homelessness as a result of the loss of SRO units. All of the LIUS units that have been developed in Greater Vancouver are located in Vancouver.

Table 9: Independent social housing units in Greater Vancouver

Sub-region	# units*	% units	Low Income Urban Singles (LIUS)
Vancouver	19,564*	48%	1,025
South of Fraser	5,514	14%	0
Inner Municipalities	9,459	23%	0
North Shore	2,320	6%	0
Northeast Sector and Ridge Meadows	3,728	9%	0
Region wide	40,495*	100%	1,025

Source: Inventory of Facilities and Services, Sept 29, 2000
*Include LIUS units

The consultation process to develop the regional plan identified the need for permanent affordable housing as an urgent priority to prevent and reduce homelessness. This includes new social housing, as well as initiatives to increase the supply of affordable private sector units. This is a priority in Inner Municipalities, Northeast Sector, Ridge Meadows, North Shore and Vancouver. There is also a need for more LIUS units in Vancouver outside the Downtown

Eastside. Federal involvement in the supply of new permanent affordable housing was identified as a key strategy.

Inadequate supply of new social and affordable housing

BC Housing's waiting list for social housing in the Lower Mainland consisted of over 9,000 households as of August 2000. The average waiting time (province-wide) before applicants are housed is about three years. This suggests the current rate of new development is not adequate to meet needs.

Affordable housing, particularly that which is affordable to those with low and moderate incomes cannot be built in the Lower Mainland without government subsidy. Many organizations have endorsed the '1% solution' which urges all levels of government to increase spending on housing from 1% of their total budgets to 2%.

The federal government provides no capital or operating subsidies for new social housing. In BC, the provincial government has been carrying most of the responsibility for developing new affordable housing, together with non-profit and municipal partners, but it cannot build an adequate supply to meet needs.

Local governments can use number of tools to facilitate the creation of new affordable housing, and these have been used successfully in some areas. These include density bonuses, provision of land at below market rates, affordable housing funds, inclusionary housing policies, and the fast tracking of development approvals.

Households paying 50% or more of their income for rent are considered to be at risk of homelessness although homeowners on a fixed income can also be at risk. This measure, while an imperfect one, is often used as an indicator of risk of homelessness. Over 65,000 renter households region-wide or 24% of renter households were in this situation in 1996. The figures below show that no sub-region is exempt from this – between 20 and 25% of renter households are at risk of homelessness because they pay more than 50% of their income for rent each month. Vancouver and Ridge Meadows have the highest proportion of renter households in this situation compared to the other Greater Vancouver municipalities. Vancouver, South of Fraser and the Inner Municipalities have the largest number of renter households at risk according to this definition.

Table 10: Renter households at risk of homelessness in Greater Vancouver

Sub-regions	% of renter households paying 50% or more of their income on rent 1996	Number of renter households paying 50% or more of their income on rent 1996
Vancouver	25%	31,250
South of Fraser	24%	11,475
Inner Municipalities	22%	13,135
North Shore	21%	4,380
Northeast Sector	23%	3,985
Ridge Meadows	25%	1,495
Region wide	24%	65,720

Source: BC Housing. *General Housing Need and Demand Indicators*. August 3, 1999. Based on 1996 Census data.

These figures suggest that the plunge into homelessness can happen to households throughout Greater Vancouver and that action needs to be taken in communities throughout the region to ensure this doesn't happen. One of the key ways is to do this is to create new social and affordable housing in communities throughout the region. With the exception of Vancouver, no housing has been developed for low-income urban singles in the region. According to BC Housing, few proposals have been received. Opportunities to serve this population in other municipalities should be explored.

Issue

An inadequate supply of new social housing and affordable housing for low and moderate income households is a direct cause of homelessness in the region.

Policy Statement

22) An adequate supply of affordable and social housing for low and moderate- income households is critical to meet needs and to help prevent homelessness in the region.
23) New social housing and housing affordable for low and moderate-income households should be distributed in communities throughout the region based on needs.

Strategies

a) Encourage the provincial government to maintain and expand its social housing supply program.
b) Encourage the federal government to establish a national social and affordable housing supply program as a solution to homelessness.
c) Encourage local governments to assist with the creation of new affordable and social housing through the use of density bonuses, secondary suite policies, leasing or selling land at below market rates and other means.
d) Create partnerships to develop new affordable housing. Potential partners include all levels of government, the private sector, non-profit housing societies, and community-based organizations (including labour).
e) Develop new social housing and housing affordable to low and moderate-income households to meet needs in communities throughout the region.
f) Develop housing in those communities with a demonstrated need for urban singles housing.
g) Develop a regional rental housing supply strategy.

The existing stock of affordable housing is being lost

A significant number of affordable rental units already exist in the private market, located in older three story walk-ups, Single Room Occupancy hotels and rooming houses. Given that new rental construction is unlikely, the existing stock is a valuable resource for low-income renters and plays a critical role in preventing homelessness. Different communities in the region have different types of rental housing stock and are facing different issues. In New Westminster for example, rental units comprise a large share of the housing stock, and most rental units are located in apartments under five stories. Many of these building were constructed with federal tax incentives in the 1960s, are reaching the end of their useful life, and will be subject to redevelopment. Indeed some redevelopment has already occurred.

SRO hotels, which are of modest quality, play an important role in meeting the housing needs of low-income renters who have few alternatives in the private market. Most SRO units in the region

are located in Vancouver but Burnaby, New Westminster and Surrey each have this type of accommodation. While they may not be the preferred housing choice of many residents, some attribute the SRO stock with acting as a buffer for people at risk of homelessness limiting the number of homeless people who actually become homeless. In fact, the City of Vancouver notes that in eight other North American cities they studied, homelessness increased when SRO stock was lost. Unfortunately, these units are subject to continual redevelopment pressure, particularly in certain locations. In Vancouver, over 4,000 SRO units have been lost since 1970, and new social housing stock has not been able to replace all these lost units.

We know little about rooming houses, except that they are unregulated, are located around the region and provide affordable housing to low income households. The issues around quality and insecurity of tenure are similar to those of SROs.

Some of the tools and strategies for preserving the stock of affordable housing are:

- demolition and/or conversion controls,
- policies of one for one replacement of SRO units,
- upgrading with RRAP for rooming houses and hotels,
- implementation and enforcement of standards of maintenance by-laws,
- monitoring trends in number and condition of units and number of units lost, and
- public acquisition and conversion to non-profit management.

However, few of these tools are used on a regular basis. According to research on local government housing initiatives,[18] several local governments have implemented demolition or conversion controls to limit the loss of affordable rental units. The city of Vancouver's SRO policy is to encourage one for one replacement, improved maintenance and management through standards of maintenance and management, non-market purchase of SRO hotels, density bonuses for SRO upgrading, and restoring advocacy services.

[18] BC Ministry for Social Development and Economic Security. 2000. Planning for Housing (Revised 2000). An Overview of Local Government Initiatives in British Columbia.

Issue

The existing stock of affordable rental housing is being lost due to redevelopment and conversion. In addition, some of this stock is of poor quality.

Policies

24) The existing stock of affordable housing is a valuable resource and preserving it is critical to reducing and preventing homelessness.
25) Replacing and/or upgrading SROs in order to meet established standards of maintenance and management is the preferred approach.

Strategies

a) Encourage the federal government to maintain and expand RRAP for rooming houses and hotels.
b) Encourage the provincial government to continue acquiring SRO hotels and converting them to non-profit management.
c) Encourage local governments to help maintain the existing stock of housing affordable to low and moderate-income households by implementing demolition and/or conversion controls, policies of one for one replacement of SRO units, standards of maintenance by-laws, and facilitating partnerships to upgrade or acquire this stock.
d) Monitor the stock and condition of housing affordable to low-income households including SROs, rooming houses and three story walk-ups.
e) Encourage a partnership approach to the public acquisition of SROs.
f) Investigate the issues affecting three story walkups and develop a strategy to help preserve them.

Individuals must apply for access to several agencies

People seeking to obtain social housing must often submit applications to several agencies, making access complicated and time consuming. BC Housing maintains a waiting list for its projects, and non-profit providers maintain their own waiting lists. Providers in the downtown core maintain waiting lists for LIUS housing. This results in barriers to accessing social housing.

It would also be useful to include affordable housing in a similar registry so that individuals seeking affordable housing have a one-stop access point for this type of housing

Additionally, there is no comprehensive information on the total number of individuals seeking affordable housing in this region. Using BC Housing waiting list figures underestimate social housing need in the region. This type of information is essential for planning purposes.

Issue

There are barriers to accessing social housing due to the lack of a coordinated system of waiting lists.

Policy Statement

26) Access to social housing is best achieved through a coordinated social housing waiting list for the Lower Mainland.
27) Accurate information on the number of people on social housing waiting lists is essential for policy and planning purposes.

Strategy

a) Support the work of the BC Non Profit Housing Association, Cooperative Housing Federation of BC and BC Housing to implement a coordinated social housing registry.
b) Encourage all housing providers to participate in the housing registry.
c) Create a separate registry for affordable housing or expand the social housing registry to include affordable housing.

4.3 *Ensure households have adequate income*

The need for households to have sufficient incomes to afford adequate housing is one of the key elements of the continuum of housing and support. This income can be from employment, transfer payments (such as income assistance, employment insurance and pensions) or a combination of these.

The vast majority of homeless people are unemployed. For example, one study of B.C. shelter clients found that only 4% of homeless people received income from employment.[19] However, many of these same people were employed at some time in the past. If a lack of income is a critical factor in causing homelessness, assisting homeless people to find employment and earn income is an essential component of a strategy to reduce homelessness.

Incomes have not been keeping up with inflation. Average household incomes in Greater Vancouver decreased by 4% between 1990 and 1995, from $56,479 to $54,055 in constant real dollars[20]. The situation was worse for renter households who saw their income decline by 11% from $40,538 in 1990 to $36,178 in 1995.

During the 1990 to 1995 period, the percentage of households in the region living below the poverty line increased from 18% to 23%.[21] In 1995, one in five families and two in five single persons were identified as poor. Certain types of households were more likely to be poor, including single parents (54%), recent immigrants (52%), aboriginal persons (49%), and unemployed persons. Of all the single persons, more than half of all elderly women, (54%) were living in poverty. The average income for families living below the poverty line in 1995 was $14,700 per year.

4.3.1 Employment

The GVRD has experienced growing employment over the last few years. The unemployment rate for the year 2000 was 5.9% compared to 7.8% in 1999 and compared to a high of 9.3% in 1993. The unemployment rate in Greater Vancouver was consistently lower than the rate for the province as a whole (see Table 11.) However, due to the changing nature of the economy, large numbers of employees are employed in the service sector and are earning the minimum wage. This means their incomes are below the poverty line, and many may be at risk of homelessness.

Table 11: Unemployment rates, 1992-2000

	1992	1993	1994	1995	1996	1997	1998	1999	2000
BC	10.2%	9.7%	9.0%	8.4%	8.7%	8.4%	8.8%	8.3%	7.2%
Greater Vancouver	9.0%	9.3%	8.6%	7.9%	8.0%	8.3%	8.1%	7.8%	5.9%
Source: BC Statistics									

[19] BC Ministry of Social Development and Economic Security and Ministry of Municipal Affairs. *Local Responses to Homelessness: A Planning Guide for B.C. Communities*. 2000

[20] City of Vancouver, based on data from Statistics Canada.

[21] Canadian Council on Social Development. *Urban Poverty in Canada, A Statistical Profile*. April 2000. Poverty is defined using Statistics Canada's before-tax Low Income Cut-Offs (LICOs). LICOs are income cutoffs that were developed to identify households that would have to spend approximately 20 percentage points more of their income than would the average Canadian household to acquire the basic necessities of food, shelter and clothing (54.7% of their income to acquire basic necessities).

Income from employment insufficient to permit some households to afford decent housing
Effective November 1, 2000, the hourly minimum wage in B.C. was increased from $7.15 to $7.60. This means that an individual who is paid for working 35 hours a week over 52 weeks each year would earn $13,832 per year, or $1,153 per month. While B.C. is fortunate in having the highest minimum wage in Canada, because of high housing costs, most households earning this amount in Greater Vancouver would still be living below the poverty line based on Low Income Cut-Offs (LICOs) estimated for the year 2000. These individuals are often referred to as the 'working poor'.

As can be seen in Table 12, the incomes of single parent households, and households where only one adult is able to obtain full-time employment would fall significantly below the poverty line. Households with two adults working full-time appear to be in a better financial position; however, families with children would incur additional expenses for childcare.

Table 12: Minimum wage compared to Low Income Cut-Offs

Family Size	LICO, estimate for the year 2000	Income if **1** person works 35 hrs/wk/yr at minimum wage	Income as percent of LICO	Income if **2** persons work 35 hrs/wks/yr at minimum wage	Income as percent of LICO
1	$17,060	$13,832	81%	N/A	N/A
2	$23,123	$13,832	60%	$27,664	120%
3	$29,393	$13,832	47%	$27,664	94%
4	$33,844	$13,832	41%	$27,664	82%
Source: National Council of Welfare, Fact Sheet: Poverty Lines 2000					

Table 13 shows that most households earning minimum wage would have great difficulty finding market housing that they could afford, except in the case of two adults renting a 1 bedroom unit. Single persons, single parent households, and households where only one adult is able to obtain full-time employment would be at risk of homelessness, as they would be required to pay between 50% and 90% of their incomes to rent.

Table 13: Annual income required to afford market rental housing

Unit Type	Average Monthly Rent Vancouver CMA	Annual Income Required to afford unit at 30% of income	Income if **1** person works 35 hrs/wk/yr	Average Rent as % of Income with one full-time employee	Income if **2** persons work 35 hrs/wk/yr	Average Rent as % of Income with 2 full-time employees
Bachelor	$598	$23,920	$13,832	51%	N/A	N/A
1 Bedroom	$695	$27,800	$13,832	60%	$27,664	30%
2 Bedroom	$890	$35,600	$13,832	77%	$27,664	39%
3 Bedroom	$1,022	$40,880	$13,832	89%	$27,664	44%
Source: Based on CMHC Rental Housing Market Information (October, 2000 survey) and assistance from the Social Planning and Research Council of BC.						

One way to ensure that working poor households can afford to obtain decent housing in the market place is to increase their disposable income. There are several ways this could be

achieved, including increasing the minimum wage so that it is commensurate with housing costs, introducing and tax initiatives (such as tax credits and other methods) to assist renter households. In Toronto, the Mayors Homelessness Action Task Force has recommended shelter allowances as a way of addressing this situation. Increasing the supply of social and affordable housing would also help to ensure working households can afford decent housing (see sections 4.2.3 and 4.2.4).

Issue

There is disparity between what some working households can afford to pay for housing and the cost of housing in Greater Vancouver, placing them at risk of homelessness.

Policy Statement

28) Working households should be able to afford safe, secure, and decent housing.

Strategies

a) Request that the provincial government examine various strategies to assist working poor households to increase their disposable income through enhanced minimum wage, renter tax credits and other measures.

Barriers to employment

It is clear from the literature and conversations with local providers that homeless individuals face many barriers to employment. Firstly, fundamental issues such as lack of housing, food, adequate health and dental care, and safety need to be addressed before homeless individuals can consider employment. It is virtually impossible to obtain employment without having a decent night's sleep, an alarm clock, a shower, a telephone and other conveniences of a home. In short, housing is a necessary first step to obtaining employment. Social support systems are also important. Low self-esteem is another fundamental issue that usually needs to be addressed before pursuing employment. It is unrealistic to expect that finding employment can be the first step. Lack of affordable childcare is another often-cited barrier to obtaining employment, particularly for single parent families. These issues also need to be addressed before individuals can participate in pre-employment programs.

Issue

Homeless individuals are unable to pursue employment or employment assistance programs until their basic needs are met and barriers to employment are addressed.

Policy Statement

29) Adequate housing, food, health care, social support and child-care as well as personal safety and self-esteem are necessary prerequisites for obtaining and maintaining employment.

Strategies

a) Implement the policies and strategies of the regional homeless plan to meet the range of needs of people who are homeless to ensure that basic needs are met.
b) Develop additional child-care spaces at affordable rates to meet needs.

Employment assistance services consist of a wide variety of services and initiatives generally aimed at reconnecting individuals with employment. Services usually include some combination of:

- job search support
- job banks
- job placement
- academic upgrading
- pre-employment training
- life-skills counseling and training
- employment counseling and training
- work experience and on the job training
- supported employment (on the job support)

The regional inventory identifies Greater Vancouver employment services targeted to homeless individuals and people with low incomes. It does not include government delivered employment assistance services or education. Education usually refers to high school upgrading and skills training offered through alternate or adult education programs of the Vancouver School Board.

Employment assistance services are delivered through non-profit service organizations such as Nisha Family Services, Fraserside Community Services Society and South Fraser Community Services Society as well as by the provincial government. Services are funded by federal and provincial funds and through fundraising. They are often strategies associated with labour market re-attachment for individuals receiving income assistance benefits. The responsibility for skills training resides with MSDES for those who are eligible for BC Benefits, job ready and looking for work. It offers labour market attachment programs, employment support services, and transfer to work benefits. In some cases, recipients of benefits are compelled to obtain employment assistance as a condition of obtaining benefits.

The following table shows that Vancouver agencies offer the bulk of employment assistance services in the region followed by the South of Fraser sub-region. There are no employment assistance services targeted to this group in several sub-regions, and there appear to be no services with a region-wide orientation.

Table 14: Employment assistance services in Greater Vancouver

Sub-region	Number of services	% services
Vancouver	13	57%
South of Fraser	6	26%
Inner municipalities	3	13%
North Shore	1	4%
Northeast Sector	0	0
Ridge Meadows	0	0
Region-wide	0	0
Total	23	100

Source: Inventory of services and facilities, Sept 29, 2000.

Local providers note that services are fairly fragmented by target group and/or eligibility criteria, and it is often difficult to find a service suitable for certain individuals. Youth are a particular focus for organizations offering employment assistance services. This is followed by services for

people with special needs, primarily mental health consumers. We found few or no services focusing on the employment assistance needs of Aboriginal people and women, although the need for gender specific or culturally specific services is unclear. Service providers indicate that Caucasian men between 20 and 40 years are particularly under-served. It is important that suitable employment assistance services are in place to help all individuals when needed.

Table 15: Employment assistance services for specific target groups

Target Group	Number of services	% of services
Youth	9	39%
Women (and families with children)	1	4%
Immigrants and refugees	2	9%
Urban Aboriginal People	0	0
Seniors	N/a	N/a
Low Income Urban Singles – adults	6	26%
People with Special Needs	5	22%
Total	23	100 %

Issue

Insufficient emphasis is placed on providing employment assistance to a range of individuals.

Policy Statement

30) Ensure that employment assistance services meet the needs of all individuals who are homeless or at risk.

Strategies

a) Identify gaps and needs for employment assistance services for the diversity of individuals who are homeless or at risk of homelessness throughout Greater Vancouver.
b) Expand eligibility of existing services or implement new targeted employment assistance for people not presently being served.

Mainstream employment strategies are ineffective

Providing homeless individuals with employment opportunities is necessary to break the cycle of homelessness.[22] However, there is evidence that mainstream employment and training programs are not effective in connecting homeless individuals with jobs, and a more specialized approach is required.[23] There are some examples in Canada and other countries where employment initiatives are specifically targeted to homeless individuals, and are part of a long-term strategy to address homelessness. Bladerunners and Option Youth Society's Picasso Café are some local examples. A variety of different approaches have been undertaken. Some initiatives involve partnerships

[22] BC Ministry of Social Development and Economic Security and Ministry of Municipal Affairs. *Local Responses to Homelessness: A Planning Guide for B.C. Communities*. 2000

[23] Rog, Debra and C.Scott Holupka. "Reconnecting Homeless Individuals and Families to the Community." in Fosburg, Linda and Deborah Dennis (eds.) *Practical Lessons: The 1998 National Symposium on Homelessness Research*. US Dept of Housing and Urban Development and Dept. of Health and Human Services. August 1999.

with private sector companies that provide training and on-the-job paid work experience. In other cases, non-profit groups have created business ventures that provide paid training and work experience for individuals who were previously homeless.

A community development approach was supported by Toronto Mayor's Task Force to create jobs for people with extremely low incomes and social assistance recipients. This approach involves the creation of small businesses by a community group to enable poor and unemployed people to participate in their community and achieve greater economic independence. These businesses are unique in how and why they were established, how they are managed, working conditions, and the nature of profits. They aim to create a welcoming, supportive social location for their employees while improving their financial status. Community economic development can provide an alternative approach to job creation for homeless individuals.

Issue

Mainstream employment and training programs are not effective in connecting homeless individuals with jobs. New approaches that are specifically targeted to homeless and homeless at risk individuals are required.

Policy Statement

31) Creating employment opportunities for homeless individuals through non-traditional means is essential to reduce homelessness.

Strategies

a) Develop new approaches that are specifically designed to create employment opportunities for people who are homeless and at risk. This should include community economic development initiatives.
b) Support regional strategies that would assist individuals working in low paying jobs to access higher paying employment opportunities through skill development and regional economic development.

4.3.2 Employment insurance

Many unemployed people are ineligible for employment insurance

While unemployment rates have dropped recently, a significant number of Greater Vancouver residents are unemployed. Many of these individuals seek employment insurance benefits. Canada's Employment Insurance system is designed to provide income support to people who temporarily lose their jobs and to help them return to work. Changes to the employment insurance system since the 1990s have lead to a dramatic decline in the number of BC residents who qualify for insurance benefits. In 1992, 77% of unemployed people in BC qualified for insurance benefits. By 1997, the percentage of individuals who qualified for these benefits fell to 49%, and as of July 2000, only 37% of unemployed British Columbians qualified for employment insurance benefits24. This has had a significant impact on the provincial government's income assistance caseload. In 1996, one in six new income assistance cases involved an applicant whose EI benefits had run out, while many others applied for income assistance because they did not qualify under new eligibility criteria.

[24] BC Statistics, *Infoline Report,* Ministry of Finance and Corporate Relations, March 20, 1998 and subsequent conversations with MSDES.

Another issue concerns the waiting period for obtaining EI benefits once approved. Eligible individuals may face an eight-week period before receiving their benefits. During this time they are ineligible for BC Benefits. According to service providers this is a major difficulty for some individuals who have no other source of income. Shelter providers say they see many clients using their facilities while waiting for EI benefits.

Issue

A significant share of unemployed individuals is ineligible for benefits under Canada's employment insurance system. Those who are eligible face a lengthy waiting period before benefits become available. This may cause extreme hardship.

Policy Statement

32) Most unemployed individuals should be able to access EI benefits and the waiting period should be reduced.

Strategies

a) Request that the federal government expand eligibility criteria for Employment Insurance benefits to ensure that 70% of individuals who apply are eligible for benefits.
b) Request that the federal government reduce the waiting period for obtaining benefits.

4.3.3 Income assistance

BC Benefits, the provincial government's income assistance program, supports eligible people who are participating in job search and work preparation programs, as well as those with disabilities or families who cannot work. Approximately 5% of the Greater Vancouver population were recipients of BC Benefits in 1999 according to Ministry of Social Development and Economic Security (MSDES) data. There are variations in the share of recipients living in each sub-region. Of about 83,000 income assistance cases for Dec. 1999, 37% were in Vancouver, 16% in Richmond, Burnaby and North Shore combined 24% in North Fraser, and 22% in Fraser South.[25]

Lack of access to benefits

Restrictions to eligibility criteria introduced in 1998 influence the number of people at risk of homelessness. Persons who quit their jobs or are dismissed for just cause are not eligible for regular assistance for 30 days. If they refuse to accept or pursue employment, they are not eligible until they do so. However, if they have children, they may be eligible for repayable hardship benefits. Persons with an outstanding indictable warrant were not eligible for assistance until recently, when this provision was changed. Other requirements for obtaining benefits such as attending a pre-eligibility orientation day are difficult for some people to comply with.

Youth under 19 who are living away from home may be eligible for BC Benefits. The major issue for some youth is that the MSDES will attempt to make contact with the parent or guardian to determine if the youth is 'welcome' at home (if the child will not be endangered at home). If the youth is 'welcome', he or she is ineligible for income assistance. In cases where there are

[25] GVRD, *Key Facts*, 2000.

child protection concerns for an applicant under 19 years of age, or the applicant is less than 17 years of age, a referral would be made to the Ministry for Children and Families.

The youth agreement implemented by the Ministry for Children and Families in 1999 is an alternative to income assistance for youth age 16 to 18 years. These agreements are intended for youth living apart from their families, who are at some degree of risk, but do not require the full child protection response. It may consist of residential, education or other support services and/or enhanced financial support. However, again, the law requires that the parent or guardian must be contacted, posing a concern for some youth. Service providers suggest it is difficult to obtain access to these benefits because of onerous eligibility criteria and there are few youth with agreements.

Issue

Some people in need of assistance are ineligible for income assistance benefits and cannot access housing or emergency shelter. Barriers prevent people with significant problems from applying for and maintaining benefits.

Policy Statement

33) Income assistance eligibility should be based on need.

Strategy

a) Request that the provincial government expand eligibility and reduce barriers to obtaining BC Benefits.

Benefits inadequate to afford decent accommodation

Inadequate income assistance rates are too low to permit people to rent decent rental housing in the market place particularly in the Lower Mainland. While basic support rates were raised earlier in the year 2000, this did not affect the shelter component. There are virtually no bachelor units available within the current maximum monthly BC Benefit shelter allowance in the Vancouver CMA.[26] While a couple could find bachelor accommodation, they would be hard pressed to find a one-bedroom unit within the maximum shelter allowance. Similarly, a couple with one child would have minimal access to a two-bedroom unit. A single parent with two children searching for a three-bedroom unit has virtually no access to these units.[27]

26 The CMHC survey includes permanent rental accommodation in apartments and row housing but does not include units in SROs or in single family dwellings (e.g. secondary suites). The BC Benefits shelter allowance covers actual provable shelter costs up to the maximum.

27 Social Planning and Research Council of BC, January 2001.

Table 16: Proportion of market rental housing units available within BC Benefits shelter maximums

Number of People	Maximum Monthly BC Benefits Shelter Allowance	Unit Type	Units Available		Total Number of Units	Average Rent Van CMA
			%	#		
1	$325	Bachelor	0.6%	70	11,752	$598
2	$520	Bachelor	25%	943	11,752	$598
		1 Bedroom	3.5%	2,254	64,973	$695
3	$610	2 Bedroom	1.1%	286	26,897	$890
		3 Bedroom	0.6%	25	4,470	$1,022
4	$650	2 Bedroom	5.1%	1,384	26,897	$890
		3 Bedroom	0.6%	28	4,470	$1,022
Source: Social Planning and Research Council of BC, January 2001, based on CMHC Rental Housing Market Information (October, 2000 survey).						

Households are unable to afford average monthly rents based on the amount they receive for shelter from BC Benefits. Average monthly rents consume between 115% of the shelter allowance for two persons seeking a bachelor unit up to 184% for a single person seeking a bachelor unit.

Table 17: Rent as a Share of BC Benefits Shelter Allowance

Number of People	Maximum Monthly BC Benefits Shelter Allowance	Unit Type	Average Rent Van CMA	Average Rent as % of Shelter allowance
1	$325	Bachelor	$598	184%
2	$520	Bachelor	$598	115%
		1 Bedroom	$695	134%
3	$610	2 Bedroom	$890	146%
		3 Bedroom	$1,022	168%
4	$650	2 Bedroom	$890	137%
		3 Bedroom	$1,022	157%

Source: Consultants using SPARC data.

Accommodation that is affordable to income assistance recipients is typically a room in a SRO hotel or rooming house. People living in SRO units are considered to be 'at risk' of becoming homeless since many of these units are neither adequate nor affordable. The rooms are small, do not contain a bathroom and are of poor quality. These units typically rent at the shelter component of welfare. There is concern that an increase in the shelter component of income assistance would not benefit recipients if landlords raised rents for these same units accordingly.

Canadian literature shows that between 50% and 60% of homeless people tend to be on income assistance.[28] Thus even those eligible for income assistance may have difficulty maintaining

[28] Canadian Centre for Social Development, 1987, McCreary Centre Society, 1994, and Eberle et al. Forthcoming.

housing for a variety of reasons. In BC, individuals who are eligible for benefits and homeless receive basic benefits but not the shelter component.

Issue

The shelter component of BC Benefits is insufficient to permit recipients to obtain decent housing in the marketplace.

Policy Statement

34) The shelter component of BC Benefits for all household sizes should reflect average market rents.

Strategy

a) Request that the provincial government raises the shelter component of income assistance and considers mechanisms to mitigate against adverse impacts, for example, to prevent landlords from raising rents commensurate with the increase in the shelter component.

4.4 Deliver support services

A range of support services is necessary to meet the varied needs of homeless individuals and individuals at risk of homelessness. The continuum of housing and support consists of outreach services, drop in centres, health services, mental health services, substance misuse services. prevention services, Aboriginal services and youth services.

4.4.1 Outreach services

Outreach services include programs or initiatives that are delivered by individuals who go directly to the client rather than waiting for the client to come to them. These services play a critical role in the continuum of housing and support. The goals of outreach include helping homeless people access whatever services they need, including a place to live. Street outreach workers generally walk the streets in designated geographic areas. They identify homeless individuals, engage them in a positive way, assess their needs, help connect them with services (e.g. food, drug and alcohol treatment, health care, income assistance, and shelter), maintain ongoing contact, and help facilitate a process of transition to enable them to obtain housing. Outreach workers aim to build a sense of trust with the street population and service agencies. They also work hard to advocate for access to services on behalf of the individuals they work with. Sometimes, the goal of outreach workers is simply to help keep homeless individuals alive.

In order to engage homeless individuals, it is necessary to go to them and meet them on their own terms. Outreach can help bridge the gap between the street and mainstream communities. In addition, outreach workers have a presence on the street. They know who is part of the street community, what is going on, and where people are staying. They understand the legitimate needs of their clients and can help them access the services they need to get off the street. Some individuals (e.g. persons with mental health issues) may be reluctant or too disorganized to obtain medical help on a regular basis. Outreach workers may provide assistance with keeping medical appointments, paying rent on time, other day-to day issues, and social support. Outreach workers can also help service agencies keep track of their clients and can help housing agencies keep track of individuals who may be on a waiting list so they can be contacted when a unit is available.

The issue raised most consistently by individuals providing outreach services is the lack of services in the community where they can refer clients. Once a homeless person has been engaged, what then? Most of the existing services are full and waiting lists are long.

The need was identified for more places that provide free food, shelters, services (including shelters) targeted specifically for women, outreach health services, and permanent affordable housing (particularly outside the Downtown Eastside). The need was also identified for more services targeted specifically for youth, including shelters, detox facilities, long term treatment centres, specialized foster homes for youth with fetal alcohol syndrome and youth who have experienced sexual abuse, crisis beds, transition housing, safe house beds, and lifeskills training.

In addition to long waiting lists, outreach workers also noted that their clients face many barriers to services. For example, access to services may be denied if homeless individuals are not eligible for income assistance, if they have mental health issues, or if they have used alcohol or drugs within the last few days.

Availability of outreach services

Outreach services may be targeted to specific populations, such as youth or individuals with mental health issues, or they could be provided to anyone on the street. Table 18 below shows

that most of the outreach services currently operating are targeted to youth in Vancouver. Outreach services for youth outside of Vancouver are more limited.

Mental health clients throughout the region have access to outreach services through the mental health services system (e.g. Assertive Community Treatment see section 4.4.4). Some mental health housing agencies, such as the Mental Patients' Association and Coast Foundation Society also provide outreach services to this population. The Interministerial Program is targeted to mental health clients in Vancouver who have also been involved with the criminal justice system. Case managers work with about 10 clients at a time. They provide assistance with lifeskills issues, provide social support and help individuals become more engaged in the community activities over time, and help connect individuals to services including treatment and better housing.

Based on the regional inventory and conversations with service providers, there are not enough outreach services for adults in the region. This is particularly true for adults who are not connected to a mental health team. In Vancouver, the Vancouver Recovery Club provided outreach services for about 5 years until the spring of 2000. From one to 4 outreach workers (depending on the time of day) walked the streets in the downtown core from 9:00 a.m. until 11:00 p.m. seven days a week and provided information to homeless people about where they could obtain a free meal, shelter, medical care, and detox or treatment services. The termination of this program has left a significant gap in Vancouver, and no other agencies have been identified that provide such outreach services in other parts of the region.

Table 18: Outreach services in Greater Vancouver

Sub-region	Youth	Urban Aboriginal	Mental Health	All	Total	% facilities
Vancouver	5*	1*	2	1	9	64%
South of Fraser	1	0	0	0	1	7%
Inner Municipalities	2	0	1	0	3	21%
North Shore	0	0	0	0	0	0%
North East Sector	0	0	0	0	0	0%
Ridge Meadows	0	1	0	0	1	7%
Total	8	2	3	1	14	100%

Source: Inventory of Facilities and Services, Sept 29, 2000
* Also includes Covenant House – not identified in inventory
** Aboriginal Youth

Issue

There are not enough outreach services in Greater Vancouver.

Policy Statement

35) Outreach services are an essential component of the continuum of housing and support and should be provided in communities throughout Greater Vancouver for all homeless individuals.

Strategy

a) Provide more outreach workers throughout Greater Vancouver to identify and work with all types of homeless individuals, engage them in a positive way, assess their needs, help connect them with services (e.g. food, drug and alcohol treatment, health care, income assistance, and shelter), maintain ongoing contact, and help facilitate a process of transition to permanent housing.
b) Provide outreach services that meet the needs of homeless individuals 7 days a week in areas where appropriate.

Lack of a co-ordinated intervention approach

The homeless service system in Greater Vancouver has developed over many years to meet specific, often crisis needs in various locations. The result is a host of providers offering an array of services for particular groups of homeless people. There has been no overall co-ordination or planning on a regional or community wide basis. While there are problems with this approach for service delivery and gaps in services, it has also resulted in a situation that may be confusing for those seeking services. People who are homeless may not know what is available, or may have to obtain services from several different locations or individuals. It may result in someone who is homeless "falling through the cracks".

Several community agencies have identified a need for greater co-ordination of services among agencies that serve homeless individuals. This could assist in making better use of resources, and provide better linkages. For example, it was suggested that if outreach workers are attached to services that provide assistance in crises, this might help to ensure that homeless individuals are more easily connected to appropriate services. It was also suggested that there should be greater co-ordination among agencies in different municipalities within the region, particularly for transient youth.

The Hard-Targeting Initiative is one example of an approach that is intended to provide a co-ordinated intervention approach for high risk youth that are street-involved or at risk of becoming street involved. The co-ordination is provided by the Downtown Eastside Neighbourhood Safety Office and partners include: community based youth outreach services, safe house/group home staff, youth detox, police, neighbourhood houses/community centres, Adolescent Services Unit (MCF) and other MCF social workers, needle exchange staff and mobile health services. The goal is to develop a consistent plan for dealing with the youth. Hard targeting meetings are held once a week. Participants discuss particular youth that have been identified as high risk, develop a strategy for intervention, and assign duties. Plans for youth presented at a previous meeting are reviewed and if the plans have proven to be inadequate or inappropriate, they are modified.

The need has also been identified to provide more continuity in services when dealing with clients. For example, an outreach worker may connect with an individual on the street, and then encourage them to meet them somewhere else (off the street) for additional services. Covenant House provides outreach services for youth and also tries to encourage youth to access their in-house services.

Enhanced communication and education about the availability of community resources for people who are homeless would also help to ensure homeless individuals are knowledgeable about the options and are able to obtain the services they need.

Issue

A lack of a co-ordinated intervention approach among agencies and individuals that work with homeless people results in a situation where some people "fall through the cracks."

Policy Statement

36) A co-ordinated intervention approach and continuity with outreach workers is necessary to ensure that homeless individuals receive the level of support they need.

Strategy

a) Agencies that work with the homeless population in Greater Vancouver should develop a strategy to ensure more co-ordination and communication. Goals should include being able to develop plans for individuals so that they can benefit from the full continuum of housing and support services, and providing some continuity with outreach workers or other personnel while they move through the continuum.
b) Develop communication and education strategies targeted to people who are homeless to publicize the availability of community resources.

4.4.2 Drop in centres

Drop-in centres can play an important role in the daily life of a person who is homeless. Along with outreach, drop-ins may be the first point of contact with services for a person who has become homeless. Drop-in centres usually offer people the ability to come in off the street where it is warm and dry, have a coffee, a meal, use a washroom and/or shower, wash clothes, obtain counseling and referral to other services, and obtain help with finding housing. Some centres offer life skills, employment and skills training as well. Some are stand alone facilities; others are part of an emergency shelter or other related service. Hours of service vary from 24-hour to evening only service to daytime service. Some drop-in centres permit clients to sleep on a mat or couch if necessary. They also differ in their willingness to serve people who are under the influence of drugs or alcohol, with some being more flexible than others are.

The regional inventory identified 24 drop-in centres throughout Greater Vancouver. However, only three facilities offer 24 hours of service daily. Two of these are in Vancouver; the other is in Surrey. With the exception of the Northeast Sector, there is at least one drop-in in each sub-region. However, most of drop-ins are located in Vancouver (71%). Almost half of the drop-in centres are open to all individuals. There is at least one drop-in centre region-wide for each sub-group, with the exception of refugees. Information on the number of people served at each drop-in centre was not included in the regional inventory.

Table 19: Drop-in centres in Greater Vancouver

Sub-region	Youth	Women	Refugees /multi-cultural	Urban Aborig-inal	Mental Health	All	Special Purpose [29]	Total	% facil-ities
Vancouver	3	3	0	1	3	5 1 (24 hr)	1 (24 hr)	17	71%
South of Fraser	1	0	0	0	0	1 (24 hr)	0	2	8%
Inner Municipalities	0	0	0	0	1	2	0	3	13%
North Shore	0	0	0	0	0	1	0	1	4%
North East Sector	0	0	0	0	0	0	0	0	0
Ridge Meadows	0	0	0	1	0	0	0	1	4%
Region-wide	4	3	0	2	4	10	1	24	100%

Source: Inventory of Facilities and Services, Sept 29, 2000

Urgent priority needs identified through the planning process include more drop-in centres particularly those that offer 24 hour service daily, and those that meet the needs of a wide range of clients including refugees, individuals with substance misuse issues and criminal justice involvement, and intravenous drug users. Particular locations identified included Surrey, Langley and the North Shore.

Inadequate access to drop-in facilities

24-hour service is an important feature of a drop-in that is flexible and meets the needs of people who are homeless. It enables those who are most vulnerable to find the services and support they need, when they need it. Homeless people who must travel by public transit, find it is not possible to travel by bus to another drop-in at 4 am. Drop-in centres that are open 24 hours a day, 7 days a week are currently available in only two of the six Greater Vancouver sub-regions. Where needs have been identified, at least one facility should provide 24-hour service in each sub-region. This may mean converting an existing daytime only facility to one that provides 24-hour service.

Issue

There is inadequate access to drop-in facilities for homeless people.

Policy Statement

37) Residents of communities throughout the region should have adequate access to 24-hour drop-in centres.

Strategy

a) Develop new 24-hour drop-in centres in communities around the region where needs have been identified.
b) Add staff at existing drop-in centres to permit 24-hour operation.

[29] For recovering alcoholics.

Drop-in centres unresponsive to unique needs

While region-wide there is a range of drop-in centres that are meant to serve the unique needs of women, youth, families, persons with mental illness or substance misuse issues and others with special needs,, this is not the case in communities around the region. For example, there are no female only facilities outside of Vancouver. Gender specific service can be extremely important to a woman who has been a victim of male violence. Likewise, drop-in centres that cater to the distinct needs of youth, by offering recreational programming and younger staff are more likely to be frequented by youth. And it may be better in some circumstances to keep youth separate from adults.

Meeting diverse needs does not necessarily mean distinct centres for each group. but rather that services are designed to be flexible and to accommodate diverse needs. However, in some instances, specialized resources may be necessary. People who are under the influence of drugs or alcohol are not permitted to use some drop-in centres. Staff finds that they are too disruptive of other clients and/or they do not have the staff resources to deal with them. This results in a situation where people who are vulnerable and need the safety and protection offered by drop-in centres are not able to access them. A dedicated drop in centre serving individuals in this condition may be preferable.

Issue

Women, youth, families, persons with mental illness or substance misuse issues and others with special needs find that drop-in centres are not always responsive to their unique needs. They may choose not to use the service at all, which means that their basic needs are not being met.

Policy Statement

38) Drop-in centres must seek to accommodate the diverse needs of people who are homeless.

Strategy

a) Identify funding for staff training to develop the expertise to serve individuals with a broad range of issues, including those with complex needs in existing facilities.
b) Develop separate drop in centres for each group where necessary.

4.4.3 Health Services

The homeless, or those at risk of homelessness, are more susceptible to physical ailments than the general population.[30] Common illnesses for this target population include, but are not limited to, abscesses, cellulitis, general foot and hand care, scabies, lice, arthritis, diabetes, endocarditis, bacteremia, hypertension, respiratory problems, liver disease, HIV/AIDS, TB, antibiotic resistant infections, drug or alcohol crises, and the consequences of trauma and violence. Lack of shelter and poor nutrition, combined with mental illness, addictions and the stress these conditions

[30] Mayor's Homelessness Action Task Force, *Taking Responsibility for Homelessness: An action plan for Toronto*, 1999
O'Connell, James J., *Utilization & Costs of Medical Services by Homeless Persons*, (Apr.1999): 3, online, Internet, 7Jan2001
McMurray-Avila , Marsha, *Medical Respite Services for Homeless People: Practical models*, (Dec.1999): 2,online, Internet, 6 Jan. 2001

engender, create a climate ripe for physical disease. Death occurs at a far higher rate per age group than in the housed population.[31]

Many of the conditions experienced by the homeless and at risk population are treatable through primary health care. Primary health care is considered to be those services provided without referral. A number of sites exist in Greater Vancouver to deliver primary health care to the homeless and those at risk. It should be noted, however, that to ensure recovery and, where possible, avoid further incidence, full treatment for a condition can involve secondary and tertiary care (i.e. specialists and hospital stays), various clinical tests, a convalescent phase, and a range of social services.

Services available for primary care to the homeless and those at risk of homelessness include:

1. Hospital emergency wards.

2. General Clinics
   a) The Vancouver/Richmond Health Board (VRHB) believes that an individual's care is better administered in a clinic setting offering a broad range of services. To this end, they have established a number of Community Health Care Centres and plan for several more. These centres are comprised of a Primary Care Clinic staffed by physicians, an Infant and Child Care component including pre-and post-natal care, parenting, school and day care visits, and immunizations, and a sections staffed by other health and community care workers, such as occupational and physio-therapists, nutritionists and social workers. Drug and alcohol counselling is available through the centres or by referral, and there are plans to provide greater access to mental health care.
   b) A number of clinics in Vancouver and one in Surrey, located in areas where the homeless and at risk are known to live and congregate, have been designed to serve this population as well as the general population. Attempts have been made to make people who are homeless feel comfortable in the clinic's setting. No appointments are required for primary care and staff is trained to provide services specific to their needs. As well as medical care, services in these clinics may include nutritional and housing information, drug and alcohol counselling, aiding the individual to apply for a Care Card so that he/she may consult a specialist or obtain a medical test, and helping the individual access financial aid. In addition, some clinics sponsor life-style support groups.

   The Simon Fraser Health Region is presently conducting a review of their entire primary care delivery service. They recently completed a 4-month pilot outreach mobile primary care program where nurses travelled to sites identified as places where the homeless and those at risk congregate. The pilot program served a population significant enough to demonstrate need, and this population will be included in the review. Providers have said that until recently funds to serve the homeless and at risk population were not readily available to areas outside Vancouver because it was not deemed to be an issue. In areas where there are no public health clinics, the first point of contact for those who are homeless or at risk, who may be transient and therefore do not have a primary care physician, is the emergency rooms of the region's hospitals. This may be true for even in areas with public health clinics.

[31] O'Connell, James J., op.cit. 4

2) Clinics with specific targets

a) *Youth* – There are stand-alone youth clinics in all the health regions, though not in all the sub-regions as identified in this Plan. In Vancouver, e youth are treated in the Community Health Care Centres. Some of these Care Centres target youth, while still offering care to all. Youth clinics serve young people up to the age of 19 or 21 or 25, depending on the clinic. The mandates of the stand-alone youth clinics tend to involve sexually transmitted diseases, related counselling and health education, pregnancy tests, birth control information and the supervision of certain medications. The services are free, confidential and do not require a Medical Services Plan number.

b) *Substance Misuse* – Although this population is treated at many of the clinics in Greater Vancouver, there are a few clinics which focus on substance misuse. An example is Sheway, a multi-disciplinary clinic in the Downtown Eastside, which cares for pregnant female substance misusers and their children up to 18 months. Staff at Sheway includes an outreach worker, a social worker, drug and alcohol counsellors, and a nutritionist. Funding comes from the V/RHB, the provincial Ministry of Children and Families, the YWCA, Vancouver Native Health and Health Canada.

c) *HIV Positive* – At least 6 clinics in the region are targeted to this population, 3 in Vancouver, 1 in Burnaby, 1 in Richmond and 1 in Surrey.

Table 20: Public Clinics in Greater Vancouver

Sub-region	**General primary care; do not require a care card**		**With a target population (e.g. HIV/AIDS, youth, etc.)**	
Vancouver	7	88%	6	43%
Inner Municipalities	0	0	4	29%
North Shore	0	0	1	7%
South of Fraser	1	13%	3	21%
Northeast Sector	0	0	0	0
Ridge Meadows	0	0	0	0
Total	8	100	14	100%

3) Mobile Services

a) The Downtown Eastside Health Outreach Van targets high risk individuals such as dual diagnosis clients, IV drug users, street youth, and sex trade workers. The van provides services in shelters, hotels, drop-in centres, and on the street. Nurses provide primary care such a dressings, vaccinations, and attention to respiratory ailments, as well as emotional/psychological support during and after hospital stays, and meal delivery and nutritional aid. Staff make referrals to detox and mental health services, and provide follow-up care after discharge from hospital until home care services can be arranged. In 1999 demands on the Outreach Van almost tripled

b) The Vancouver Native Health Society provides outreach services for people who are HIV positive.

c) Needle exchange vans travel in Vancouver and down the Kingsway Corridor.

d) Outreach nurses visit some shelters on a regular schedule.

The need for access to medical history

To adequately treat an individual, it is necessary to have access to their medical history. Without this, medical patterns cannot be discerned and there is no record of previous treatment, tests, medications and immunizations. This might well lead to either too much or too little care. Several

health care providers have noted that some patients have been over-immunized as a result of not being able to access an individual's health records.

Non-access to previous treatment can result from a patient not remembering details of care. This is then compounded by the variety of heath services – clinics, emergency rooms, and outreach – each keeping separate records on that patient. A number of health care providers have indicated that to treat patients properly they need a safe, secure, electronically-accessed site from which they can retrieve an individual's health record. Such a site would have to adhere to strict patient confidentiality, while still being readily available to providers. The V/RHB has begun work on such a record keeping system. They are now tracking immunizations only.

Issue

Health care providers are often unable to access a patient's complete medical record due to the number of different services available to a patient and the lack of central database.

Policy Statement

39) There should be a patient record data base system(s), adhering to strict patient confidentiality, which can be electronically accessed by health care providers so that they can give proper service to their patients.

Strategy

a) Encourage the health authorities to determine the need for a patient record data base system, and where appropriate, devise a suitable data base that adheres to strict patient confidentiality while being readily usable to health care providers.

The importance of convalescent beds to the homeless and at risk population

In the housed population, an individual with an illness visits a family doctor and then goes home to recover. If that person is hospitalized, he/she usually recuperates at home as well. Food is easily available and medication can be kept in the proper conditions and taken at the right time. But the homeless or those at risk are unlikely to have an adequate place in which to convalesce from any illness or trauma, major or minor. An individual living on the second floor of a walk-up, with a bathroom down the hall, who breaks his hip, cannot go back to his room upon leaving hospital. Instead he requires a convalescent bed where care can be provided and meals served until he can climb stairs again. A homeless individual suffering from a condition that in the housed population is easily treated and cured, might well need a place to recuperate to prevent that condition from flaring into something serious, requiring treatment traumatic to the individual and far more expensive.

It has also been noted that in the absence of convalescent beds, doctors may more readily admit the homeless or those at risk to high-cost acute care hospital beds. An English study noted that the homeless population was being admitted to hospital for much milder conditions than the housed population.[32] Anecdotal evidence in Vancouver indicates that patients may well be kept in hospital longer than is necessary because no adequate recuperative bed can be found for them.

There are a number of options for recuperative or convalescent beds. These might include:

- A medical unit;

[32] ibid.

- Emergency shelter-based models where the shelter contains a discrete 24-hour staff unit, or where beds in the shelter are made available on request and then served by on-call staff; and
- Motel/hotel units or referrals to continuing care facilities.

Convalescence is part of a continuum of care. The homeless should not be expected to recover in the streets or in inadequate housing. If full recovery is to be made and recurrence minimized, recuperation must include prevention and social services along with nursing care and food delivery. As well, convalescent beds in emergency shelters should not become a burden on the shelter. Such beds should be full funded and be in addition to the shelter's capacity. In Vancouver, recuperating homeless individuals or those at risk are sometimes being placed in existing emergency shelter beds with support services brought in as needed via outreach staff. In the opinion of one provider, emergency shelters are becoming places that warehouse people who need medical care because there is no place else for them to go. There is particular need for long term convalescent care for brain-injured individuals. These individuals often need to recuperate for longer than they can stay in a shelter.

The hotel/motel option has been suggested as the most suitable for a homeless family where one member is ill.

Issue

There is a need for convalescent beds for homeless individuals and those with unstable accommodations who are recovering from an illness or trauma.

Policy Statement

40) There should be adequate convalescent health services available to individuals who are homeless or in unstable accommodations throughout Greater Vancouver as needed.

Strategy

a) Encourage health authorities to determine where the need exists across Greater Vancouver and assess the best method(s) for providing convalescent care for the homeless or those at risk.

The need for dental care for the homeless or those at risk

Dental care is a necessary part of the continuum of health. Early detection of problems and good oral hygiene can avoid serious problems, such as tooth loss or dental abscesses. Periodontal disease can develop into infections that lead to strokes, heart attacks, respiratory diseases and premature babies.

Many families in British Columbia have dental insurance through their place of employment. For children of families without such insurance, the province offers a preventative dental program. As well there are outreach services in elementary schools and selected day cares. Dental hygienists and certified dental assistants also provide adults in group homes and long-term care facilities with similar outreach oral hygiene services. However, providers of care to the homeless and those at risk have indicated a lack of dental services across Greater Vancouver for this population. Anecdotal evidence suggests that for adults, the dental care received is more invasive and less preventative than for that found in the housed population.

Issue

There is a lack of dental health services in Greater Vancouver for adults who are homeless or at risk, and it is sometimes difficult for children to access complete dental care.

Policy Statement

41) Dental care is part of good health care management and should be offered as a service where needed to the homeless and those at risk in Greater Vancouver.

Strategies

a) Encourage health authorities to assess the need for dental care for the homeless and those at risk in Greater Vancouver, and establish services where needed.

4.4.4 Mental Health Services

Mental health services cover a broad range of inpatient and outpatient services and programs that are best delivered through an integrated system and provided in each local mental health area. The system should encompass a continuum of services and be flexible enough to respond to the changing needs of clients.

There is general agreement among service providers that between one third and one half of individuals who are homeless suffer from a serious mental illness such as schizophrenia or bipolar disorder. The illness is often exacerbated by the difficulty of receiving appropriate mental health services while not living in permanent accommodation. Clients who are transient, or have unstable housing, present a unique set of challenges for the delivery of mental health services.

The over representation among the homeless population of individuals with a severe mental health problem is one of the most visible manifestations of the failure in the 1970s and 1980s to co-ordinate deinstitutionalization with the development of a comprehensive range of community mental health resources. Although there are currently a wide range of services available (see Table: 1 below) including emergency services, case management, outreach, and acute care, these services evolved in a piecemeal manner. The process has lacked focus and there has been minimal co-ordination among providers until recently. Programs and services have been developed in ways that do not always accommodate complex and changing consumer needs.

The situation is further complicated for multi-diagnosed clients, such as those with a long-term serious mental illness combined with substance misuse, drug and alcohol dependencies, Fetal Alcohol Syndrome/Effect and HIV/AIDS. Appropriate treatment and care for these individuals is often a shared responsibility across several provincial ministries, service agencies and the local health region.

While the four health regions in Greater Vancouver have made steady progress in the implementation of both best practices in mental health care and community-based delivery, the provision of these services to homeless people and those at risk continues to present serious challenges. All the health regions have included the development of services for people at risk in their strategic planning, but outside of Vancouver these services are more limited.

Research and practice has demonstrated that appropriate specific treatments and services can be effective for mental illness. Many of the services and practices now in place in the region are derived from evidence-based research and work well. However, there is not adequate capacity throughout the system to meet the mental health needs of those with a serious and persistent illness. The 1998 BC Mental Health Plan clearly established the target population to be served and the range of services required, but for a variety of reasons adequate levels of funding have not been provided to support and increase the capacity of the system.

Table 21: Mental Health Services

Sub-region	Assertive Community Treatment and Bridging (teams)	Emergency Shelter/Short Stay/Crisis and Respite (beds)	Hospital Psychiatric Acute Care (beds)	Mental Health Centres (teams)	Riverview (tertiary beds)
Vancouver	2	103	143	8	
South of Fraser	4	18	74	5	
Inner Municipalities	2	10	54 Burnaby and New West 20 Richmond	6	
North Shore	1	6	26	4	
Northeast Sector/ Ridge Meadows	2	10 (same beds as the Inner Municipalities)	15	2	
Province-wide					808

* Source: Inventory of Facilities and Services, Sept 29, 2000 and information gathered from interviews

The importance of Assertive Community Treatment for complex needs

Assertive Community Treatment (ACT) provides flexible comprehensive intensive services to individuals with complex needs. The target population has a serious and persistent mental illness, other functional disabilities and is an intensive user of services. ACT is different from other case management models for the delivery of mental health services because it uses a low staff-to-consumer ratio, a team approach, assertive outreach, continuous services (24-hours/day, seven days a week) and attempts to connect clients to stable housing. ACT teams are located in all the sub-regions and generally operate with a similar mandate and approach.

The primary function of ACT teams is to focus on the reduction and management of symptoms through skill teaching, clinical management and support within the client's community. Clients may have been homeless at times in their lives because of repeated evictions and/or inappropriate social behaviours. They likely have substance misuse problems of significant duration.

The ACT program is targeted at intensive users of acute care beds, Riverview Hospital, jails and forensic services. Although ACT is an expensive alternative to other forms of community care it is relatively cheap when compared to the costs of acute care hospital beds or Riverview Hospital. The program is not adequately funded to meet the demand of those who qualify for the service.

Issue

There continues to be under-funding of Assertive Community Treatment and many individuals who would benefit from this approach are not served

Policy Statement

42) Assertive Community Treatment should be a priority response for individuals who qualify for the program and are intensive users of acute care beds, Riverview Hospital, jails and forensic services.

Strategy

a) Health authorities should determine the demand for additional Assertive Community Treatment by requesting health regions to demonstrate their need for additional ACT resources.
b) Health authorities should advocate that the Provincial Government meets the funding targets for programs and services outlined in the 1998 BC Mental Health Plan.

There are currently shortages of emergency shelter, short stay crisis and respite beds
If a mental health client is homeless in Vancouver, but not in crisis, they can be referred to Triage and Lookout Emergency Shelter. As well, up to 15% of their clients come from other communities in Greater Vancouver. Both facilities are licensed, have staff with knowledge about mental illnesses, a staff nurse and are closely linked to the mental health system. Lookout has an additional proposal for another licensed shelter under development on Yukon Street outside of the Downtown Eastside.

Although there are several emergency shelters outside of Vancouver, currently Lookout and Triage are the only facilities in Greater Vancouver to provide emergency shelter that includes mental health services (see Section 4.2.1 for turnaway statistics). There are two active proposals to develop new second stage/short stay housing facilities in New Westminster and Surrey. These proposals have the support of their respective health regions for funding to ensure that individuals with a serious mental health problem would be provided support and connected to appropriate services. However, if successful, neither of these facilities will be licensed.

Several facilities in Greater Vancouver provide emergency care or respite for individuals connected to the mental health system who are experiencing a crisis. Periodic or episodic decompensation, the return of psychotic symptoms, is a common experience for individuals with a serious and persistent mental illness.

- Venture is a 20-bed community care facility located in Vancouver that provides 24-hour residential treatment for clients of the Vancouver Community Mental Health Services (VCMHS). It provides a structured therapeutic program in a homelike environment. Verbal or aggressive behaviour is not permitted while in residence at the facility. The VCMHS also provides emergency response capacity through Mental Health Emergency Services – Car 87. The Vancouver Police Department and V/RHB jointly fund this service. Car 87 is available from 1900 to 0300 hours and includes a psychiatric nurse and a plainclothes police officer who undertake on site assessments seven days a week. Referrals are taken from any source.

- Winston Manor in Vancouver is an 8 bed respite/step-down facility in which two of the beds are reserved for step down use for individuals leaving a hospital, but not yet able to move to

residential care or supported housing. Six of the beds are intended for respite care for individuals living in a residential facility (24-hour licensed care) or mental health funded supported housing, but who need temporary separation from their living situation. Duke House, with 5 beds, located in Vancouver is also a step-down facility for individuals leaving hospital who require a period of time to stabilize and prepare to move on to supported housing.

- Two Community Residential Short Stay and Treatment (CRESST) facilities are located in New Westminster (10 beds) and Surrey (8 beds operational with 12 bed capacity) to serve the Simon Fraser and the South Fraser Health Regions respectively. These 24-hour licensed facilities provide emergency therapeutic and respite care in a structured environment. Referrals can come from acute care hospitals, licensed residential facilities or directly from psychiatrists. The South Fraser Health Region has recently added an emergency response unit, car 67, which is similar to Car--87 in Vancouver.

- The licensed Magnolia House (6 beds) provides crisis stabilization and respite care for the North Shore Health Region. The region also has an emergency response service that operates from 9:00 a.m. to 2 a.m.

- Scottsdale House located in Delta serves the South Fraser Health Region, but takes referrals from other areas. It is staffed 24-hours a day and provides emergency short stay housing and respite care, but does not provide medical care. Clients must be stabilized and able to self medicate. Referrals come from hospitals, Social Services and Mental Health Services.

The current facilities and services that provide emergency and respite care to those who are connected to the mental health system are operating at or very near capacity all the time in Greater Vancouver. The emergency shelter system is operating at or above capacity and can not provide appropriate care and assessment for all those who are homeless and have a serious mental illness.

Issue

The supply of emergency non-hospital shelter and respite resources for mentally ill individuals who are homeless or at risk is inadequate to meet current needs.

Policy Statement

43) Mentally ill homeless persons or those at risk who are not connected to the mental health system in their community should have access to emergency housing that includes professional mental health services throughout Greater Vancouver.

Strategy

a) Develop appropriate emergency shelter and respite beds for mentally ill clients throughout the region that include staff who are knowledgeable about mental health services in the community and are trained to provide mental health assessment and support.

Demand for emergency psychiatric hospital beds exceeds supply

Over the last few years a number of factors have caused additional pressure on the acute care mental health system in the Lower Mainland. The number of individuals admitted to acute care hospital beds has increased and the seriousness of their illness is increasing, thus requiring longer stays and blocking access to beds. The system has been operating at 100% capacity since 1996. In

some hospitals patients have to stay in emergency ward beds because there are no available beds in the psychiatric ward. These resources are often in such demand that patients are sometimes released prematurely before being stabilized and/or housing and care resources in the community have been identified or are available. This outcome can lead to the individual becoming homeless or forced to live in inadequate accommodation that may exacerbate the illness.

The mentally ill homeless person is often a chronic user of hospital emergency services. The use of these resources to stabilize and assess those with a chronic illness is both the most expensive intervention option and often the least effective method of providing a lasting solution.

Bridging teams/workers link users to more appropriate community resources. The ACT/Bridging Program in Vancouver has combined the functions provided by the ACT team with the Bridging Program initiated in 1993 as a partnership between Vancouver Community Mental Health Services and Riverview Hospital. Simon Fraser and South Fraser Health Regions share a bridging worker for New Westminster and North Surrey and Simon Fraser Health Region has another operating in the Tri-Cities/Maple Ridge. Bridging teams assist with the discharge of patients from hospital and the transition to community living. These services include:

- Assessing the client's needs while in hospital;
- Identifying resources in the community;
- Familarizing the client with available services;
- Connecting to drug and alcohol programs;
- Connecting to physical health resources;
- Co-ordinating early intervention and return to hospital if required; and
- Keeping the case manager informed.

Simon Fraser Health Region also has two Hospital Admission Diversion workers located in New Westminster and Maple Ridge. They find alternative resources to hospital admission and follow-up with their clients to determine if the placements are successful.

Although the bridging teams/workers described above provide the capacity to direct hospitalized patients away from emergency beds and into community mental health resources, often the lack of available resources delays discharge and therefore creates a backlog of patients who are waiting for admission to hospital beds. However, there are issues related to the discharge of patients from a hospital psychiatric ward in one region into a community resource in another region. There are currently no protocol arrangements in place to accommodate the reciprocal movement of program funding between health regions.

Riverview Hospital (RVH) is a provincial tertiary treatment facility. It admits patients from acute hospitals around the province, although predominantly from the Lower Mainland. Patients are referred for specialized assessment, diagnosis and treatment. Historically RVH was the only mental health resource in the province. In 1987 it had 1,220 beds, but the continuing development of the community based care model and the subsequent deinstitutionalization of the mental health system, reduced the capacity to the current 808 beds. Historically patients received treatment for varying periods of time and were discharged back to their community into the care of a mental health team or their doctor. RVH provides long-term refuge or sanctuary for many patients who for a variety of reasons can not be returned to community care including those who are seriously ill with related behavioural issues.

Riverview's policy is to release patients into planned community care. There are always a substantial number of RVH patients who have been treated and are ready to move to community care, but who must wait until housing and care becomes available. This has led to a constant

waiting period for referrals from acute care beds in hospitals to RVH and is partially responsible for the backlog the hospitals must manage. In short, the system is saturated.

There may be co-ordination issues related to admission requests from hospitals to RVH. However, the Lower Mainland Mental Health Steering Committee which includes representatives of all the health regions and Riverview, regularly looks at ways to improve the admissions process. As well, each health region has set up a co-management committee with Riverview to expedite admissions.

Issue

There is a constant backlog in acute care psychiatric beds in hospitals in the region, and the system is saturated. The release of seriously ill individuals without planned or available community care in place often leads to/or perpetuates homelessness. There are inadequate community care resources in the mental health system to accommodate individuals who qualify for these services.

Policy Statement

44) Individuals with a persistent and serious mental illness who require acute care beds or the specialized resources of Riverview Hospital should not have to wait an unreasonable time to be admitted and receive treatment.
45) Adequate community care resources must be funded throughout Greater Vancouver so that people waiting for release to the community from acute care hospital beds and from Riverview Hospital have appropriate housing and support services or licensed care.

Strategies

a) The four health regions in Greater Vancouver and Riverview Hospital should be encouraged to continue to improve co-ordination of admissions and discharges from Riverview.
b) A regional strategy should be developed to encourage the provincial government to meet funding targets for programs and services outlined in 1998 BC Mental Health Plan[33] and the federal government to immediately restore transfer payments to the provinces.

Individuals who are diagnosed with a less serious mental health problem are falling between the cracks

In the early 70's the Greater Vancouver Mental Health Services Society (since merged with the Vancouver/Richmond Health Board) decided that the majority of the mental health resources should be directed to individuals with a serious and persistent mental illness. Those needing primary care (services provided without referral) with a less serious mental health problem such as depression or coping with a family crisis would be encouraged to use private doctors, psychologists and counsellors. In the other three health regions, these services continued to be available through mental health centres or specialized teams.

Both approaches have advantages and disadvantages. The primary advantage of the Vancouver model is that those with a serious mental illness have access to a more comprehensive menu of

[33] Ministry of Health and Ministry Responsible for Seniors, *Revitalizing and Rebalancing British Columbia's Mental Health System; The 1998 Mental Health Plan, pages 43-48*

services. The disadvantage is that individuals with less serious mental health problems who are homeless or at risk may not be able to access the primary care that would help to stabilize their lives because the waiting period for a private psychiatrist is approximately six months. Mental health teams in Vancouver attempt to assess these clients when they come to the team and identify resources in the community that are appropriate, but because an individual can require a substantial amount of counselling time, options are limited.

Vancouver mental health teams in a number of locations include Community Response Units (CRU). These small CRU teams of health care workers provide emergency response capacity to the system. They will go into the field, undertake an assessment and work with clients who have less serious mental health problems. The CRU team has access to the resources of the team to assist with assessments and can offer up to three months of treatment. They are also very knowledgeable about community resources and can marshal services from other providers. There is an Outreach Team attached to the Strathcona Mental Health team that provides similar services to the Downtown Eastside. This group spends most of its time in the community.

While the other three health regions place the highest priority on services for clients with a serious and persistent mental illness, they also provide services to those who have less serious mental health problems or who are experiencing a crisis. The South Fraser Health Region operates a primary care clinic that provides mental health services to the less seriously ill as well as an intake and emergency response team out of the Surrey Central Mental Health Centre. The less seriously ill are often multi-diagnosed with presenting behaviours such as drug and alcohol misuse, attention seeking, suicidal gestures and personality disorders. These individuals are at risk of becoming homeless without mental health services, and the community supports and housing that will stabilize their lives.

Consistently available primary mental health care for the homeless and at risk who have a less serious mental illness or who are experiencing a crisis is a missing component of the mental health service system across the region.

Issue

Individuals with a less serious mental health problem who are homeless or at risk do not have consistent access to primary mental health services.

Policy Statement

46) All individuals who have a diagnosed mental health problem should have access to primary mental health services throughout Greater Vancouver.

Strategies

a) Health regions should study models for the delivery of primary mental health care for homeless and at risk clients and fund pilot programs to demonstrate which are most effective. Two potential models include attaching mental health care workers to health clinics and placing mental health workers from mental health teams/centres in health clinics. The latter option has the advantage of providing access to the resources and backup of the team/centre.

Mental health teams carry heavy caseloads

Mental health teams and mental health centres are located in all sub-regions. Generally staffing levels are similar, based on the caseload carried by each case manager. Teams include case

managers, who typically have a social work or psychiatric nursing background, and mental health workers. Physicians, psychologists and psychiatrists usually, but not always, work on a part-time basis and are referred patients by the case managers. Teams provide treatment involving medication, supportive counselling and rehabilitation services to the client, and consultations with general practitioners to assist them with treatment of their patients.

The delivery of mental health treatment by teams/centres varies slightly from health region to health region. For example, in Vancouver and Richmond the teams are focused on clients with the most severe and persistent mental illnesses, although they also provide assessment and referral services to clients outside the criteria. In the other jurisdictions, mental health services are delivered through mental health centres where services are offered for a broader range of needs including those with a less serious mental health problem.

The common denominator across the system is that most teams carry heavy caseloads that may preclude staff from providing the level of service that is required by their clients. Underfunding of the system forces providers to continuously juggle resources in an attempt to respond to needs that outstrip capacity.

Issue

The services provided by mental health teams/centres are an essential part of the mental health system, but are underfunded.

Policy Statement

47) Adequate levels of primary mental health services are essential to meet the needs of individuals with serious mental health problems.

Strategy

a) The services of mental health teams/centres should be included in the development of the co-ordinated common position on consolidated requirements for mental health services recommended by Policy Statement 34) and 35).

4.4.5 Prevention Services

We can help prevent people from becoming homeless and attempt to reintegrate them into society once they are homeless. The most obvious way of preventing homelessness is to ensure that everyone has adequate affordable housing, income and support services. Without these fundamental elements of daily living, homelessness is not preventable. (Sections 3.2 and 3.3 of this plan address the housing and income components of the continuum of housing and support.)

Prevention *services* are defined as programs or services aimed at helping to prevent people who are currently housed, but at risk of homelessness from becoming homeless. They are a particularly desirable strategy as the potential pay-off, in terms of both avoided financial and human costs are great. Prevention efforts can be direct, as in helping a family that is about to be evicted because they can't afford next month's rent by providing them with the necessary funds, or counseling that helps prevent the breakdown of a family in crisis. Studies have shown that helping people avoid eviction, for example, can reduce the number of people who become

homeless.[34] Indirect prevention services address collective needs, as in advocacy work to protect tenants rights. The following provides some examples of each:

a) Direct assistance:
- Prevent evictions (e.g. through legal services and financial assistance, such as crisis grants to address short-term arrears),
- Support stable tenancies (e.g. through information and education), and
- Find affordable housing (e.g. housing registries and information services).

b) Social programs designed to support the family unit and help prevent the breakdown of families. (These types of services are not included in the regional inventory).

Indirect assistance:
c) Advocacy work aimed at addressing housing and poverty issues.

Evictions are a fact of life in the Lower Mainland although data on the number of evictions is not available.[35] The Tenants Rights Action Coalition reports that evictions are the third largest reason for calls to its Tenant Hot Line, representing about 11-15% of calls (BC wide) in 1998, 1999 and 2000.[36] There are two programs available to eligible tenants throughout Greater Vancouver to help prevent evictions and one in Vancouver only (Downtown Eastside Resident's Association, DERA). These include crisis grants available to families in receipt of BC Benefits, and legal representation to dispute an eviction (available to households that qualify for legal aid). Services may include negotiating with landlords, helping clients prepare for arbitration hearings, and attending arbitration hearings with clients. Rent bank services, such as those available in Toronto, are not available in the Lower Mainland.

Four agencies in Greater Vancouver help to support stable tenancies. The Residential Tenancy Offices, Tenants Rights Hot Line and New Westminster Tenants Association offer information and advice to all tenants about their rights and responsibilities. A program in the South of Fraser sub-region is targeted to mental health consumers.

Six programs to help low-income households find affordable accommodation are available in Greater Vancouver - two programs operate region wide and four are Vancouver-based. The Community Housing Registry is available to all types of households, while the Seniors Housing Information Program is targeted to seniors. PovNet, an electronic service on the Internet provides information about housing and welfare resources in B.C. Four programs operate in Vancouver to help households find affordable housing through information and referral services. One of these programs is targeted to recent immigrants and refugees.

[34] Linda Lapointe, Options for Eviction Prevention, Nov. 1998
[35] Seeking stats through Freedom of Information.
[36] Tenants Rights Action Coalition. Sept. 2000.

Table 22: Prevention Services in Greater Vancouver

Sub-region	Preventing Evictions	Supporting Stable Tenancies	Housing Assistance and Referral Information
BC/Lower Mainland	BC Benefits- (families in receipt of BC Benefits) Legal Services Society (eligible for legal aid)	Residential Tenancy Office (all) Tenants Rights Hot Line (all) New West Tenants Association (all)	PovNet (all) Seniors Housing Information Program (seniors) Community Housing Registry (all)
Vancouver	DERA (Downtown Eastside residents)		Tenant Assistance Program (all) Downtown South Residents' Rights Assoc (all) First United Church (all) MOSAIC (recent immigrants and refugees)
South of Fraser		Newton Advocacy Group (mental health consumers)	

While there appears to be a broad range of prevention services in Greater Vancouver, accessibility is an issue. Agencies suggest that while there are many good services, their resources are stretched and in some cases, people may not receive the attention they need. There is also the possibility that there is uneven access to advocacy services around the region, even for services that are meant to be region-wide. The income cut-off for legal aid assistance is too low, meaning that many families who cannot afford a lawyer are also not eligible for legal aid. Barriers also prevent some services from being as effective as they could be, for example, language barriers, location and physical access issues.

The stakeholder workshop identified the need for a 24-hour housing registries/information service as a priority.

Some of the services are not individually oriented, but address collective issues and operate region-wide. There are three province-wide programs that engage in advocacy to address affordable housing and poverty issues: Tenants Rights Action Coalition, End Legislated Poverty and the Housing and Homeless Network of BC.

Issue

Prevention oriented resources are stretched to provide adequate service and there are barriers to accessing these services.

Policy Statement

48) Priority should be given to preventing households from becoming homeless. Prevention services are an effective way of accomplishing this. Efforts to prevent evictions, support stable tenancies and provide housing assistance and referral information are essential components of the continuum of housing and support.

Strategy

a) Fund research to determine the extent to which evictions contribute to homelessness in Greater Vancouver and factors that may lead to failure to pay rent.
b) Determine what additional programs, if any should be developed to help households maintain existing tenancies, for example, rent banks.
c) Encourage the provincial government to raise income limits for eligibility for legal aid.
d) Protect the existing stock of affordable rental housing (see section 4.2.4)
e) Ensure that services are offered in language(s) that are reflective of the population being served.

Lack of support for families

One of the reasons homeless people often cite as the immediate reason for becoming homeless is family breakdown. In some cases, this refers to a marriage or common-law break-up. In other cases, particularly for homeless youth, parental abuse or neglect is given as the reason for homelessness. It may also be as simple as disagreements over youth rights and responsibilities. Or, a young single mother may have difficulty coping with the demands of parenthood and need assistance, such as childcare, that might make all the difference.

It is also becoming recognized that people at risk of homelessness, who actually become homeless, are individuals who have limited or no social networks, no families or friends they can turn to in times of crisis, and is the result of a process called 'social exclusion'. This may be because they have exhausted these resources, and friends have 'given up'. In other cases, particularly in the case of youth that are in state care, they have no support network to rely on.

Many studies, including Canadian research, report an over representation of people with a foster care history among the homeless.[37] For example, a study of homeless youth in Calgary found that 37% reported having had child welfare status at some point in their lives,[38] and a study of Vancouver street youth reported that over 40% had lived in a foster home or group home.[39]

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[37] Downing-Orr, Kristina. 1996. *Alienation and Social Support, A Social Psychological Study of Homeless Young People in London and Sydney*. Aldershot, England: Ashgate Publishing Limited.
Roman, Nan P. and Wolfe, Phyllis B. 1997. 'The Relationship between Foster Care and Homelessness.' *Public Welfare*. 55 (1).

[38] Kukfeldt, Kathleen and Barbara Burrows (eds). 1994. *Issues Affecting Public Policies and Services for Homeless Youth. Executive Summary*. Submitted to National Welfare Grants.

[39] McCarthy, Bill (1995) *On the Streets Youth in Vancouver*. Victoria: BC Ministry of Social Services.

Reasons include insufficient counseling or therapy to address the problems precipitating care, abusive foster care placements, multiple placements and others. With family breakdown preceding involvement in the child protection system, the obvious prevention issue becomes how to support families before the situation reaches a crisis, as well as improving the foster care system so that it is more able to meet needs.

Social services to families and individuals can step in to fill these gaps to some extent and can take many forms, for example, counseling, childcare and home support, but only if there are sufficient resources and staff to do so. Not all family breakdown can be prevented, nor is it necessarily desirable, but in some cases, early intervention has been found to improve 'success rates'. Some services are geared more to helping to prevent homelessness and to help at risk individuals maintain their housing. For example, parents and teachers who work with youth who are at risk may call for these services to help keep youth in school and off the streets. Other types of support services can include taking residents (e.g. the multi-diagnosed) to medical appointments, and in helping to provide a variety of social supports. Such work can be very time consuming, but is essential to help a variety of clients maintain their housing.

Anecdotally, social service providers in the Vancouver region point to a lack of social support for families that has resulted from a decline or withdrawal of funding over the past several years. It is felt that insufficient support to families is a contributing factor to increasing homelessness. However, further work is necessary to obtain a better understanding of the role that support to families might play in helping to prevent homelessness.

Issue

There is a lack of social services to help prevent family breakdown and other risk factors for homelessness. The child protection system may also be exacerbating homelessness.

Policy Statement

49) Family support programs and social services play a critical role in stabilizing families and ultimately preventing homelessness.

Strategy

a) Conduct research to obtain a better understanding of the connection between family breakdown, social services (including child protection services) and homelessness in the Greater Vancouver region.
b) Promote greater awareness of the critical role that prevention and early intervention services play in preventing family breakdown and reducing homelessness.
c) Request an increase in funding for social services for families at risk where needs have been identified.
d) Provide more support workers throughout Greater Vancouver to help individuals and families at risk of homelessness to maintain their housing, and prevent them from becoming homeless.

4.4.6 Substance misuse services

Homelessness and addiction are inextricably linked, although estimates of drug and alcohol addictions among the homeless vary widely. A review of the literature undertaken for the Toronto Mayor's Homelessness Action Task Force concluded alcoholism is viewed as the most pervasive health problem of the homeless. This trend is evident in the clients seen by Lower Mainland service providers. Many emergency shelters note an increase in the incidence of clients with addictions. While not all people who are homeless have an addiction, a significant share does.

The 1998 report of the Provincial Health Officer stated that "For the past decade British Columbia has had an epidemic of deaths and disease related to injection drug use (IDU).[40] Overdose from IDU has become the leading cause of death for adults age 30-49 in this province, with more than 300 deaths annually. The leading cause of new cases of HIV infection is now IDU, and we have epidemics of hepatitis B and C related to IDU as well". Cities in the Lower Mainland are struggling with this issue. The epidemic is centred in the Downtown Eastside of Vancouver although it reaches beyond Vancouver as well. Several recent studies have stressed that that the injection drug use epidemic has spread to other municipalities in Greater Vancouver as well.[41]

There are societal costs of addictions. BC had the highest per capita illicit drug related costs in Canada according to a national study.[42] Health care, workplace loss, productivity loss, prevention and treatment and law enforcement costs exceeded $207 million in 1992. This study excluded the substance abuse costs related to property crime. Urgent priorities identified through the consultation process to date are for residential detox and treatment for youth, women and Aboriginal people. Specific needs for a sobering centre, dual diagnosis treatment and methadone treatment were also identified. These were seen as particularly urgent priorities in the South of Fraser and Vancouver sub-regions.

The Ministry for Children and Families funds a variety of addictions services throughout the region, and in Vancouver and Richmond, the Vancouver/Richmond Health Board has the responsibility for adult addiction services. The table below shows the regional distribution of residential addiction treatment services. While there are many non-residential forms of treatment, such as outpatient counseling or day treatment, people who are homeless are most likely to require treatment in a residential setting.

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[40] IDU is the injection of an illegal drug into the vein or artery. The drugs involved are primarily heroin and cocaine, either alone or in combination with each other.

[41] Lower Mainland Municipal Association. Towards a Lower Mainland Crime and Drug Misuse Prevention Strategy. Needs Assessment and Identification of Issues. 2000 and CCENDU. Vancouver Canadian Community Epidemiology Network on Drug Use Report. 2000.

[42] Canadian Centre on Substance Abuse. *The Costs of Substance Abuse in Canada*. 1996.

Table 23: Residential Detox and Treatment, and Needle Exchange Programs

Sub-region	Detoxification (beds)	Residential Treatment/ Recovery (beds)	Needle Exchange (programs)	Total beds	% beds
Vancouver	52	198	2	250	36%
South of Fraser	0	200	1	200	29%
Inner Municipalities	22	71	1	93	13%
North Shore	0	0	0	0	0
Northeast Sector	0	102	0	102	15%
Ridge Meadows	0	50	0	50	7%
Region wide	74	621	4	695	100%

Source: Inventory of Facilities and Services, Sept 29, 2000.

Thirty six percent of detox and residential treatment/recovery beds are located in Vancouver. Most residential detox spaces are located in Vancouver (70%), while residential treatment beds are spread more broadly throughout the various sub-regions with Vancouver and South of Fraser having the majority of spaces. It should be noted that some of these facilities are provincial resources, and while physically located in one municipality, are meant to serve a much larger area. Residential treatment beds are available in all sub-regions except the North Shore. The North Shore has no residential addiction services at all. Needle exchange programs are located in Vancouver, South of Fraser and the Inner Municipalities. There are 224 units of drug and alcohol free housing with varying levels of support and 39 supportive housing units for individuals recovering from addictions.

Table 24: Residential Treatment and Needle Exchange Programs by Target Group

Target group	Detoxification (beds)	Residential Treatment (beds)	Needle Exchange (programs)	Total beds	% of beds
Youth	13	37	0	50	7%
Women (and families with children)	16	132	0	148	20
Immigrants and Refugees	0	0	0	0	0
Urban Aboriginal People	0	7	0	7	1
Seniors	0	0	0	0	0
Low Income Urban Singles (mix adults)	19	52	0	71	10
People with Special Needs	0	0[43]	0	0	0
Adult males	36	433	0	469	63
Total	84	661	4	745	100

Source: Inventory of Facilities and Services, Sept. 29, 2000

Most residential addiction services (63%) are targeted toward adult males (36 of 84 detox beds and 433 of 661 residential treatment beds). Some facilities, notably those funded by MCF or V/RHB, are coed (10%). Specialized detox for youth and women are available in very limited numbers. Overall 27% of all residential detox and treatment beds are for youth and women. There

[43] One 50-bed facility is for men and individuals with dual diagnosis.

are limited resources specifically for Aboriginal people. Needle exchange programs are for the most part available to all.

Addiction treatment is a fundamental component of the continuum of housing and support, and it is an urgent priority for addressing homelessness in the region. This plan makes strong policy recommendations, but makes fewer recommendations for specific facilities and services. There are two processes underway at the present time that will help define a region-wide strategy for substance misuse. First, a comprehensive substance misuse strategy with a focus on the Downtown Eastside of Vancouver is under development in connection with the *Vancouver Agreement*. Second, the Lower Mainland Municipal Association (LMMA) is developing a *Regional Crime Prevention and Drug Strategy* that will identify addiction services needs and propose solutions. In addition, the City of Vancouver recently released a draft framework for a drug strategy for the City of Vancouver.[44] It proposes a 'four pillar' approach to drug and alcohol misuse: prevention, treatment, enforcement and harm reduction. This four pronged approach is supported by the work of the LMMA as well.

Lack of residential treatment capacity

The most recent examination of the availability of addiction treatment services in the region was commissioned by the LMMA. Based on its research with stakeholders, it concluded that 'access to drug and alcohol treatment services is a problem everywhere in the Lower Mainland' and pointed out that long delays in obtaining help are commonplace. This is echoed by numerous other reports and studies.[45] There is also a sense the situation

There are gaps in the existing continuum of addiction services, both region-wide and sub-regionally. For example, the Kaiser Youth Foundation states that British Columbia's attempt to provide an appropriate "continuum of services" for the users and abusers of alcohol, drugs and gambling is today a broken chain.[46] Vancouver has the bulk of addiction service, and has significant unmet needs. Needs arise in other sub-regions as well. For example, the City of Richmond has convened a task force to address alcohol and drug related issues in that municipality. Residential treatment beds are located in all sub-regions except the North Shore. There are no needle exchange programs in the North Shore, Northeast Sector and Ridge Meadows. There are few supportive substance-free housing projects for individuals recovering from addictions. Programs designed for high risk, female, youth, Aboriginal, mentally ill and homeless injection drug users tend to be clustered in Vancouver and insufficient to meet the needs of the region as a whole.

It is not necessary for all services to be located in each sub-region. Some facilities will serve the region or the province. Different growth rates in some of Greater Vancouver's sub-regions over the past few years may mean that some sub-regions are under-represented. However, all residents must have access to adequate services region wide. Decisions on which resources should be region wide and which should be available to residents locally are important and require attention.

A move towards more non-residential detox and treatment options is underway. This may assist individuals who have stable homes and may free up some residential beds for homeless

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[44] City of Vancouver. A Framework for Action. A Four Pillar Approach to Drug Problems in Vancouver. November 21, 2000.

[45] City of Vancouver ibid. InfoWest Consulting, 1999. Health Association of BC, 1998.

[46] *The Case for an Independent Substance Abuse Prevention and Addictions Commission for British Columbia.* May 15, 2000.

individuals who need these services. However, this strategy is not likely to result in sufficient resources to meet the needs of the homeless.

According to the LMMA, the key elements for successful treatment include:

- Directing individuals with serious problems into treatment as soon as they are ready
- Keeping them in treatment for as long as necessary
- Providing incentives to maintain them in treatment within a positive and supportive environment
- Offering aftercare assistance and supporting the long term recovery process
- Offering continued assistance as required with employment, housing and medical help. 67

The *Vancouver Agreement* has identified expanded or enhanced sobering services, withdrawal management, stabilization services, treatment programs and housing options as priorities for the Downtown Eastside.

Issue

The lack of residential and other addiction treatment capacity in the region contributes to homelessness. There are gaps in addiction services around the region.

Policy Statement

50) A full range of alcohol and drug addiction treatment services and housing should be distributed in communities throughout Greater Vancouver to meet needs.
51) A range of core addiction services including: sobering centres, detox, outpatient treatment, counseling, residential treatment, methadone treatment, needle exchange and medium and long-term permanent supportive housing should be distributed in communities throughout the region to meet needs.

Strategy

a) Develop a comprehensive, coordinated substance misuse treatment strategy for the Lower Mainland to guide decision-making about new facilities and to ensure a full range of services.
b) Determine needs and resources required in communities throughout the region.
c) Implement the strategy.

People who have completed addiction treatment have few safe places to live

One of the most critical needs in the addiction services continuum in the region is supportive housing, a place for people recovering from addictions to go upon completion of a treatment program. Such housing would provide an environment conducive to supportive recovery and increases the likelihood of success. Portland, Oregon has a significant stock of alcohol and drug free, damp and wet supportive housing as part of its continuum of services.

- 'Wet' refers to a place in which substance misuse is tolerated and is not considered a reason to bar or discharge a person.

- Damp housing tolerates substance misuse off site and provides support to help people make the transition to abstinence.

- Dry housing refers to the expectation of abstinence.

Vancouver has few spaces and other sub-regions none. One of the worst scenarios is recovering addicts returning to live in the Downtown Eastside SRO hotels after treatment where they are once again immersed in a drug culture. The *Vancouver Agreement* identifies housing for drug and alcohol clients as a priority for the Downtown Eastside. The draft Vancouver *Framework for Action* also cites the importance of housing in the overall framework of actions to deal with substance misuse and recommends development of housing for persons with addictions problems.

Issue

People who have completed addiction treatment programs have few safe places to live with environments conducive to supportive recovery.

Policy Statement

52) Supportive housing should be available for individuals recovering from addictions. Alcohol and drug-free environments are preferred in some instances.

Strategies

a) Develop a range of supportive housing for individuals recovering from addictions.
b) Encourage MCF (Addictions Branch) and the Vancouver/Richmond Health Board to participate in funding the support component of supportive housing for individuals recovering from addictions.

People with dual diagnosis, women, youth and Aboriginal people are not well served by existing residential addiction services

Stakeholders, the inventory and other studies confirm that various sub-groups, particularly people with dual diagnosis, women, youth and Aboriginal people are not well served by existing residential addictions services. People in these special populations experience difficulties in accessing treatment and recovery resources because these services are in short supply, have long waiting lists, services do not meet their needs, and/or programs have narrow eligibility requirements. In addition people from minority ethnic groups, in particular those for whom English is not their first language, experience difficulties in obtaining the help they need.

Inadequate detox and residential treatment facilities for youth and women are an urgent concern of many service providers connected with the homeless. The lack of treatment resources for youth in Lower Mainland are "shamefully inadequate" according to the LMMA, and many youth go without treatment or if they are able, seek help outside the region or province.

Women, particularly pregnant and parenting women face significant barriers to accessing services, due to fears about being judged and fears that their children will be apprehended. In addition, people with the dual diagnoses of mental illness and addictions are not well served by existing facilities.

The co-occurrence of mental illness and addictions is extremely frequent but facilities meant to treat one diagnosis are not able to treat the other or the presence of the second diagnosis might mean they are excluded from service on the basis that the presence of another disorder is an obstacle to successful treatment of the other. Recent research suggests that specialized facilities that offer treatments for both diagnoses concurrently are more promising.

Aboriginal people are over-represented among the homeless, and also face difficulties accessing appropriate addiction services. The LMMA report stressed the need for more culturally sensitive drug and alcohol programs throughout the region, including healing circles to address broader issues of violence and substance misuse. The *Vancouver Agreement* identifies residential recovery programs for women and individuals with dual diagnosis as a priority.

Issue

Individuals with a dual diagnosis, women, youth, Aboriginal people are not well served by existing residential addiction services.

Policy Statement

53) Residential addiction services should meet the diverse needs of all those with addictions particularly individuals with a dual diagnosis, women, youth and Aboriginal people.

Strategy

a) Develop targeted detox and residential addiction treatment services to meet the needs of individuals with a dual diagnosis, women, youth and Aboriginal people.

Timely access to services not available

It is essential to offer entry-level service when an individual expresses a wish to make some change in their drug/alcohol use patterns. The BC Medical Association stresses that when an addict experiences a crisis, a 'window' to treatment may open for a short period of time. However, if there is a significant delay, the window closes until the next crisis. In addition, as reported by the LMMA, addiction is a progressive condition and there is a better chance of successful treatment at an early stage.

Currently, access to residential services is not available in a timely way due to a shortage of spaces. It is impossible to obtain reliable data on the number of people seeking treatment because waiting lists, if they are maintained at all, are not cross-referenced to account for duplication. A quick telephone survey of 4 out of 6 detox facilities in the Lower Mainland revealed a waiting period of between 1 to 5 days for access to a residential detox program. Most facilities don't maintain waiting lists, although one facility had a wait list of 25 names. Instead, they require an individual to phone every day to see if space has become available.

The Association of Substance Abuse Programs (ASAP-BC) has drafted a position paper which asserts that gaps in the province's intervention and treatment capabilities are resulting in wait lists that prevent clients who need help from entering into appropriate treatment during their "window" of readiness. And, because eviction for behavioural reasons due to addictions may contribute to homelessness, it is important that treatment be available on a timely basis. Both the *Vancouver Agreement* and the draft Vancouver *Framework for Action* identify expansion of residential withdrawal management as a priority.

Issue

Timely access to addiction treatment service is not available due to a lack of sufficient resources.

Policy Statement

54) People with addictions should have timely access to treatment, as the lack of treatment is a contributing factor to homelessness.
55) Homeless people should have access to residential addiction treatment.

Strategy

a) Increase detox and treatment capacity to ensure timely access.

How to deal with people who have not entered treatment

Some people with addictions are not ready to enter treatment. Presently, there is little in the way of service for these individuals, who often are barred from using services and facilities while intoxicated. Often they will spend inordinate amounts of time in the health care and criminal justice system. Rather than creating expensive residential treatment capacity for people with low motivation, the harm reduction approach attempts to reduce harm to the community and to the individual. It recognizes that abstinence may not be a realistic goal for some users, at least in the short term and is particularly applicable to those who are street entrenched. Harm includes physical harm such as HIV/AIDs, spread of illness and accidents and violence, psychological harm, societal harm and economic harm (such as the impact of the illegal drug trade). The federal/provincial Harm Reduction Working Group has developed five guiding principles of harm reduction.[47] Harm reduction suggests that these individuals need a variety of services, information and tools to help prevent the worst consequences of substance misuse, such as communicable disease. Examples of harm reduction strategies recommended in the draft Vancouver Framework for Action include: low threshold support programs or day centres, safe injection rooms, and wet or damp short term shelter and housing options.

[47] See p.53 City of Vancouver. *A Framework for Action*. 2000.

Issue

Some people with addictions are not ready to enter treatment; they are prevented from accessing services yet they may harm themselves and others.

Policy Statement

56) Harm reduction strategies should be part of a comprehensive substance misuse strategy to help minimize the negative health and other consequences of substance misuse, contributing to homelessness.

Strategy

a) Collaborate with parties to the *Vancouver Agreement*, the Lower Mainland Municipal Association and the Federal /Provincial Harm Reduction Working Group to ensure that harm reduction strategies are incorporated in planning for addiction services.
b) Develop services and facilities, including a continuum of housing where use is permitted, to meet the needs of homeless people who are not ready to enter treatment.

4.4.7 Aboriginal services

To be completed.

4.4.8 Youth services

To be completed.

5 Appendices

Appendix A - Regional Steering Committee on Homelessness membership and terms of reference

Appendix B – Glossary of Terms

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