

# Visions

BC's Mental Health and Addictions Journal

Vol. 4 No. 1 | Summer 2007



housing



&

homelessness



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### bc partners

Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health Care, Jessie's Hope Society and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

### visions

Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. *Visions* is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

The BC Partners are grateful to BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority, for providing financial support for the production of *Visions*



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*"They don't need spare change, they need social change."*  
—US 'homelessness czar' Philip Mangano during a recent BC visit

**H**ousing is fundamental to mental health. A decent, affordable, safe and private space—a home—to call your own can be so easy to take for granted. Having it doesn't make life perfect, but it's hard to work on other parts of your life, including managing a mental illness, without it.

As someone who has been involved with *Visions* since 1999, I can say on behalf of our team that this has perhaps been the hardest issue to put together—the most complex and the most poignant. We have been overwhelmed with stories from people in the field, but even more by people who have been or are currently homeless and their loved ones. Most have never written for *Visions* before and are excited to share their often painful, frequently hope-filled journeys with us. And if there were any doubts, in this issue you will see first-hand the inter-relationships between trauma/abuse, mental health problems and substance use problems; between income, employment and housing; between victimization and criminalization. And the little things—the common-sense innovations and approaches and values—that are giving so much hope to so many trying to survive on the fringes of our communities.

Even for those who live with mental illness and/or addictions, if we've never been on the margins ourselves, it can become safe to think of people who are homeless as 'the other.' Oh no, not like me. Couldn't happen to me. Even humanity gets lost: people with very diverse and complex needs tend to get lumped together in the media and at the water cooler as 'the homeless' or 'the mentally ill' or 'the addict.' I hope the stories in this issue open our collective eyes and challenge this common us-and-them thinking.

Finally, I'd like to extend a huge thank you to our outgoing Policy Editor, Christina Martens, who has been an invaluable help these past two years and lives the values of *Visions* in her daily work at CMHA on Vancouver Island. I'm pleased she will continue on our Editorial Board. I'd also like to introduce two others whom our contributors know well, but readers may not: our Structural Editor, Vicki McCullough and our new Editorial Assistant, Megan Dumas. It's an amazing team to be a part of. We look forward to your letters on what I feel is, in many ways, a landmark issue of *Visions Journal*. ■

Sarah Hamid-Balma

*Sarah is Visions Editor and Director of Public Education and Communications at the Canadian Mental Health Association's BC Division. She also has personal experience with mental illness*

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If you have personal experience with mental health or substance use problems as a consumer of services or as a family member, or provide mental health or addictions services in the public or voluntary sector, and you reside in BC, you are entitled to receive *Visions* free of charge (one free copy per agency address). You may also be receiving *Visions* as a member of one of the seven provincial agencies that make up the BC Partners. For all others, subscriptions are \$25 (Cdn.) for four issues. Back issues are \$7 for hard copies, or are freely available from our website. Contact us to inquire about receiving, writing for, or advertising in the journal. Advertising rates and deadlines are also online. See [www.heretohelp.bc.ca/publications/visions](http://www.heretohelp.bc.ca/publications/visions).

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*The opinions expressed in this journal are those of the writers and do not necessarily reflect the views of the member agencies of the BC Partners for Mental Health and Addictions Information or any of their branch offices*



# Health and Housing Partnerships for Success



**Karyn French**

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**Margaret McNeil**

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**W**e immediately said ‘yes’ when asked to guest edit this issue of *Visions*. The topic of housing for people with mental illnesses and addictions is a key direction for both BC Housing and housing providers such as Pacifica Housing Advisory Association. We are especially pleased that the link between housing and health is being recognized. Programs are emerging that ensure both these elements are present to support successful outcomes for people with mental illnesses and addictions.

In 1974, the federal Minister of Health at the time, Mark Lalonde, issued a report establishing the key factors that influence health status.<sup>1</sup> These were lifestyle, the environment, human biology and health services.

Since 1974, additional evidence has greatly expanded the list of factors influencing population health. Key factors now include income and social support networks, education, employment and working conditions, social environments, physical environments, personal health practices and coping skills, healthy childhood development, biology and genetic endowment, health services, gender and culture.<sup>2</sup>

People with mental ill-

nesses and/or addictions experience many challenges. Without a secure, stable home and without services and supports to help them stay stable, their ability to manage the rest of their lives is impaired. Something that seems so simple—having a place to sleep at night, receive mail, keep personal goods, cook meals and socialize—provides the foundation from which people live their lives. As such, this issue of *Visions* is both timely and important in its in-depth exploration of housing, homelessness and health.

Homelessness is a complex matter. It is overwhelming for those in the cycle of homelessness—and for those trying to address the problem. And there is no one model for addressing the problem of homelessness. But it’s clear that ‘bricks and mortar’ (i.e., buildings) alone will not solve this problem.

Complexity, however, leads to innovation and creativity. One place this innovation can be seen is through the Premier’s Task Force on Homelessness, Mental Illness and Addictions. Created in 2004, the task force is a collaboration between the provincial and local governments to develop new resources to address issues related to homelessness, and its innova-

tion is the recognition that people with mental health and addictions issues may need specialized strategies for stabilizing in housing.

Linking housing and health has certainly led to supported environments that are working. The focus is on creating a range of options that enable the best fit possible between a person’s needs and their environment.

And, while there are many models of housing with support services, there are simply not enough supportive housing units available. Economically, supportive housing as part of the solution to end homelessness makes sense. In 2001, the BC Ministry of Community, Aboriginal and Women’s Services published a study that found: “When combined, the service and shelter costs of the homeless people...ranged from \$30,000 to \$40,000 on average per person for one year (including the costs of staying in an emergency shelter).”<sup>3</sup> On the other hand: “The combined costs of services and housing for the housed individuals ranged from \$22,000 to \$28,000 per person per year.”<sup>3</sup>

Fortunately, various provincial government initiatives, including the Premier’s Task Force on Homelessness, Mental Illness and Addictions, have

created excitement about the possibilities of new programs and housing units being developed. While it will take some time to see new units built and in operation, there have been other measures announced that will help to preserve low-income housing stock for the future. The recent purchase of 10 single room occupancy (SRO) hotels in Vancouver, two townhouse developments in Burnaby and three apartment buildings in Victoria is an example. And the Provincial Homelessness Initiative, launched as a result of the Premier's Task Force, has also resulted in nearly 1,300 new supportive housing units being developed across BC.

The Addiction Recovery Program is an example of a successful initiative. Through a partnership between BC Housing and Vancouver Coastal Health, this program provides transitional, supported housing to people in recovery from problematic substance use. Over the last five years, the program has expanded from providing 15 units of alcohol- and drug-free housing to 125 units scattered throughout the Lower Mainland. This partnership between BC Housing and the regional health authorities speaks to the success of providing housing and delivering needed services to people where they live. More examples of initiatives that link services to housing are described in this issue of *Visions*.

Matching supply with the demand will always be a challenge—although committed and passionate members at all levels of our communities are working

together to end homelessness. Community-based non-profit societies continue to actively seek the financial means and strategic partnerships, in both the private and public sectors, to create more housing units with support services. This issue provides many examples of effective partnerships.

These innovative and effective projects can and do make a difference in people's lives—and in the communities we call home. It's up to us to continue developing this system of combined housing and support services. We encourage you to continue the conversation. Find ways to take the ideas shared in this *Visions* forward in your own communities. **i**

**footnotes**

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I learned your upcoming issue is on homelessness and housing and want to share my story. I left London, Ontario just after 9/11 for Kelowna, BC where some of my family reside. Little did I know I was going to experience the worst kind of stigmatization—on such a grand scale because of my mental disability. (I suffer from manic depression and borderline personality disorder). Aid to Afghanistan, global warming and pollution in the environment stand a better chance of getting attention and funding.

I've been on subsidized housing lists since 2001 and haven't had a response. I'm not eligible for financial aid for housing because new policies no longer cover those between 19 and 65 years of age who are single.

I am so shocked to realize that the BC Liberals have brought my health to the worst it has ever been. It's criminal to design policies that don't respect civil rights and *human rights* of those between 19 and 65 years of age who suffer mental disabilities. *I am ashamed to call myself a Canadian.*

According to a speech by Jenny Kwan in the BC legislature in June 2007: "Public policy is one of the root causes of homelessness, and it is homelessness and poverty which lead to many health effects including depression and mental health... this government's policies are brutal, aggressive and, show a profound lack of empathy... and I have never seen the situation as bad and as dire as it is today... —which, I might add, is a direct result of a creation of her government's policies."

You can email comments to me at [trinker@telus.net](mailto:trinker@telus.net)

—Catherine Kennedy, Kelowna BC

**we want your feedback!**

*If you have a comment about something you've read in Visions that you'd like to share, please email us at [bcpartners@heretohelp.bc.ca](mailto:bcpartners@heretohelp.bc.ca) with 'Visions Letter' in the subject line. Or fax us at 604-688-3236. Or mail your letter to the address on page 3. Letters should be no longer than 300 words and may be edited for length and/or clarity. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive.*

**housing glossary**

*Disclaimer* These definitions are adapted from ones found in key literature in the field. We hope they will help readers outside the housing/rehabilitation fields to better understand some of the terms used in this issue. They are purposely brief and in plain language. As such, these definitions may not include all nuances or variations of a term, and alternate or expanded definitions may be used by some organizations. These have been developed by editorial staff and may not be definitions in use by all member agencies in the BC Partners or its funder.

<b>Permanent</b>	Long-term housing with no maximum length of stay.
<b>Transitional</b>	Time-limited, affordable, supported or independent housing. Tenants can usually remain in transitional housing for up to 2 or 3 years.
<b>Emergency</b>	Short-term shelter for people in crisis. Some emergency shelters also provide meals and support services to the people who stay there.
<b>Supported</b>	Affordable housing where the tenants have access to support services in addition to housing. These services vary and can include: <ul style="list-style-type: none"> <li>o Life skills training: income management, job training, medication management</li> <li>o Medical care</li> <li>o Social activities</li> <li>o Problem substance use rehabilitation programs</li> <li>o Case management</li> </ul>

continued on next page >>

if you see this symbol (†) next to a term in an article, the term is in this glossary

## housing glossary

## other important terms

<b>Abstinence-Based or Dry Housing</b>	Housing where tenants are not allowed to drink alcohol or use other drugs while in tenancy. Tenants are expected to be “clean” before moving in and actively working on their recovery while living there. Tenants may be discharged from the program if they refuse treatment for a relapse.
<b>Low Barrier Housing</b>	Housing where a minimum number of expectations are placed on people who wish to live there. The aim is to have as few barriers as possible to allow more people access to services. In housing this often means that tenants are not expected to abstain from using alcohol or other drugs, or from carrying on with street activities while living on-site, so long as they do not engage in these activities in common areas of the house and are respectful of other tenants and staff. Low-barrier facilities follow a harm reduction philosophy. See below for more about harm reduction.
<b>Wet Housing</b>	Housing where tenants are not expected to abstain from using alcohol and other drugs, and where entering a rehabilitation program is not a requirement. Tenants have access to recovery services and get to decide if and when they use these services. Wet housing programs follow a harm reduction philosophy. For more on harm reduction see below.
<b>Damp Housing</b>	Housing where tenants do not need to be “clean” when entering the program but are expected to be actively working on recovery from substance use problems.
<b>Scattered Site</b>	Housing units are spread out in apartments in various locations around the city rather than all in one common building. These apartments may be either market or social housing.
<b>Dedicated Site</b>	Housing units that are placed in a common building where all the tenants are part of the program.
<b>Private Market</b>	Traditional rental housing that is run by private landlords rather than a housing program.
<b>Subsidized</b>	Housing that receives funding from the government or community organization. Tenants who live in subsidized housing pay rent that is less than market value.
<b>Social Housing</b>	Housing provided by the government (public housing) or a community organization (non-profit housing).
<b>Public Housing</b>	Housing that is owned by the government.
<b>Non-Profit or Community Housing</b>	Housing that is run by a community organization.
<b>Single Room Occupancy (SRO)</b>	Small, one-room apartments that are rented on a monthly or weekly basis. Tenants share common bathrooms and sometimes also share kitchen facilities.
<b>Hardest to House</b>	Refers to people with more complex needs and multiple challenges when it comes to housing, such as mental illness(es), addiction(s), other conditions or disabilities, justice-system histories, etc.
<b>Group Home</b>	A home that is shared by a number of tenants who are generally expected to participate in shared living arrangements and activities. There is usually 24-hour support staff on site.
<b>Harm Reduction</b>	A philosophy that focuses on the risks and consequences of a particular behaviour, rather than on the behaviour itself. In terms of substance use, it means focusing on strategies to reduce harm from high-risk use, rather than insisting on abstinence. Abstinence is neither condoned nor condemned. Instead it is considered one strategy among many others. Underlying harm reduction is the acceptance that many people use substances, and that a drug-free society is both an unrealistic and impractical goal. With regard to housing, harm reduction means that tenants have access to services to help them address their substance use issues. It is based on the understanding that recovery is a long process, and that users need a stable living arrangement in order to overcome their addictions. Focus is on being healthier rather than on the unrealistic goal of being perfectly healthy right away. See wet and low-barrier housing above.
<b>Concurrent Disorders</b>	When a person is diagnosed with two or more conditions at the same time. In Visions Journal, and in many mental health contexts, “concurrent disorders” is used to describe a person with both mental illness and substance use issues. (Dual diagnosis, which also means co-existing conditions, in Visions tends to be used to describe a co-existing mental illness and a developmental disability.)
<b>Absolute Homelessness</b>	People are considered absolutely homeless if they have no physical shelter at all. These are people who are living on the street or in emergency shelters. This is also called ‘living rough.’
<b>Relative or At-Risk of Homelessness</b>	People who are living in sub-standard, unstable or unsafe housing. This includes people who are “couch surfing,” which means they are staying with family or friends, living in trailers, doubled or tripled up in small apartments or living in unsafe and unsanitary conditions.

# The Faces of Homelessness Across BC

Homeless people have become familiar faces in BC's suburbs and cities. However, homelessness is also a problem in small, rural communities. While the most visible homeless are those living on the streets, many more people live in poor-quality housing and are at risk of homelessness.

People used to think that homelessness only affected a marginalized group of high-risk people. Since the 1980s this has changed: the homeless population has become more and more diverse. Rising inflation, rents and unemployment have caused many more people to become at risk for homelessness. Additionally, reduced eligibility for social assistance has made it harder for people to get benefits. Cutbacks in government housing programs and a reduced supply of low-cost housing meant there was less help for people living in unstable housing.

## A number of subgroups are commonly found in the homeless population:

**Families** are one of the fastest-growing groups showing up at shelters. The reasons for this include a rise in poverty, changing job markets and a lack of affordable housing. Pressures such as cuts to social programs and an ever-tightening rental market also put many families at risk. Family breakdown and abuse have often been named as the main reasons for youth homelessness. A rise in homeless youth with mental health and/or addiction problems has been noted in both urban and rural settings across BC.

**Abused women and their families** share many of the same risk factors as families who are homeless: poverty and lack of affordable housing. There are, however, differences between the needs of abused and non-abused families. The main differences are related to safety and the emotional impact of abuse. About 20% of women who leave abusive partnerships continue to live with violence during or after the separation.<sup>1</sup> This abuse often becomes more severe. Custody and access present a particular safety problem for abused women. They may be assaulted when they go to pick up or drop off their children and, therefore, may require special arrangements for their own safety at these times. And the shelter system is not always a safe place for homeless women. Many "couch surf" at the homes of friends or acquaintances. Some end up in the sex trade.

**Immigrants and refugees** also face unique challenges. Many live in poverty and cannot find suitable, affordable housing. Some have experienced trauma in their home country and have left family and support networks behind. Although they may not end up on

the street, many live in unsafe housing conditions. It is not uncommon to hear of a number of families sharing an apartment to save money. Refugee claimants (about 50% of all refugees in Canada)<sup>2</sup> do not receive any government support until they've had their first interview with the immigration office and are allowed to apply for permanent residence. Of all immigrants, refugee claimants are most at risk of becoming homeless, because they don't have access to settlement services or financial assistance. Most arrive in Canada with little or no money or possessions, and the refugee determination process can be long (a year or more), especially if there is an appeal. Refugees in Canada need language training, help getting the required documentation so they can look for work, and help obtaining housing.

**Aboriginal peoples in BC** are over-represented among the homeless. It's estimated that 41% of BC's Aboriginal peoples are at risk of homelessness and 23% are absolutely homeless.<sup>3</sup> Aboriginal people are affected by many of the same factors that put other subgroups at risk of homelessness. However, the historical and colonial legacy that has uprooted families, communities and an Aboriginal way of life must also be considered. Many generations of Aboriginal people have experienced residential schools, wardship through the child welfare system, and economic and social exclusion from mainstream society. These have all contributed to Aboriginal homelessness.

**People with severe addictions and/or mental illness** can be found in all of the subgroups outlined above. People with severe addictions and/or mental illness make up anywhere from 33% to over 60% of the homeless population.<sup>2</sup> About 11% of the homeless population has a diagnosis of schizophrenia.<sup>4</sup> Approximately 136,000 adults in BC have a severe addiction and/or mental illness, and between 8,000 and 15,500 of these people are street homeless.<sup>5</sup>

**Michelle Patterson, PhD, RPsych**

*Michelle is a Research Scientist and Clinical Psychologist working at the Centre for Applied Research in Mental Health and Addiction (CARMHA) at Simon Fraser University*

## footnotes

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\*\* See Megan Dumas' article on p. 26

### Which comes first, mental illness or homelessness?

There is considerable debate about the extent to which homelessness is a consequence of mental illness, or whether homelessness helps cause mental illness. The harsh reality of living on the street—lack of food, exposure to weather, sleep deprivation, poor hygiene, victimization, etc.—can certainly trigger mental illness.

Mental illness, though, is likely a contributing risk factor. Because of the cyclical and long-term nature of severe mental illness, people often have difficulty getting and keeping employment. Without a regular income, many people depend on provincial and federal benefit programs. However, these programs do not provide enough assistance to cover basic food and shelter costs, and people with addictions and mental illness are often not able to qualify for these programs. Once people are accepted into these programs, the loss or

interruption of benefits (e.g., due to relapse) may cause more episodes of homelessness.

Among people who have severe addictions and/or mental illness, there are a number of reasons for the rise in homelessness:

- closing large institutions for people with mental illness (e.g., Riverview Hospital in BC) without increasing the supply of community-based services
- poor discharge planning and community follow-up after people leave hospital or the criminal justice system
- lack of affordable housing
- changing economic factors (e.g., increasing poverty, tighter housing markets)

Homelessness harms not only the people who are homeless, but also their communities and social systems. Prevention and long-term approaches\*\* must replace the reactive, emergency-based programs that have been used to date. **i**

## a profile of marginalized and street-involved youth in BC

### against the odds

Annie Smith

Annie is the Managing Director of the McCreary Centre Society and co-author of the report, *Against the Odds: A Profile of Marginalized and Street-involved Youth in BC*. The report is available for free download at [www.mcs.bc.ca](http://www.mcs.bc.ca)

A new study<sup>1</sup> of almost 800 street-involved youth found that while their lives are often filled with danger and difficulty, these young people are working hard to try to build a better future.

The results show that whether youth live in big cities like Vancouver and Victoria or smaller towns like Prince Rupert and Kamloops, they share similar experiences:

- o Street involved youth are three times more likely than youth surveyed in school to have been physically and sexually abused
- o Over half report mental or emotional health problems
- o More than one in three have traded sex to survive

In the survey the youth talked about problems they had experienced before they were homeless. This gave us some key information about the need to help children and their families before things get so bad that they either leave home or get kicked out. For example, one in four youth had used drugs and alcohol before they were 11 years old, yet most had not left home or been kicked out until they were

around 14.

There has been a worrying rise in the percentage of Aboriginal street-involved youth from 36% to 57% (in the communities that participated in the survey in both 2000 and 2006). This supports the need to fund Aboriginal services that can provide safe and supported housing to Aboriginal youth.

The study also found that although the odds were stacked against them, the youth were working hard, going to school and looking to change their lives for the better. The more stable a youth's home, the more likely it was that they would be in school. Yet, one in three of those who were living in the worst conditions (staying in a tent, a car, a squat or on the street) were still going to school. This shows how much the youth value school and their relationships with the teachers and counselors who work there.

More than a quarter of the youth planned to continue their education through college or university. As well as going to school, many of the youth were employed. One

in three had a job, and over half of those with jobs were working more than 20 hours a week.

Friends were very important, with many youth saying that they turned to their friends for help rather than professionals. This was true, even if they needed special help like medications or medical advice.

Despite many youth having problems with their families they also felt strong connections to them. This was positive. For example, youth were 60% less likely to attempt suicide or to self-harm if they felt strongly connected to their family than if they did not.

Whether youth were surveyed in the North, the Interior or the Lower Mainland, their message was the same about what was needed in their community—safe and supported housing and job training opportunities.

### footnotes

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# Substance Use: **Pathway to homelessness?** **Or a way of adapting to street life?**

Eugenia Didenko and  
Nicole Pankratz

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*Eugenia is a Research  
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For decades, researchers have been examining the dynamics of homelessness and substance use. While estimates of alcohol and drug use rates among the homeless vary considerably,<sup>1</sup> there is agreement among experts that homeless people have much higher rates of substance use than the general population.<sup>2-4</sup> At the same time, the number of people without adequate and secure housing among those who experience problems from substance use is high as well.<sup>5</sup>

One fact is clear: homeless individuals with alcohol, drug and mental disorders are among the most underprivileged and vulnerable groups in society.<sup>6-7</sup> What is still up for debate, however, is whether substance use leads to homelessness, or homelessness leads to substance use.

It is easy for most of us to imagine how problem substance use could lead to homelessness. After all, if using alcohol or other drugs becomes more important than a person's work, health and relationships, it would logically follow that they might lose these important social and economic supports in their lives.

On the other hand, it is equally clear that becoming homeless could trigger a new substance use problem or worsen an existing one. A person might lean on alcohol or other drugs to help get through a tough night or face unpleasantness during the day—shame, fear, hunger and pain are just a few of the challenges a homeless person may experience.

## **Social selection: Substance use can lead to the streets**

Most of the current evidence about the relationship between homelessness and substance use supports a social selection model. This model indicates that problem substance use may be a direct pathway to homelessness.

A number of studies provide support to this theory. Research reveals that approximately two-thirds of

homeless people cite alcohol and/or other drugs as a major, and at times primary, reason for becoming homeless.<sup>4,8-9</sup> In fact, many homeless people develop problems with alcohol and other drugs before losing their homes. One US study reports that, for people who have ever experienced homelessness, the median age (i.e., the mid-point across the participants' ages) at first street experience was 28 years. The median age at first symptoms of alcohol problems, however, was 22 years, and for drug problems, 25 years.<sup>10</sup> Clearly, problem substance use is a significant risk factor that decreases a person's ability to respond to life's challenges.

## **Social causation: Street life increases substance use**

There is also considerable evidence pointing to the social causation model. This model suggests that substance use increases as a very clear consequence of homelessness and serves as a method of coping with the stresses of street life. As early as 1946, researchers estimated that one-third of the homeless people in their investigation became heavy drinkers as a consequence

## **footnotes**

visit [www.heretohelp.bc.ca/publications/visions](http://www.heretohelp.bc.ca/publications/visions) for Eugenia and Nicole's complete footnotes or contact us by phone, fax or email (see page 3)



One fact is clear: homeless individuals with alcohol, drug and mental disorders are among the most **underprivileged and vulnerable** groups in society.

of homelessness and related factors.<sup>10</sup> In another example, from the UK, 80% of respondents revealed they had started using at least one new drug since living without a roof over their heads.<sup>8</sup>

There is nothing new about the idea that people on the street self-medicate to relieve life's stresses. After all, the non-homeless population also uses more alcohol and other drugs when they have trouble coping in their world.

Nor is it surprising to learn that alcohol consumption is key to acceptance in the homeless subculture, and thereby supports the causation theory. Our mainstream teen subculture, for instance, practises a similar kind of ritual.

### Developing an integrated response to housing and treatment

Homelessness and substance use are complex issues. As our understanding of the relationship between them grows, it becomes increasingly evident that the question is not either/or, but rather, and. Our focus should be on seeking ways of addressing both issues simultaneously. It is critical that we do not let one problem lead to the other. This doubles the health care and

social support costs<sup>11</sup> and, more importantly, demoralizes an already disadvantaged population.<sup>12</sup>

Far too often, however, there has been a stronger emphasis on substance use and addictions treatment, than on providing other support services to substance users, including those who live on the street. Yet, research confirms that stable housing, both during and after treatment, is a key to successful treatment, because it decreases the risk of relapse.<sup>2,13</sup>

It is also important to understand that as the pattern of substance use changes, so does the need for housing and supports. What is urgently needed, then, is the provision of safe and affordable housing with services that respond to each individual's unique needs. Furthermore, we should not only tackle homelessness and substance use, but should also help society's most vulnerable people boost their self-confidence and develop strong social networks.<sup>14</sup>

If housing, treatment and other social agencies work together toward developing a comprehensive response to the problems of homeless substance users, the whole community will benefit. **i**

## Homelessness Not just an urban phenomenon

**F**or those of us living in big cities, the sight of people panhandling for change, binning for empty bottles and sleeping on sidewalks has become all too common. Though a large portion of the actual urban homeless population isn't on the streets,<sup>1</sup> this is the face of homelessness and poverty that we see in the "big city."

There is another face of homelessness—the face of rural homelessness. It exists in almost every small community in the province.<sup>2</sup> But in contrast to urban centres, smaller communities generally lack visible signs of homelessness.

According to one researcher, homeless people remain unseen in smaller communities because there are fewer services for them. Because of this, there are fewer opportunities for the homeless to visibly gather together. This same researcher also states there is simply a lack of tolerance for visible homelessness in small communities.<sup>3</sup>

Instead of sleeping on the sidewalks and gathering in front of a shelter or soup kitchen, homeless people in smaller communities are in the bush in tents or campers. They're sleeping under bridges or on the edge of people's properties. They're "couch surfing" with family or friends and, most often, they're behind closed doors in a house that is rundown, unsafe and bad for their health.

### A closer look in BC: Small communities; large problem

At the Canadian Mental Health Association, BC Division (CMHA BC), we recently completed two small research initiatives on homelessness in small BC communities.<sup>4,5</sup> This research adds to what we've been learning from our one-year Income/Homeless Outreach Project that has outreach workers engaging with, and providing services to, homeless people in eight communities throughout the province.

As part of this research, we talked to front-line workers in 27 small BC communities about the needs and numbers of homeless people in their area. These front-line workers included those in shelters, food banks and social assistance offices. We also interviewed mental health workers and members of the RCMP.

Responses in 25 of the 27 communities surveyed indicated that homelessness was an issue in their town. In fact, three of the smallest communities—100 Mile House

**Teya Greenberg**

*Teya is the Coordinator for the Canadian Mental Health Association, BC Division, Income/Homeless Outreach Project*

### did you know?

- Alcohol use is more common among older homeless people, while illicit drug use is more common among homeless youth.
- In the Greater Vancouver Regional District, 48% of the homeless people reported addiction in 2005, up from 39% in 2002.<sup>15</sup>
- Research in British Columbia suggests that the combined health care, social and justice system costs per homeless person per year range from \$30,000 to 40,000.<sup>11</sup>



“Situations of homelessness are still rooted in experiences of poverty, colonization and trauma.”

(pop. 1,885), Lillooet (pop. 2,324), and Port Hardy (pop. 3,822)—all said there were 30 to 40 homeless people in their communities. These numbers tell us what people in small BC communities know too well: extreme poverty and homelessness is not just an urban phenomenon.

### **Small communities: 'Known' people; few landowners**

In many ways, homeless populations in small communities don't differ much from those in urban centres. Situations of homelessness are still rooted in experiences of poverty, colonization and trauma; there is still the same overrepresentation of First Nations people; landlords still discriminate against First Nations people, youth and people on income assistance.

There are, however, issues and barriers that are unique to small communities. One of the biggest differences between being homeless in a large urban centre and being homeless in a small community is the number of housing options that are available. Small communities have fewer housing options.

A major challenge, identified in the research noted above and in one-on-one interviews with landlords and property managers, is that homeless people have difficulty getting housing in small BC communities because they're 'known.' Many have “burned their bridges”—that is, have ruined their relationships—with landlords in town.

We also found that, in some instances, just one or two property management companies or landlords own most of the real estate in the town.

This combination of 'known' people and only a few landowners results in a situation where people who are ready to make changes in their lives have very few housing options.

### **Community-specific barriers**

Small communities may have different challenges, depending on their size, location and geography (e.g., climate). In some communities:

- Transportation is a huge issue, because there is either no public transportation or poor public transportation between town and the places where low-cost housing exists.
- For tourism-focused areas, seasonal evictions are an issue; low-income motel/hotel tenants are evicted so landlords can raise their rates to capitalize on the influx of tourists.
- When there isn't a local welfare office, applying for income assistance—which is sometimes necessary to pay rent—is difficult for people who are facing multiple barriers. Income assistance applications can be very challenging to complete, and people don't get the same kind of personalized service applying through a call centre as they might in person.
- Municipalities either don't have any regulations or don't have the ability to enforce regulations requiring landlords to do regular upkeep on their low-income suites.

All of these factors contribute to the largest underlying problem: a lack of accessible, secure, affordable housing.

### **City–Country: Similar problems; similar solutions**

While the face of homelessness and the issues and barriers faced by homeless people may differ in communities, both small and large, the need to address these issues is the same.

Renowned advocate David Hulchanski, Director of the Centre for Urban and Community Studies at the University of Toronto, writes, “Homelessness is not just a housing problem, [but] it is always a housing problem.”<sup>6</sup> So, while solutions to homelessness must cen-

*for more information on CMHA's Income Outreach Project, see [www.cmha.bc.ca/advocacy/homelessness](http://www.cmha.bc.ca/advocacy/homelessness)*



## the landlord perspective

Landlords generally don't enter into real estate as an opportunity to do social work. And much of the media attention regarding landlords who own low-income buildings centres on those who let their buildings fall into disrepair and view their properties solely as a financial investment. However, many landlords—when faced with the reality of operating a low-income building and the informal social work that it entails—see it as part of their community responsibility.

In the spring of 2007, Teya Greenberg conducted a series of interviews with landlords and property managers who were housing outreach clients in small BC communities. Most interviews took place on location at their properties.

Those interviewed for this study spoke compassionately about their tenants:

*“We provide homes to the ones who cannot afford houses.”*

*“It's hard on me to evict them. That's a human being; you can't just kick him in the rear end and say, you're gone.”*

*“People who are trying hard, you help them and give them a chance . . . I'll revoke an eviction notice if someone starts to change behaviour.”*

A number of common themes emerged from the interviews:

### Active addictions = housing instability

Landlords and property managers consistently identified that drug use or association with drug culture was the number one reason for both evictions and rejection of potential tenants.

They noted that often it isn't the tenant, but the tenant's wider community that causes disruption leading to eventual eviction.

*“These aren't bad people; it's just that they get caught up in the wrong crowd—the drug culture; next thing you know, all these drug dealers are in the building.”*

### Landlords would benefit from support services

The most common suggestion was for an accessible person who would talk to tenants, mediate conflicts between tenants and landlords, and provide life skills training and other supports to tenants—in other words, a housing support or housing outreach worker.

*“Somebody accessible, with authority, who could come in and talk to tenants—teach them to be good tenants; someone who would come and talk about living in community with other people; somebody neutral.”*

The landlords and property managers also suggested that tenants need access to emergency rent money to help them keep their housing during short-term financial crises.

In addition, landlords/property managers felt that income assistance rent cheques should come directly to them and that all rent-related costs—particularly hydro—should be included in the rent cheque.

*“People hook up hydro, then bail on the apartment and don't pay the hydro bill. Landlords get stuck paying the bill.”*

It became clear that, to end homelessness, housing support services for both tenants and landlords/property managers of market housing units<sup>†</sup> need to be provided. The benefits are, at minimum, twofold:

- o Hands-on support to tenants helps increase the ability of tenants to keep from being evicted.
- o The burden of responsibility on landlords and property managers to maintain tenant stability on their own is reduced, so they are more liable to rent to low-income and hard-to-house tenants.

*“With more supports available, I might be less zero-tolerance.”*

tre on the provision of actual affordable housing units, these units must also be strengthened with a variety of supports and services. And these supports must be accessible and relevant to the people needing them.

Here are six recommendations we heard consistently from people across the province:

1. Increase the number of supported housing units (i.e., affordable housing with staff that provide assistance to residents).
2. Increase funding for First Nations' support workers. First Nations people are highly over-represented among the homeless population, and it is best practice to have First Nations workers providing support to First Nations people.
3. Increase municipal government action against landlords who do not do regular upkeep on their housing units.
4. Increase the income assistance shelter allowance and reform policies on direct-to-landlord rent payment and on earning exemptions.<sup>7-8</sup>
5. Develop housing support services throughout the province.
6. Increase addiction treatment options and mental health and addictions outreach services. **i**

### footnotes

visit [www.heretohelp.bc.ca/publications/visions](http://www.heretohelp.bc.ca/publications/visions) for Teya's complete footnotes or contact us by phone, fax or email (see page 3)

# Applying for Subsidized Housing in BC

The wait for subsidized housing can be long and stressful. There are many more people on the applicant list than there are homes available. Over 80,000 people in British Columbia currently receive housing subsidies from BC Housing. As of March 31, 2007, there were 14,228 people on the applicant list.

## Subsidized housing—What? Who?

Subsidies and rental assistance are provided by the provincial government and by non-profit housing societies. Public<sup>†</sup> and non-profit housing<sup>†</sup> is intended for people with low incomes, including those who receive income assistance. Rent supplements available through BC Housing (Shelter Aid for Elderly Renters and the Rental Assistance Program) are not available to people on income assistance.

Subsidized housing in BC takes several forms:

### Public housing

Owned and managed by BC Housing, a provincial crown agency. BC Housing is responsible for tenant selection and is the landlord.

### Non-profit housing

Owned and managed by local non-profit housing societies. The housing provider selects

tenants and is the landlord. The housing society sets its own policies.

### Housing co-operatives

Managed by the members who live there. Members are responsible for new member selection.

### Subsidized housing—How? Where?

The Housing Registry is a partnership between BC Housing, the BC Non-Profit Housing Association, the Co-operative Housing Federation of BC, non-profit housing providers, housing co-operatives, municipalities, information and referral service groups, and other community-based organizations. It provides its members with a database of applicant information they can access when units become available.

Many non-profit and co-operative housing providers are members of the Housing Registry. BC Housing is also a Housing Registry member and uses the database to fill units as they become available.

You only need to complete one application form to be considered for subsidized housing at all the member sites. However, a section of the application form allows you to note preferred locations; you can choose cities, towns or specific buildings. You must apply on your own. If you feel unable to follow up on your own, you may sign a release form

allowing any further correspondence to go through a family member or friend.

Applicants should familiarize themselves with the Housing Listings, an online resource directory that provides maps and addresses of subsidized housing developments across the province for families, seniors and people with mental and/or physical disabilities. These listings include a variety of helpful information,

including how to apply to specific developments. They are available at [www.bchousing.org](http://www.bchousing.org).

The Housing Listings also includes information on developments where the individual housing providers maintain their own applicant lists and fill vacancies from these lists. If you want to be considered for a home in these sites, you need to apply directly to them.

Erin Smandych

*Erin has been Manager of Housing Services for BC Housing since 1996. She joined BC Housing in 1990 and took on a variety of roles in Housing Services, including helping people apply for subsidized housing*

## who uses bc housing services?

5,101 people who currently reside in emergency shelters and housing for the homeless, including 2,332 homeless served in nightly shelters and 2,769 homeless housed

15,045 people living in transitional supportive and assisted living, including 9,314 with special needs and 5,731 seniors

43,639 people living in independent social housing, including 24,293 low-income seniors, 15,988 low-income families and 3,358 Aboriginal families and individuals

16,941 people who are receiving rent assistance in the private market, including 15,387 seniors and 1,554 families



\* For more information on applying for housing, or to find out the eligibility requirements for rent assistance programs: phone The Housing Registry at 604-433-2218 or 1-800-257-7756 toll-free from outside the Lower Mainland; drop in at #101-4555 Kingsway in Burnaby; or visit online at [www.bchousing.org](http://www.bchousing.org)

**How are people chosen for subsidized housing?**

Some housing providers use chronological wait-lists; however, many others prioritize applicants according to need. Priority for developments managed by BC Housing is given to people with the greatest need. These include women and children fleeing abuse; people at risk of homelessness; people with chronic health issues, including frail seniors and people with mental illnesses, physical disabilities or substance use issues; and families and youth.

Non-profit and co-operative housing providers often have different criteria for choosing residents. Some use a first-come, first-served system, while others use a point system to determine greatest need. Co-ops accept new members based on their willingness to participate in running the development, as well as their need.

Wait times are unpredictable as they depend on the number of unit turnovers and the needs of other applicants.

**Important things to remember when applying for subsidized housing**

**Take time to review the Housing Listings.**

- It is important that you only select buildings or areas you are willing to move to.

- Warning: Your file with the Housing Registry will be cancelled if you refuse two offers of housing.
- Be sure to find out what the rules about refusing offers of housing are for housing providers in the Housing Listings that manage their own wait-lists.

**Provide a way for the housing provider to contact you.**

- A housing provider needs to reach you quickly and reliably when a unit becomes available.
- Provide a daytime phone number or the name and number of a contact person who can take a message.
- If you do not have a phone, this contact person can be a friend, family member or outreach worker.

**Keep your application up-to-date.**

- Let the Housing Registry know if you move, if the number of people living with you changes, if you receive a rent increase or if you have a change in your household income.
- At a minimum, you must contact the Housing Registry at least once every six months to keep your application active.
- You can contact the Housing Registry by phoning a toll-free number or stopping by their office.\*
- Find out what the updating requirements are for housing providers that are not in the Housing Listings but are not members of the Housing Registry.

**Be realistic.**

- The Housing Registry does not provide emergency housing.
- It is not possible for the provider to know when a unit may become available.
- There are more people looking for housing than available units. This means that some applicants may never receive an offer of housing.
- Being too specific about which building you want can delay the process. If you really only want to live in the one building that is walking distance from your children's school, understand that your wait may be very long.

**Pursue other housing options.**

- Consider applying directly to those housing providers identified on the Housing Listings as managing their own applicant lists.
- Contact the Housing Registry to see if you meet the eligibility requirements for programs that provide cash assistance with monthly rent payments in the private market.† The Shelter Aid for Elderly Renters (SAFER) program assists eligible seniors over age 60, while the Rental Assistance Program assists low-income working families.
- If you are connected with Mental Health Services, speak to your case manager to discuss other possible housing options. **i**

for more on BC Housing services, see the online-only Visions article by Craig Crawford

**Co-Occurring Disorders  
Advanced Citation**


Learn skills for working with people who have mental health and addiction problems.

This advanced program - the first in BC - gives workers in the helping professions the tools to understand the challenges of co-occurring disorders.

The program is suitable for those with a certificate, diploma, or degree in social services and allied professions or related experience.

- ▶ **Information session Wed, October 17**  
6:30pm, Room 2802, New Westminster Campus, 700 Royal Ave. (one block from the New Westminster Sky Train station)
- ▶ **Classes start in January 2008**  
All courses are offered in the evening. Limited seating. Register early.
- ▶ **For more information, contact John Fox, 604-220-9114 or Bob Shebib, 604-527-5139.**

07-184

 **Douglas College** [douglascollege.ca/cod](http://douglascollege.ca/cod)



# Life on the Streets

I've been on the streets a lot in my life. In my early teens I ran away from home. Now, at the age of 23, I find myself back on the streets for something I never thought would happen to me. I was fired from a job because I lost my temper with a customer. I didn't find a new job in time to pay my rent and was evicted.

On March 11, I went to a men's shelter in Vernon called Howard House. They helped me get on welfare and I started paying rent of \$450 a month. The Ministry of Employment and Income Assistance (MEIA) only gave me hardship coverage, which means I only got three months of assistance. Come April, Howard House raised the rent to \$500. I was only able to give them the \$375 income assistance shelter allowance. I gave them that, but was kicked out on April 4 anyway. The money went back to welfare and I was without a place.

I heard there was another shelter that was free to stay at. But when I got there, I found it had closed due to lack of funding. I was left with no place to stay. I kept my hopes up, though, because I still had a place to eat called the Upper Room Mission. The staff there really care about the people who go there.

With the free shelter closed and a bylaw against homeless people sleeping in parks or on city streets, there was no place to sleep at night. The staff at the Upper Room Mission, however, said we could sleep in their parking lot. This is what I, along with about 20 other people, have been doing. We face many hardships, like people driving by and yelling at us. Once someone even drove into the lot while we were asleep and screeched around, doing a smoke show. Yet, ever since the newspaper wrote an article about what is happening to the homeless, many people have come to bring us food, blankets and clothing.

Since being back on the streets, my hope of getting back on my feet is falling into the dark. Before becoming homeless again, I'd been drug-free for six years. But because of depression and the stress of being homeless, I've gotten back into using ecstasy and smoking weed.

When you live on the streets with no money, crime becomes a big temptation. So far, I've been able to ignore the temptation, but for how long I don't know. Between the ages of 13 and 19, I was in and out of jail for breaking and entering, auto theft, drug charges and assault. I've been out of jail for three years now. I still have a warrant for my arrest, though, from Thunder Bay, Ontario. I can't be arrested on that warrant here unless I commit another crime and was told the warrant will be dropped if I can evade it for seven years.



With three years behind me, I'm hoping I can get through the next four.

I fear that if I don't get a job and a home soon, I may find myself back in jail. Some people look at being in jail as "at least I am off the streets." As true as that is, besides having a bed and food every day, jail is much like the streets: you still have to deal with drug use, other people's tempers, and even cop-like people. This is why I would much rather find a job, get back into the working world and have a house of my own.

I want to work. I've done odd jobs for people to make money so I could eat and buy smokes. I did six days of labour on a farm for \$480, and then I did one day's work putting siding on a house for \$60. It's more like no one wants to hire me because I'm homeless. But I'm homeless because I don't have money to pay rent, and I don't have money because no one wants to hire me until I have a place. So it's a Catch-22.<sup>1</sup>

I've also been prescribed medication for attention deficit, split personality and bipolar disorders. The medication I was first given when I was working was not covered by any Canadian medical plan. Since being homeless, getting the medication I desperately need has been very difficult. My doctor just recently found a medicine that my BC medical plan will cover. So now I am back on medication, but it took from March 11 until May 24 for that to happen.

I've met many different people while living on the streets and not all of them are homeless. I've met a very kind and warm-hearted married couple, who are a great support in keeping my hopes of getting a job high. I'm thankful for meeting them. I also met my now girlfriend on the streets. She is not homeless, but has slept with me on the street a few nights. It makes me very happy that she understands me, and I know she's there for me no matter what I'm facing. A few other people I've met are not the best people to know, and I wish I'd never met them.

My biggest wish is that the public would realize we homeless people are just like everyone else; we're just having a rough time in our lives. Many of us have good hearts and are trying to find a home and a better life. We just have some mighty big obstacles to face. ■

**Jon Mercier**

*Jon is 23 and lives in Vernon. He has two beautiful sons and, although he is homeless, he is working toward a better future*

### related resource

for even more personal experience, see online-only Visions articles by Aaron, Jessie, Michael and Jake

### footnotes

visit [www.heretohelp.bc.ca/publications/visions](http://www.heretohelp.bc.ca/publications/visions) for Jon's complete footnotes or contact us by phone, fax or email (see page 3)

## Recipes for an SRO

There is an unexpected knock at my door, this December day in 2006. It's my brother, who I haven't seen or spoken with in a year.

He has quite literally been missing. I reported him missing to the Vancouver Police Department missing persons registry around Thanksgiving, as my elderly mother hadn't seen him for six weeks.

The police reported that he was in town, withdrawing small amounts from his bank account. This behaviour, they said, was characteristic of someone living in the chaos of the Downtown Eastside (DTES). He was not psychotic enough, however, to be hospitalized under the Mental Health Act. At least I found out that he was alive and not one of the "missing." The current pig farmer<sup>1</sup> trial adds a double edge to family members of people who are missing.

My brother has dropped out of his mental health treatment program and moved to the DTES. In the past year, he has moved from his own apartment, to my mom's condo on the eve of spending New Year's in a homeless shelter, to a respite bed because my mom couldn't have him in her tiny space any longer, and then from one single room occupancy hotel (SRO)<sup>†</sup> to another in the DTES.

He is homeless. He is not counted among the 1,200 people who sleep in our streets every night, but he does not have a secure

and healthy place to call home. He has a single room in a welfare hotel for which he pays \$425 per month. He has no running water in his room and the toilet is down the hall. He showers at a Vancouver parks board swimming pool, when he can get to one. Though he is housed, his housing could disappear with the next hotel upgrade that occurs as the City of Vancouver prepares for the Winter Olympics in 2010. He is a member of the underclass, created by governments that have not invested in housing for people like my brother.

I ask if he's hungry. He says he is. But it's a very proud "yes." He says he has a microwave in his hotel room, but he has no way of preparing food and doesn't have any refrigeration. He's having trouble including enough vegetables in his diet. He can't buy any in his neighbourhood, even though he lives on the edge of Chinatown and is actually quite close to several produce stores—he has a delusion that Asians are conspiring to take over the world, and he won't go near them. He has learned this is not a socially acceptable delusion, so when he is well he downplays this. But he still won't go in their stores.

I rack my brain to think of already-prepared food I could give him. I ask him if he's tried heating canned stew or soup in his microwave. He says he has a bowl he could put in the microwave.

I ask if he has a can opener. He says, "No."

"Would you like one?"

"Yes."

Getting to yes with someone with oppositional defiant disorder is a major victory. You have no idea how pleasurable it is to give a homeless, mentally ill person a can opener.

I carefully suggest that, now that he has a can opener, he could open a can of soup and heat the soup up in his bowl in the micro-

Maggie

Maggie\* is a safely housed sister

\* pseudonym



wave—it is ceramic; okay for the microwave. His mental wheels turn.

"Do you have any soup I can take with me?"

I get a can of soup. It's the kind that doesn't even need a can opener. I show him how to pull the tab on the lid to open it. He watches with real interest.

"You're hungry then?"

He replies that yes, he is hungry, and he doesn't feel well. He's adamant he isn't sleeping because he isn't

eating well. And, in case I was going to bring it up, he does not have a mental illness.

I recall that disordered sleep is often an early warning sign of a psychotic episode.

“Did you have any breakfast?”

“No, I haven’t, and I don’t want you to make me any food.”

I get the picture. He is homeless, broke, hungry and proud. All I can do is think of food I can give him that will meet his criteria for working out in an SRO hotel with only a tiny microwave, no water or refrigeration in the room, and a city water system under safety alert due to heavy winter rains. And that, above all, will allow him to maintain his dignity.

I see that most of the food in my cupboard requires preparation. I’m a devotee of How to Be a Domestic Goddess, so my brother and I are far apart. And yet, there is an art to cooking in an SRO on welfare. Every social service and health worker who is paid to care for homeless people should try it out for a week.

There is an unopened box with eight packages of instant oatmeal in my cupboard. Would he like that?

“Oatmeal is good.”

I also throw some apples in what has become the food bag. He tells me he has a coffee maker in his room. Would he like some tea to take with him? Yes, he would like some—just the orange pekoe type. How about some bottled water? Yes, he would take some.

“Have you thought about going to the shelters for lunches and dinners?”

“No.” He knows the DTES scene. He says the quality of the food and the hassle of the experience is not worth it.

Mentally ill people are called “bugs” in the homeless community, and they are fair game to pick on. Junkies working for their next fix are extremely aggressive, particularly meth addicts. But above all, and despite the reality of his existence in the poorest postal code in Canada, he cannot bring himself to join the ranks of the walking wounded living on the social system in the DTES. He cannot ask for help. His logic: if I do not receive

“You have no idea how *pleasurable* it is to give a homeless, mentally ill person a *can opener*.”

help, then I am not ill with one of the most discriminated-against conditions in the medical dictionary: schizophrenia.

My brother has what psychiatrists call “refractory or treatment-resistant mental illness.” One doctor told me that he lacks “executive function”; that is, the frontal lobe can’t coordinate. It doesn’t seem to matter what my mother and I do. We can’t treat him. But for some 20 years we’ve kept a gentle, dignified watch around him—something the system doesn’t know how to do.

“I’m moving to Surrey.” He says they have golf courses in Surrey and he can find a better place to live there. He talks about

not liking the DTES. There are bugs in his room.

“I understand. Are you safe?”

“I don’t like living there.”

This is the closest he has come to expressing despair about his living situation. He doesn’t use drugs, so the depravity that goes with mental illness and concurrent addiction is quite a horror to his ‘plain ordinary’ psychoses and delusional thinking. His psychosis is ever-present. And yet seems to come and go within the moment. Some moments are clear; others are baffling. I am never quite sure which is which until he reaches the end of a sentence or paragraph.

My brother is part of the cash/no benefit economy. He wants to move away from the crisis-prone poverty community he lives in and the health care system that knows something about him, but consistently humiliates him. It forces him to take treatment and never gives the kind of support he wants to get well, like support to get a job.

I can see he is starting to unravel. I’ve seen him approach the edge of madness numerous times before.

“I just need to eat the right food and then I would feel better. I could then move to Surrey and go golfing.” He stands up and takes a swing with an imaginary club. “Yup. Go

to Surrey and golf.”

I am desperately trying to think of some way to make Surrey seem less desirable to him. The Surrey he can afford is ripe with meth users, and the scene is tough. I try a new approach.

“It would be great if you lived near us, as Mom is 82 and is getting frail.”

“She has been getting frail for several years now, and that’s her problem, not mine. I have to look out for myself.”

I know the conversation is rather fruitless. And I know there is no safe housing for someone like my brother outside of the DTES. My neighbours actively campaign against such housing. I am suddenly shamed by the reality of the housing situation in Vancouver for people with a mental illness who are homeless. I understand how going to Surrey, a community where he is unknown, is a more appealing choice outside of the DTES. But I worry that the stresses of moving may also push him over the edge that separates functionality from madness.

He stands up suddenly. He grabs his plastic shopping bag of food, puts on his shoes and stomps out into the snow. Here this moment; gone to Surrey tomorrow . . . Maybe.

I hope he can figure out how to microwave the food he took. And I hope he can’t figure out the way to Surrey. Better he lives with the dream of golfing in Surrey. And wonderful that he is still capable of imagining a better future in the midst of chaos, disability and hunger. ■

footnotes

visit [www.heretohelp.bc.ca/publications/visions](http://www.heretohelp.bc.ca/publications/visions) for Maggie’s complete footnotes or contact us by phone, fax or email (see page 3)



## Living with Bekele

### Recovery and relationships in a small family home

Medr  
Medr\* and his wife Makeda\* live in Burnaby with their two sons, Kassa\* and Bekele\*

\* pseudonyms

**M**y wife and I immigrated to Canada as newlyweds so that we would be able to provide a better life for our future family. We have a strong marriage and are devoted to our boys. My oldest son, Kassa, is 12 and has just completed grade seven at our local school. My second son, Bekele, is 10.

We live in an apartment that is far too small to meet our family's needs.

Bekele, after many hospital stays, was diagnosed with bipolar disorder. One part of Bekele's illness is depression. When he is depressed, he cries. Because our small apartment is so small, this upsets everyone else as well.

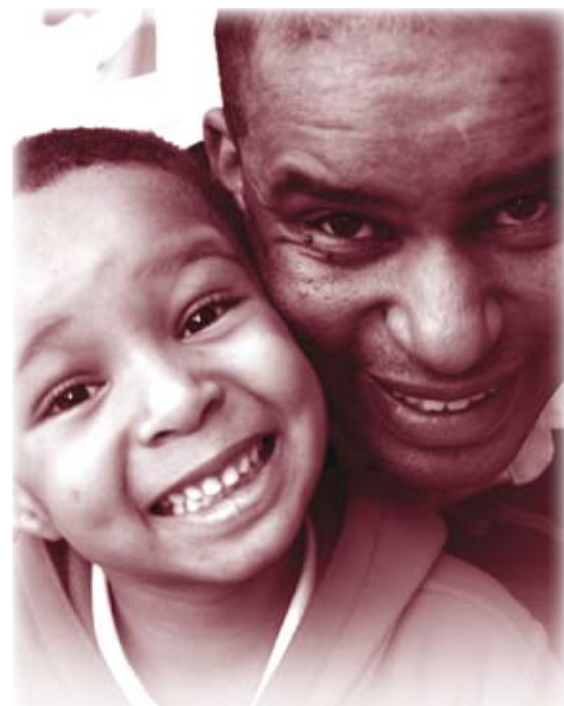
The other part of Bekele's illness is that he feels restless. People, noise and confined spaces make him restless, and he runs, jumps, paces and makes noise in an attempt to calm himself down. But he is unable to calm himself. Whether he is inside or outside, Bekele is in constant motion. I take him out when I can, but it is impossible to be out at the park at all times.

Staff at the hospital have come to know my son, and have provided a special room for him there. His room is away from the other children, so he has a place with less noise and distraction where he can go to calm down and relax. Because of our close space, Bekele has not been able to come home for weekends when he's been in hospital.

Bekele's need for a room where he can be calm is an important part of his treatment plan, and we are unable to provide this in our home. If we had a place with another room and a small yard, it would provide more opportunities for him to be on his own in a safe environment where he could be supervised.

Our home has only two bedrooms, so the boys have to share a room. Sharing a bedroom with Bekele is very difficult for Kassa. Kassa needs his own space to do his homework or just have his own down time. Right now, Kassa has no place to go in our home to be alone and just relax. He does his homework at the kitchen table, and is constantly distracted from his work by Bekele pacing and running. If Kasse goes into the bedroom, it makes little difference as the bedroom is right beside the rest of the living space—and it is also Bekele's room.

At night it's very difficult for Kassa to get any sleep. Bekele only sleeps about four hours. Often, Kassa will be woken at five in the morning by Bekele jumping on



his bed. This makes it very hard for Kassa to get up in the morning and go to school. He is usually very tired and finds it hard to concentrate at school. All of this has had a detrimental effect on his schoolwork. While Kassa is very worried about his brother, one of his reactions to Bekele's recent hospitalization was: "Finally, I can get some rest."

This situation also impacts my wife and our relationship. Makeda works outside the home. I am able to stay at home with the boys because of a permanent back injury. When my wife comes home from work, we are both tired. Being with Bekele all day, around his constant movement and being constantly on guard, is exhausting and increases my back pain. When Makeda comes home from work I would sometimes like to be able to take a break from home and go for a coffee. This has become impossible because we have no place for Bekele to be while I am out of the house. He becomes agitated and has hurt his mother while trying to get out of the house to find me. I feel that if he had his own space, he could go there and we could all have some time to relax in our home.

Two years ago we applied to BC Housing for a larger home for our family. The professionals who work with us supported our application. I was told that, on the BC Housing rating scale, we have only a 60% rating for needing a bigger home, which means that those with higher ratings would be provided a home before we would be.

Last month BC housing finally contacted us to look at some housing. The house they showed us was right on the highway. I told them that living on the highway would be too dangerous for Bekele, so we couldn't accept this housing.

Bekele is unaware of his own safety. We live on the second floor of our building. There is a steep flight of

stairs that leads to our apartment. When Bekele is pacing and moving, he will often open the door, dart down the stairs and run out into the traffic. Recently, we had an incident when I was going to take Bekele out to the park. I was putting on my shoes, and in the time it took for me to tie my laces, he was down the stairs, across the street and running toward the traffic. I went after him as fast as I could, calling his name, running into the street after him. As he turned to run back to me, we were both nearly hit by a car.

Because we did not take the house, BC Housing cancelled our file and we can no longer apply for a new home.

Makeda and I are currently challenging BC Housing's decision. But we have already waited two years—and who knows if we will ever be able to improve our situation. So we struggle on, continuing to make the best of a bad situation—trying to provide a safe, productive home for our family. **i**

## My Woman Under Plastic

**O**ne December Sunday in 1995 I spoke to a shopping cart surrounded by black plastic in a doorway behind a Kitsilano supermarket.

"Hi, I'm Claire. And how are you doing?" I asked.

A pair of dark eyes emerged. "I'm okay. You don't need to bother about me," said my new acquaintance.

We chatted about the weather (cold). I asked her if she had eaten. She told me she gets hot water at a nearby convenience store each morning for her tea. As I bid her goodbye, she told me her name was Kathy, and I told her I'd be back to see her again.

When you think of the homeless, of what—of whom—do you think? Someone stumbling down Cordova Street or sprawled on East Hastings? The panhandler who last approached you? Or the bundled-up person sleeping in your local library? What about the person sleeping in the garage in Kerrisdale? Is your thinking filled with stereotypes? Do you think about the homeless at all? Well, let me share my

glimpse into Kathy's reality of homelessness.

A phone call to emergency housing services that Sunday evening began my education of what it's like to try and find shelter in this huge city of great wealth and astonishing poverty. Eight calls later, I reached Dale at Triage Emergency Services & Care Society. He promised to hold a bed for her. So back I went to that dank doorway. "Oh no, it's too far. I'm better off here," was her immediate response when I told her about the vacancy at Triage.

When I called Dale back to free up the bed, he asked what the first thing she had said was. He quickly agreed that it was far. And he pointed out that the quiet, perhaps dull West Side was much safer than the mean streets of the Downtown Eastside, where the Triage shelter is located: "She could stay here one night. But I'd have to turn her out the next day, and she's not safe down here."

Besides, Kathy wouldn't give me her last name. That refusal—an expression of her right to



**Claire Hurley**

*Claire is a Delta journalist, who has a master's degree in counselling psychology*

privacy—trapped her in a gaping crater in the system. Not registered with the (then) Ministry of Social Services? Too bad; no bed for you. Shelters are funded by various ministries, foundations and sometimes the federal government. But registry with social services seemed to be essential; without it, the shelters don't get funding for the use of that bed. So I was unable to land her a shelter bed.

Three years ago—after she first arrived in Vancouver seeking work, with enough money to last just two weeks—Kathy ended up in a shelter on the

Downtown Eastside for a weekend. At the time, the shelter's policy was that people could only stay there for one weekend. So, boom! She was out on the street. And as happens all too often with women forced to sleep in the streets, Kathy was raped.

I called a Vancouver city councillor about the homelessness issue, in December when the torrents of rain made outdoor sleeping impossible. He did make comments to city council, but the seemingly feigned concern of council members—seen by thousands of viewers, as Rogers Cable graciously rebroadcast this council

meeting on several occasions—failed to spark any immediate action.

I wonder what routes city councillors travel. Perhaps they wear blinders. Alert politicians in San Diego, a city with a climate much milder than ours, had, since 1991, opened the municipal gym in Balboa Park for the homeless in inclement weather. At Hastings Park in Vancouver, the BC Building, which meets fire code and health standards, had no bookings that December. And the schools around the city were heading into Christmas break, when their gyms would be unused.

For five days I stopped by to check on Kathy, who was still in the supermarket doorway. One morning I found her trying to dry her

stuff, then at me. When I smiled, they were stymied and stunned.

One night when snow was forecast, I phoned Lookout and Convents and Triage and St. James Social Services and counsellor friends and my church—no one had space in their shelter for this one person. And Kathy is just one of what may be thousands of people living outdoors.

My neighbour donated some clothing and cash to help. I had learned that Kathy had literally just two cents left to her name. She had last picked up a social assistance cheque in November, only to find it had been slashed in half. That's half of the \$211 that was her food and basic essentials allowance for a month. Kathy was supposed to return mid-month, but her painful ankle and foot made walking a hopeless contest and pushing that shopping cart was a monumental task. The walk from Arbutus to Oak Street, a walk of less than five kilometres, took her two days.

One day I phoned a nearby social services office and explained the situation to a worker. I asked for an electronic transfer of her records to his office. He refused. I guess my request was against the rules. When he said, "She can walk," I wanted to say, "How do we spell callous, boys and girls?"

The next day Kathy and I visited my doctor at his drop-in clinic in Kerrisdale. She agreed to the visit, I think, because I kept telling

her "he's 38 and cute." When the doctor ordered X-rays of her ankle and foot, he asked me to call her worker at social services about medical coverage. He told me to say that I was her "advocate."

Goodness me—what a difference an "advocate" can make. I was certainly impressed with the speed and efficiency of the social services office! When we arrived we were seen right away by a smiling, concerned worker who proved to be most helpful. The worker produced the needed medical coverage, reviewed Kathy's classification, and off we went for those X-rays. By the time we returned, this caring person had added extended medical benefits so glasses broken months ago could be replaced. And she had found Kathy a shelter, thanks to the Salvation Army. This may be a good news story after all!

As you sit there complacent and read my wee tome, contemplate this: how many pay cheques can you lose before you're out on the street?

The homeless are people who need our attention right now. You might be wondering how you can help. Well, you can raise hell about the loss of subsidized housing in False Creek after the Olympics, petition and phone politicians, give money to Triage and Lookout, donate food to shelters, phone government and city agencies, and try to find useable space. Don't take no for an answer. Get the churches involved. Make helping others your mantra.

And keep in mind that, someday, you and I may be homeless too. ■

**“That refusal—an expression of her right to privacy—trapped her in a gaping crater in the system.”**

clothing in the faint sunshine. On another occasion we tied her possessions to her shopping cart and hobbled over to the convenience store. We hobbled, because Kathy had broken her ankle. When she went to see her worker way over near Oak Street, she was told she had no medical benefits, so the ankle has never healed properly. As we approached the store, a woman gave Kathy half a sandwich. Then I sat outside, guarding her possessions, as she sought some hot water. Passersby stared at the collection of

Want to help? See [stophomelessness.ca](http://stophomelessness.ca)



# Outside In

## When someone living rough is given a home

One bright and sunny morning, I was rushing down Granville Street, already late for a meeting. A male voice called my name: “Judy!” I turned. He looked vaguely familiar—I waved and hurried on. He caught up with me and stood in front of me, blocking my way.

Clean cut, hands on his hips, sandy hair, hazel eyes. “Don’t you know me?” he asked. “I’m Richard!”

I couldn’t place him, and it must have showed.

“Four days ago,” he said, “you woke me up on the sidewalk. You got me on welfare; you got me my own room; you spent the whole day with me.”

The picture suddenly came together: a foul-smelling creature with greasy hair I thought was brown, oversized clothing damp from a rainy night on the sidewalk, and hazel eyes that didn’t seem to focus. Now, here he was in front of me—a different man, created by a hundred dollars of support money from welfare—and a room in a residential hotel with a door that locked.

Even after years of helping the homeless find homes, I could scarcely believe the difference that three nights safe sleep, a couple of showers, a haircut, a shave and clothing “new” from a thrift shop could make.

### From street to housing—the first few days

The transition from outside to inside, from street homeless to housed, does not always go so smoothly. This is a more difficult transition than we can imagine.

Often, people who have been living outside will sleep on the floor of their room for the first month or two. They say they have become so accustomed to hard surfaces that they are uncomfortable on the bed. They may return to the street and sleep outside for the first few weeks, gradually becoming accustomed to the warm, still air indoors.

Outside, living on the sidewalk, the din of traffic is deafening but constant. People say it is hard to get used to the quiet being disrupted by abrupt noises inside a building—doors slamming, elevator doors, banging of garbage cans in the hallways, voices in the next room. Each loud bang in the quiet is a shock. As well, social phobias may make it difficult to connect with the building manager, or to cope with other tenants in the building.

Although all we have to offer them is a tiny room, people who have been living rough are very glad to have it. Finally, they can put down their backpack

Judy Graves

*Judy advocates with homeless and low-income tenants for the City of Vancouver. She is currently collaborating with author Stephen Legault to write a book, 101 Solutions to Homelessness, for New Society Publishers*

**related resource**  
for another outreach worker’s perspective, see Kara’s online-only Visions article

### 6 tips if your relative or friend is living outside

6 tips

**Don’t pressure them.** Don’t send them anywhere—their experience is overwhelming and they will not be able to follow directions consistently. Gently lead them. Walk beside them.

**Adore them.** Bring them good food, wool socks, dry shoes, clothing and cigarettes, if they smoke. Old, drab clothing and shoes are less likely to be stolen from them. Take them out for lunch—ask them where they want to go. Be sure you are a source of comfort to them. Don’t pressure; don’t scold.

**Don’t burden them with possessions.** They have to carry everything they own at all times. Things can be exhausting.

**When finding them housing, don’t be fussy.** A room that appears cramped and grubby to you will be a life-giving beginning for your friend. Help them through securing the room every step of the way.

**Don’t smother.** This is hard, because your impulse will be to make their “home” nice. But it is important that people furnish their own nest in their own way sometime after they move in. A good move-in gift would be a light washable blanket, a towel, a can opener, a spoon, a bowl and a few cans of stew. Let your friend take it from there. Some will prefer a minimalistic existence; some will decorate surprisingly well with things they find in the alley.

**If they are evicted—stay calm!** Don’t worry—take it in stride. Just help them find another room somewhere, and help them move. Sometimes it takes three or four attempts before it “sticks.” This is normal.



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without fear it will be stolen.

The most important part for them comes when I say goodbye and they turn the lock on the door behind me. Alone. Safe. They haven't experienced privacy or safety the entire time they've lived outside.

The first few days in the room may be a busy time. Often they sleep a long time and wake up disoriented. They take long showers, and go to a laundromat. There is sudden attention to grooming, haircuts, using a toothbrush, buying white socks, replacing humiliating clothing. More sleep. They go to doctors to start clearing skin conditions that resulted from living on wet cement, and to get back on medication they took before becoming homeless. And then they cocoon.

### The first three months— an emotional adjustment

It is fascinating to listen to formerly homeless people describe their first months inside. Each is so individual, and each life is full of its own meaning, yet patterns emerge that seem common to most.

After the first few days of high activity between long sleeps, there is a period, for about two months, of numbness broken by unbearably sharp feelings. People talk about not wanting to do anything, of being still and not even watching TV. During this time, most reduce their use of street drugs—they're no longer the easy victims of predatory drug dealers in the streets. They drink little alcohol, though they may smoke a lot of marijuana to dull their anxiety. Then, suddenly, they relapse, binging on street drugs or alcohol. And then they return to reduced use. Gradually, they say, they learn to stay asleep at night, and are able to develop a regular sleep pattern.

In the second month, when sleep is regular, they start to become hungry at regular intervals.

In the third month, they tell us, they become interested in the world beyond themselves. They may begin to go outside every day. They may start to check out things that interested them before they became homeless—may join the library or go to a movie. Toward the end of this third month, they often begin to seek help for mental health conditions like depression and anxiety. And they start to take a real interest in food.

### By the fourth month—re-emergence

It's the fourth month of living inside that I find the most exciting to witness. This is the month when individuality, creativity and energy suddenly re-emerge. Some, who are able, start looking for work, or find a course that will lead them to employment. Others may join groups at a drop-in centre or start to volunteer at a church or service agency. One started to write a book on the computer at the library—a half hour at a time. Another bought art supplies and started to paint. Diabetics start cooking for themselves and take an interest in their diets. Some folk decide to move out of the city to a quieter community away from the memories of homelessness. There is a focused look about them. They sustain eye contact and smile easily. They can think more clearly now and want to talk.

When they lived outside, they could think only of the next few hours. After four months living inside, they look forward to a long future. **i**

#### related resource

"Welcome to Your Home" starter kits are being distributed to low-income tenants through a \$1-million grant to the BC Non-Profit Housing Association by the Ministry of Employment and Income Assistance. The kits (valued at around \$570) contain over 100 essential items for the kitchen, bedroom and bathroom including cooking sets, cutlery and utensils, bedding, towels, toiletries, basic first aid supplies and a tool kit. Kit distribution begins September 2007. See [www.gov.bc.ca/eia](http://www.gov.bc.ca/eia)



“Although all we have to offer them is a tiny room, people who have been living rough are very glad to have it.”

a collage of experiences ...

“Living on the Edge”  
1981 to 1991

For the past year I've been working as a volunteer at a homeless shelter here in the Okanagan Valley. When I help people, I remember my own 10-year experience living on the streets of Toronto and Vancouver and in one of the many skid row hotels in Vancouver's east end. A person is considered homeless by the BC government even if you have a room.

I remember the feeling of living on the edge of society, of going round and round in a cycle of poverty and homelessness, not mixing with so-called normal people. My life seemed far removed from my earlier years as a university student in Vancouver.

Eleven years after graduating in 1970, I became ill while employed interviewing people for Gallup polls. I became jobless and homeless—and soon after ended up in the psychiatric ward at UBC Hospital because of panic attacks and schizophrenia. In subsequent years, I was treated on Vancouver General Hospital's psychiatric ward and by the Strathcona mental health team on Vancouver's east side.

Because my housing and surroundings were so substandard, I, myself, felt worthless. I developed a serious inferiority complex, withdrawing into myself. People around me experienced the same effects. Although I don't suffer from depression, homelessness caused some of



my friends to sink into depression and turn to hard drugs. One day I came home and found the ambulance outside our hotel. They'd come for my friend Patrick, who lived in the room next to mine. He had overdosed (probably heroin) and later died.

I think there should be more drop-in centres and more recreational and social activities and outings. There should also be more solicitation for food donations. The homeless are always hungry.

More one-on-one counselling for psychiatric patients is needed. A friend of mine died of

# Leonard's Story

Leonard Larsen  
*Leonard lives in  
Penticton. He  
hopes that by  
sharing his story  
he can help others*

My journey through the mental health system began when I was 12 years old. My mother died, and I took an overdose. There was sexual abuse in our family by my father and his friends. I turned my father in to the police for sexual assault regarding my younger brother and sister. I hated my father for the trauma he caused me. I never did recover from that trauma. I had three overdoses by the time I was 14.

When I was older, I had a battle with street drugs and started drinking a lot. There are a lot of years that are blank due to heavy drinking. I've been obsessed with taking my life. I didn't plan to live past 20.

Due to excess drinking and drugs, I've often been without a place to live. Due to mental health issues, I've slept in parking lots. One

exposure while sleeping in an abandoned truck, with a bottle of cheap Canadian sherry by her side; she was only 30. She could have benefited from counselling. Losing my friend was the worst experience I had while being homeless in Toronto.

Homeless women have some different fears than men do. When living in hostels or poor, rough neighbourhoods, women risk being raped or beaten up. Once, a man tried to break down my door to get to me. Luckily, a neighbour intervened.

My sister-in-law in the North Okanagan helped me get off the

place I lived in had bullet holes in the windows.

I had no self-worth. I felt lower than a snake. I remember staying in a shelter where I was too scared to sleep because I might be killed in my sleep. When I was living on the street in Toronto, I got pneumonia, but was too stubborn to get help with a place to live. I was obsessed with taking my life so I wouldn't feel so trapped. So my life would no longer be painful.

“Due to mental health issues, I've slept in parking lots. One place I lived in had **BULLET HOLES** in the windows.”

I got so messed up that I cared about nothing. My family wanted nothing to do with me. But on January 31, 1978, my sister's youngest daughter was beaten to death in Winnipeg. That was

the point when my life started to turn around.

I had to get help dealing with the trauma of my niece dying. I had blamed myself for her death and for other traumas that had happened in my life. I stopped drinking and doing drugs.

Today I have a good life. I've become closer to my family. I still have some rocky times—have been in hospital with life-threatening illness—but most times my life is very fulfilling. I live in a nice clean one-bedroom apartment, paying market-value rent. And I work part-

time at a recycling depot, which is very helpful.

I don't want to forget where I came from. I will always be open to helping someone. I hope this writing might help. ❖

Lindy Ruth  
Cunnington

*Lindy is a client with  
Vernon Mental Health.  
She volunteers at the  
homeless shelter in  
Vernon*

street. In 1991 she arranged for an apartment I could afford to rent. I've lived in it ever since. It's regular market housing,<sup>†</sup> but I do receive a rent subsidy. I also have disability income, plus supplemental earnings from my volunteer employment.

I'm so thankful I have a cozy apartment, with two cats and a backyard. I no longer have to “dumpster dive” behind the Chinese grocery store in order to make a vegetable stew for my supper. And my mental health is now so good I no longer need to see a psychiatrist. Here's to having a warm and comfortable home and hearth! ❖



# Fighting ‘Roadblocks’ on My Way Back

I want my children and my life back and I’m willing to fight for them.

I’ve been homeless on Vancouver’s North Shore for the last five years. Two deaths in the family, a marriage breakup, loss of family life, a gambling addiction and depression created this nightmare. But how I got here isn’t as important as how I get my life back.

I feel I have a responsibility to myself, my family and society to turn my life around and be a contributing citizen. I have sweet young children who need a father in their lives, and I haven’t been able to be that person. But I have no one to blame but myself. And that has to change.

I finally sought help from the North Shore branch of the Canadian Mental Health Association (CMHA). Through their Homelessness Income/Outreach Program, I received help getting on income assistance quickly and without ID. Through the Ministry of Employment and Income Assistance (MEIA), I got medical coverage, a referral to job counselling and hope.

Then came roadblocks and frustration. To get a job and keep it, you need a residence. Being homeless, it’s hard to keep yourself clean and healthy. It’s nearly impossible to hold down a job under these circumstances.

For the last four months I have, with help from my CMHA Outreach workers, looked very hard for accommodations. It’s almost impossible to find a room on the North

Shore for the \$375 a month that MEIA allows you. When you do find something in the price range, you then have to deal with other issues.

Landlords discriminate because I’m male, because of my age (52) and because I lack a good history of previous tenancy. Landlords also don’t want to sign a MEIA intent to rent form, because they don’t want the government to know they have rental units; they’d have to pay tax on their rental income. Same goes for looking for somewhere to live off the North Shore; same problems. It’s enough to

## Brian Felstead

*Brian is a divorced father of three, who has lived on the North Shore for 12 years and has worked as a licensed mechanic for 11 years. A struggle with depression resulted in job loss and homelessness, but Brian secured housing in July and is now getting back on his feet*

drive me back to the bottom of the depression pit. And the general public wonders why there are so many homeless people on the streets.

Homelessness is everywhere. Is there a solution to this problem? I believe there is. I’ve already said I have to be accountable. The federal, provincial and municipal governments have to be held responsible as well. The provincial Ministry of Employment and Income Assistance offers the homeless \$375 a month that they can’t use. Why offer me something I can’t use? Thanks for nothing.

How about this: don’t give me money; give me a clean, suitable accommodation that I could afford if I had a job. Then pay the rent for an allotted amount of time, and I can pay back the cost of the rent when I get work, in small amounts each month. This would be similar to

a student loan.

The homeless people need a voice on the North Shore, and I can be that voice. The governments have to start listening—and to whom better than someone who’s been there. **i**

## A Mother’s Perspective

### Martha Scales

*Martha is retired and lives in Salmon Arm with her husband and two dogs. She has just completed six years on the board of CMHA Salmon Arm*

*\*pseudonym*

My story isn’t what you might call a “good news” story. Yet, it has elements of very good news.

My 40-year-old son is homeless. I hadn’t seen him for several years, but last August his picture was on the front page of the *North Shore Outlook*, a community newspaper serving North and West Vancouver. He was the only one, out of a group of homeless people, who consented to being interviewed for an article.

I was able to send Rick\* an e-mail because of this article. I told him how much I love him. I told him I remember his strong sensitivity and compassion for others. This value shone through when he was a child, and it continues.

During the past winter, Rick was fortunate to have a

roof over his head, and we were able to talk on the phone. He expressed interest in making significant changes in his life, so my daughter and I quickly gathered information about detox and treatment centres and offered support and assistance. However, Rick chose not to go this route. Again.

One evening shortly after Christmas, Rick and I had a phone conversation that I will long remember. There was nothing profound about our conversation, except that both of us stayed in the present moment—no talk about past sorrows or future hopes. We remembered little things and fun times, and we laughed a lot. He thanked me for the Christmas package with socks, a blanket and



home-baked cookies—and he told me how he'd shared the package with his friends. This phone call was one delightful piece of our time in communication.

I've lost track of Rick again; the cell phone he was able to use is no longer available. However, throughout that time of being in touch, I was transformed. I realized that the bottom line is: I love him regardless of what choices he makes. I hold him in my heart and in my prayers—and at the same time I "let go." I have my life to live.

I've learned not to feel responsible for his situation. I no longer spend a lot of energy and time worrying about him. Rick calls himself a survivor—and that he is, for better and for worse. If he chooses to make changes, he knows where to go and who to ask. If he wants family, he knows where to find us.

I do live with hope—but I don't hope for a prescribed outcome. I live with the love and support of family and friends. I am familiar with the support services that are in the community and know how to access them. I volunteer at the Canadian Mental Health Association in order to give back some of what I receive.

I also live with gratitude that Rick is part of my life, whether or not we're directly in touch with each other. And I am ever grateful that Rick's children are part of our lives. They are well cared for in a loving home. We are preparing now for their summer visit, which is bound to be fun and high energy. I'm up for that! **i**

## “The Truth of the Streets And my life thereafter . . .”

I've been on and off the streets for eight years. Street life is emotional. It breaks my heart to see very young kids (12 to 14 years old) starting to use hard drugs.

When I first came to be on the streets, I was 19 years old (I'm now 26). I was doing drugs such as LSD, pot and alcohol, and my parents tried to help me stop. But I didn't listen to their rules. So I went to live on the streets.

And I should tell you—I

On the streets of Vancouver, I was introduced to crystal meth, which was very fun at first. After a while meth lost its appeal, but by that time, drugs had a powerful grip on me.

Lots of other people I knew would get me to do drugs with them for free, because I was a fun person to be around when I was high. Sometimes they'd get me to get high with them because they knew that if they shared with me when I had no drugs, I'd be more likely to share with them when they had none.

When I was using drugs, I'd stay up for days at a time. I'd do different things to get my drugs: p a n h a n d l e , dumpster dive,

watch over other people's stuff while they were busy. Most of the time I'd get the drugs I was looking for by 'streetcombing' for objects I could trade.

There was more to being homeless than just the drugs. There were gangs, violence and other things like that. I've had a couple of close calls with death. I've had other street people pull weapons on me—guns, canes, swords and knives. Sometimes I'd witness situations that were very dangerous and disturbing—like

Vance Hughes

*Vance moved to Kamloops to escape the drug scene in Vancouver. He's working toward a better life and healing his relationship with his parents*

a person getting beaten up by a group of people.

And some of the personal relationships I forged led to me getting hurt. I've been manipulated by people I thought were my friends, but who turned into enemies I didn't want in my life any more. To this day, it's hard for me to trust new people.

Right now I'm living in the South Hills Psychosocial Rehabilitation Centre<sup>1</sup> in Kamloops, working toward placement in a family home. I lived on my own for a while, but was too lonely and would go looking for social contact and usually end up in trouble again. But I've been sober for almost a year. I volunteer at an organic garden and at the SPCA. And I have hope that my life will get better and better. **i**

“Lots of people I knew would GET ME TO DO DRUGS with them for free, because I was a fun person to be around when I was high.”

have a mental disorder. At age eight I was put on medication for attention deficit disorder (ADD) and ever since have struggled with ADD, addiction, depression, anxiety, psychosis—you name it.



### footnote

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# Innovative Approaches to Housing the Homeless

Megan Dumas

Megan is a Communications Officer at CMHA BC Division and is the Editorial Assistant for Visions

Last year the Social Planning and Research Council of BC (SPARC BC) released a report entitled *Housing and Services for People with Substance Use and Mental Health Issues*.<sup>1</sup> The report highlights the key findings of two studies conducted for the federal government.<sup>2,3</sup> It reviews housing programs for the high number of homeless people who have mental illness and/or addiction issues. Twenty-one groundbreaking housing programs in North America and the UK are recognized for offering innovative approaches to this complex issue. Outlines of five of these programs follow.

## Canadian Mental Health Association (CMHA), Ottawa Branch

**Where** Ottawa, Ontario

**Type of clients** Participants must have a serious mental illness. Most also have substance use problems.

**Type of housing** Permanent.<sup>†</sup>

**Scattered or dedicated site** Scattered.<sup>†</sup>

**Services offered** CMHA Ottawa provides integrated treatment services. The client controls where, when and if they participate in treatment.

**Harm reduction or abstinence based** Harm reduction.<sup>†</sup> While clients are encouraged to reduce their use or to opt for less harmful substances, there is no expectation that they practise abstinence while in housing.

**Why they're unique** While most housing programs find it challenging to find suitable housing for their clients, CMHA Ottawa has successfully formed agreements with both non-profit housing providers and private landlords. This allows CMHA to provide a higher calibre of housing for their residents. Most of their units have amenities such as exercise rooms, pools, in-suite laundry and one even has a Jacuzzi! They believe that by placing their clients in better apartments, they are setting them up for success. So far it's working: "90% of the clients using their services were still housed after nine months."<sup>1</sup>

## Mainstay Residence, Winnipeg

**Where** Winnipeg, Manitoba

**Type of clients** Single men and women with a history of substance use make up 30% of the residents, 20% have mental health issues and 40% have concurrent disorders.<sup>†</sup>

**Type of housing** Transitional.<sup>†</sup>

**Scattered or dedicated site** Dedicated.<sup>†</sup>

**Services offered** Residents have access to a community mental health worker specially trained to work with patients with concurrent disorders.<sup>†</sup> Case managers offer a wide range of services designed to help residents reintegrate into the community.

**Harm reduction or abstinence based** Abstinence based.<sup>†</sup> Residents are expected to remain abstinent or be working toward abstinence. Residents may be sent temporarily to another treatment facility if they suffer a relapse, but are not discharged from the program for using.

**Why they're unique** Residents are required to work toward abstinence during their stay and must also actively work on developing life skills to help them stay off the streets.

## Westview Dual Diagnosis Program

**Where** Regina, Saskatchewan

**Type of clients** All clients must have a concurrent diagnosis of severe mental illness and substance abuse.

**Type of housing** Transitional. Westview is considered a treatment facility.

**Scattered or dedicated site** Dedicated.

**Services offered** The focus is on integrated services concentrating on both mental health and addictions issues. Each resident works with a key worker to develop a personal recovery plan.

**Harm reduction or abstinence based** Abstinence and harm reduction based. While the residence itself is "dry" and residents are to be working towards abstinence, it is understood that relapse is part of the recovery process and residents will not be evicted for using drugs or alcohol. Those who relapse are expected to commit to a detox plan.

**Why they're unique** By adopting elements of both harm reduction and abstinence based approaches, they are able to focus on abstinence as an ultimate goal but support their residents during periods of relapse.

## Anishnabe Wakiagun

**Where** Minneapolis, Minnesota, US

**Type of clients** Residents are mostly American Indians\* who suffer from late stage chronic alcoholism. This is a population that is much more likely than the average American to have substance abuse issues.

**Type of housing** Permanent.

### footnotes

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**Scattered or dedicated site** Dedicated.

**Services offered** Services focus primarily on medical care and health issues. Program participation is not mandatory.

**Harm reduction or abstinence based** Residents may consume alcohol in their own rooms, but it is forbidden in all common areas. The possession and use of other drugs is strictly prohibited and residents caught using will be discharged immediately.

**Why they're unique** Treatment reflects American Indian cultural value.

### New York Pathways Program

**Where** New York City, New York, US

**Type of clients** Accepts people with mental illness, who are chronically homeless. Ninety percent of residents suffer from a substance abuse disorder.

**Type of housing** Permanent.

**Scattered or dedicated site** Scattered.

**Services offered** Support services are centred around what the client wants; participation is totally optional.

**Harm reduction or abstinence based** Harm reduction based. There is no expectation of sobriety or participation in treatment programs; however, addiction services are available. Relapses are accepted as a part of the recovery process.

**Why they're unique** By building the program around what each client wants, Pathways has achieved success: "Between 1993 and 1997, 88% of Pathways clients remained in their housing compared to 47% of those who went through a New York City treatment system."<sup>1</sup>

Each program offers a variety of support services ranging from mental health and addictions counselling to money management and life skills training. CMHA Ottawa offers staff access until 10:00 p.m. and the other four organizations offer 24-hour on-site staffing.

### The common thread

The key to success across all these programs seems to be offering housing and services based on the clients' strengths, goals and needs. While this approach may seem like common sense, it has not traditionally been used. A client-centred approach requires access to a range of housing options—that is, wet<sup>†</sup> and dry,<sup>†</sup> scattered and dedicated—as well as a variety of service options for the residents. This allows clients to decide what is best for themselves, effectively reducing the chances of relapse.

While this report does lend some hope to a desperate situation, it also makes clear there is still much research that needs to be done. **i**

*\*The terms American Indians and Native Americans are commonly used in the US, even today.*

### footnotes

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# Mental Health Supported Housing Means Less Time in Hospital

When a serious mental illness strikes, it can completely turn your life upside down. Not only do you have to deal with all the daily challenges of a mental illness, but you now have added financial pressures. You find your rent is so high it leaves you with too little money to feed yourself properly. You could even find yourself living in a dirty, rundown, bug-infested room in a Downtown Eastside hotel, because now it's all you can afford. Under these conditions,

it's no surprise that your mental health doesn't improve. And it's no surprise that you are now at much higher risk for other health problems like diabetes, heart disease, asthma and high blood pressure.

It has been shown that there is a strong link between having access to safe, secure and affordable housing and better health.<sup>1</sup> Therefore, having supported<sup>†</sup> housing should help improve overall health and, in particular, mental health.

Health (VCH)—which serves Richmond, Vancouver, North Shore, Coast Garibaldi and Bella Bella/Bella Coola—strongly believes we can best support people with a mental ill-

ness by ensuring affordable housing and a broad range of support for those who need it. About 1,400 people in the VCH region live in mental health supported housing.

Linda Thomas, MSW

*Linda is the Director of Vancouver Housing Services for Vancouver Coastal Health*

### did you know?

- o 30% of all general hospital days in Canada involved a patient diagnosed with mental illness
- o 37% of patients with a diagnosis of mental illness discharged from a general hospital were readmitted within one year<sup>7</sup>

### What is “supported housing”?

Supported housing is a place that you can afford, even if you are on income assistance.

Supported housing is not treatment, but it does help people to maintain their links to treatment and to get maximum benefit from it. Staff are there to help you keep your appointments with a mental health counsellor and a physician, and to help you take your medication. These supports are in addition to the help you would get from a mental health professional at a community team or a doctor’s office.

Supported living staff also help you learn basic skills to manage a household, look for a job or go back to school.

People living in supported housing speak passionately about how it has changed their lives for the better. They speak about how having an affordable place to live and support staff to help manage day-to-day challenges gives them the energy to focus on getting well. They say this is the key to putting the pieces of their lives back together.

### Our research findings

As a health organization, we wanted to find out if there were measurable changes in the use of hospital services. In particular, we wanted to see whether living in supported housing would mean fewer visits to the emergency room or to less time spent in hospital.

To find out, we looked at 263 people who had moved into mental health supported housing. We counted their visits to the emergency



“there is a **strong link** between having access to **safe, secure and affordable housing** and **better health.**”

room and the number of days spent in hospital in the year before getting into supported housing and in the first year they spent in housing.

We found that emergency room visits went down by almost one-third and that days spent in hospital went down by over half in the first year spent in supported housing.

Somewhat to our surprise, we found that almost all the reductions in the hospital stays were related to psychiatric admissions as opposed to medical concerns. While almost everyone who moved in was already getting treated for their mental illness, getting into supported housing was a very significant stabilizing factor.<sup>2-3</sup> It is obviously very positive for people with a mental illness to be in stable housing and not needing to be in hospital.

For the broader community, it means more hospital beds are available for others who are in need. In fact, this study found that one less

hospital bed was used for every 60 people who moved into supported housing—an important finding at a time when empty hospital beds are scarce.<sup>2-3</sup>

The results of our study are similar to previous work done locally<sup>2-3</sup> and are consistent with other studies done in the United States.<sup>4-6</sup>

### Why it works

What appears to make the difference is the combination of mental health treatment and supported housing together. While mental health treatment is necessary for recovery from a mental illness, it is not enough on its own. Without the practical, day-to-day support offered by supported housing staff, it is not possible to intervene quickly enough to keep people out of hospital. Having someone visit regularly, however, can help reduce day-to-day stress or identify whether medication changes are needed. This tells us we should make supported housing available whenever possible. **i**

### did you know?

mental disorders account for more than half of hospital stays among homeless people in Canada.<sup>8</sup>

### footnotes

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# From Streets to Homes

## ASK Wellness Centre's Housing Outreach Program

Imagine waking up tomorrow to find yourself without a home, income or support. Imagine you also have a crippling substance use problem and a chronic mental health condition. And now imagine trying to join the ranks of society and enter the world of market housing in 21<sup>st</sup> century British Columbia!

This is the problem facing many of the people we at the Aids Society of Kamloops (ASK) Wellness Centre have been working with for the past year and a half.

### The evolution of ASK's housing services

Our Housing Outreach program was created in November 2005 by a groundbreaking group of funders called the Kamloops Integrated Project. This group consists of representatives from BC Housing, Mental Health and Addictions, the Ministry of Employment and Income Assistance (MEIA), Forensic Psychiatric Services and the City of Kamloops. Members of the Integrated Project were very clear that the people in the community who had the biggest needs were running into huge barriers to meeting the most basic of needs: housing.

By June 2006, our initial full-time outreach worker was joined by another full-time outreach worker funded by BC Housing, a weekend worker funded by Interior Health, and another full-time worker from the CMHA Income/Homeless Outreach pilot project. Our outreach team has had their hands full applying the "streets to home" model, helping homeless people access a legitimate income, find stable housing, and move their belongings.

To secure housing, a person needs money to pay a damage deposit and to pay rent every month. With the support of the MEIA, we've been able to fast-track people looking for housing—in many cases on the day of first contact—to get on income assistance. Sure, it's not the ideal income, but this beginning allows those who are homeless to enter a society norm most of us take for granted—that is, having a place to live, an income, medical care and much more.

Perhaps one of the most unique aspects of our program is our ability to respond quickly to people's housing needs. As a non-profit organization, we are able to put money set aside by the Kamloops Integrated Project directly into the hands of landlords and support service providers. Because of this, we've been able to bypass the usual red tape challenges of most large organizations. For example, we are able to provide a damage deposit or, in some cases, the entire rent should the

client not able to access income assistance or another source of funding. In other isolated instances, we've paid emergency repair costs to a landlord when the tenant has damaged the property.

We at ASK take great care to move those who are either on the verge of homelessness, or who are chronically homeless, into stable, long-term housing. With the addition of our Sustainable Housing Worker in July of this year, we now provide mediation services to help resolve ongoing tenancy issues in an effort to prevent evictions. We will also engage other community supports such as mental health and addictions services as needed.

### Landlords—our most valuable resource

To make sure that we're not adding to the cycle of homelessness, we make every effort to prevent these placements from breaking down. An important part of this is building relationships with the landlords and property managers in our community.

At ASK we see ourselves as social property managers. We've hosted two landlord luncheons, because we recognize the crucial role landlords play in housing the hard-to-house<sup>†</sup> in our community. On both occasions between 15 and 20 landlords attended; they described the challenges they face and shared helpful strategies for managing their properties. Landlords have an open invitation to drop in to our centre; the coffee is always on.

### The results speak

The results of our program speak for themselves. Of the 310 people who have accessed the program, 223 have not come back for more assistance. And of the 87 who have come back for assistance? They've been evicted. In many cases, the reason for eviction is problems related to crack and cocaine use.

Our hope is that now, with more supports in place—like our landlord mediation service and assistance for clients in managing money and lifestyle choices—we will be able to lower the number of people returning to the streets and shelters for survival. **i**

**Bob Hughes**

*Bob is Executive Director of the AIDS Society of Kamloops Wellness Centre. He previously worked as an addictions counsellor with the Phoenix Centre in Kamloops and Interior Health in the Shuswap, and has a long history of working with marginalized people*

*“Perhaps one of the most unique aspects of our program is our ability to respond quickly to people's housing needs.”*



# Housing First—The Triage Experience

Leslie Remund

*Leslie is Associate Director of Triage Emergency Services & Care Society. She's been a front-line worker in Downtown Eastside emergency shelters, and an HIV street outreach worker. Leslie has developed and coordinated homeless services, and has presented at conferences on women's issues, including homelessness, concurrent disorders and barriers to care*

*For more information on our Housing First projects, visit our website at [www.triage.bc.ca](http://www.triage.bc.ca)*

In 2000, Triage Emergency Services & Care Society began to adopt a new housing model, called Housing First. This model was created in the US to respond to chronic homelessness.

From years of operating an emergency shelter in Vancouver's Downtown Eastside, we knew that local shelters were operating over capacity and that many of the same people were returning over and over again. Our statistics showed that over 54% of people were repeatedly returning to Triage Shelter. A significant group of people had either never secured housing between their shelter stays, or they had lost their housing shortly after moving in.

This trend of repeated shelter use was being reported across North America. Homelessness organizations were talking about the "shelterization" of the homeless population. Emergency shelters that were intended to be a short-term solution to a person's housing crisis were becoming, for some people, their only real housing option.

Housing First programs provide direct access to housing. Unlike housing programs that have specific conditions that need to be met in order to become a tenant, the goal is to re-house the person regardless of past or current behaviours. In

Housing First projects, we don't, for example, require mental health treatment plans, addiction recovery, or other forms of compliance prior to moving in.

Once a person is housed, staff support and work with the tenants to solve any issues that create problems in housing. This approach can greatly reduce the amount of time people spend homeless.

or medication. They had histories of evictions, had lived with no fixed address for lengthy periods of time or had adapted to a transient, street-based lifestyle. Our goal was to provide a high-tolerance environment that would create housing stability.

We learned a lot from the early days of Princess Rooms. We learned that there is often a transition

as people adjust to indoor living at their own pace.

We learned that people who have been homeless develop survival skills; the streets are rough. Violence, aggression, problem guests, damage to rooms and buildings, hoarding, psychosis and non-payment of rent are all behaviours that we routinely encounter.

We created formal partnerships with health care providers and community organizations to increase our tenants' access to services. We brought services to the tenants. People's health issues, mainly untreated, include mental illness, addictions, HIV, hepatitis (A, B and C), wounds and abscesses, poor dental health and malnutrition. Connections to psychiatric treatment, doctors and other health care providers increased.

We researched current best practices and implemented the Strengths Perspective<sup>1</sup> for our support work and case management.

This model of working with people was designed by the University of Kansas School of Social Welfare. Instead of focusing on a person's weaknesses, deficits or "issues" and trying to 'fix' them, we focus on their strengths: resiliency, knowledge from past experiences, per-



**"people who have been homeless develop survival skills; the streets are rough."**

## Princess Rooms

Triage's first project, Princess Rooms, opened in 2001 to house chronically homeless men and women. We knew the tenants would primarily be active substance users, that most had a mental illness and that they rarely accessed health treatment

period that our tenants undergo from being homeless to being housed. We learned that people who have spent significant periods of time homeless have difficulty trusting others. Most feel excluded from the systems that are supposed to help them. We learned to be patient

## footnotes

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sonal interests, hopes and skills. These strengths are often the same personal resources and talents that have helped the person survive and continue on through incredibly difficult situations. We also emphasize harm reduction† and health promotion, within the strengths-based approach.

We advocated with government funders for higher than usual—but appropriate—staffing levels. Typically, supported housing projects have one or two day staff and may or may not have overnight staff. Our Housing First projects have a minimum of two staff on at all times.

Despite the numerous challenges, we were encouraged by our success. Men and women who had previously been unable to maintain their housing for any significant period of time were actually staying.

### The Vivian

Building upon the success of Princess Rooms, the Vivian Transitional Housing Program for Women opened in November 2004. The Vivian was a response to the unique needs of chronically homeless women.

We found that women were less likely to enter the shelter system, and if they did come to Triage Shelter, they stayed for a much shorter time than men stayed. And, disturbingly, the majority of women were checked out of the shelter to unknown circumstances. Women's survival mechanisms on the street often differ from men's. For example, many

women will find an overnight or temporary solution, like staying on a floor or couch of an acquaintance, before choosing a shelter. Our statistics at Triage Shelter from 2003 showed that out of 345 women intakes, 43% of the women checked out to unknown circumstances, compared to 27% of male intakes.

The Vivian recognizes that there is a complex interrelationship between women's mental health, substance use, homelessness and experiences with violence. Existing services were designed to work with one aspect of women's experiences, but often excluded others. For example, many women who use substances can't access adequate mental health care, or women who live with daily exposure to violence because of sex trade work don't fit the mandate of women's transition houses. No women's housing project was specifically designed to work with chronically homeless women.

The Vivian houses the most marginalized women in our community. These women, based on their housing histories, are the least likely to succeed in supported housing, mental health, addiction or women's services.

Despite all the challenges associated with operating Housing First projects, Triage recognizes that housing stability leads to enhanced health and well-being. We believe that housing is a basic human right. **i**

# Lookout Emergency Aid Society

**W**ho would have thought, in 1971, that the need to get high-risk people off the streets of Vancouver's Downtown Eastside would expand to the point of needing several shelter, residential and support programs reaching across the Lower Mainland? No one anticipated that every form of social safety net would be as overwhelmed as they've become.

The Lookout Emergency Aid Society's housing program began 36 years ago with a three-bed, night-time emergency shelter in what was then known as Skid Row—and now known as the Downtown Eastside (DTES). This shelter opened in response to a growing trend of older homeless men showing up at a youth hostel. Since then, Lookout has grown to offer a range of housing options, including some that have 24-hour staff support and others that are for more independent clients, with support offered as needed.

Our vision is larger than “emergency shelter.” We are a safety net for society's most vulnerable people. We don't limit ourselves to a narrow mandate, except that as an adult-oriented service, we are not suitable for children. Those coming to us face a wide variety of challenges, including mental illness, chronic alcoholism, problem substance use, mental/physical handicaps, chronic health problems (including HIV/AIDS), and legal issues—or they are simply unable to cope. People dealing with mental health issues predominate, particularly those with addictions or other issues that prevent them from securing or maintaining stable housing.

### Much more than just a bed and meals

In an internal survey Lookout did in the mid '90s, we found that 4% of those with multiple problems living in the DTES die within one year if we only provide emergency shelter during crisis. Where we have been able to engage and assist people with our take-care-of-whatever-is-today's-problem type of outreach service, we have seen the mortality rate change to 0.4%. This is a tenfold improvement in life expectancy—and immeasurable quality-of-life improvement goes along with it.

Lookout's 24-hour shelters are much more than a bed and meals. We provide crisis interventions, access to a free phone and internet, free laundry, clothing and showering facilities. Lookout staff assess needs, do case planning, provide liaison/referral services and advocacy, and try to bridge people to treatment services and financial supports. We work with each individual to link them to the supports they need to break the cycle of homelessness.

Our society realized that, as a shelter provider, we were serving in a band-aid role—that housing was the real

**Al Mitchell**

*Al is the Emergency Services Manager at the Lookout Emergency Aid Society*

solution needed. Today, we have several supportive housing programs in existing Vancouver market<sup>†</sup> housing (the Jubilee, Pender and Avalon Hotels in the DTES). Through relationships with local landlords—built on a basis of: “the landlord gets the rent; Lookout workers assist with the problems”—we are able to provide housing without having to construct new buildings. We have built some housing, though, including BC’s first apartments specifically for people at high risk of, or having a chronic history of, homelessness. We named it after Jim Green, a man who has established a number of housing units for people in the DTES.

### Challenges of a low-barrier approach

Offering consistent, non-judgmental, non-sectarian, individualized service, with as low-barrier<sup>†</sup> an approach as possible, has worked well for Lookout.

There are challenges to having a low-barrier approach, however. The main one is that you must always work to keep to your purpose: to help those in need. In what is a housing provider’s or landlord’s market, it’s very easy to avoid helping those who are considered difficult to house—there are always ‘reasons’ to evict or to not even choose to house a difficult or challenging person. So be aware of the trap of serving only those people who are easy to serve.

We have adopted a philosophy of only barring people when there is no alternative for their own or for other’s safety. We often review and lift those bars if circumstances change. For example, we had a tenant pull a knife on a staff member. This caused safety concerns, so the tenant was removed from the program. A couple

years later, this tenant was again looking for housing. After reviewing his rehabilitation activities, we allowed him to move back in.

Currently, there is a lot of discussion in BC around building social housing.<sup>†</sup> One issue that has come up is the size of the housing units provided. My gut feeling is that at Lookout we see better quality-of-life outcomes when people are in larger living spaces. We are not enamoured with suites of less than 200 sq. ft., and we fully support having toilets and showers in suites, rather than shared. When units are very small, we are constantly mitigating against the depressing and constraining effects it has on people by developing other amenity spaces and support programs nearby. We have our greatest turnover in the SRO or smaller spaces, and the most success with people in the 500-550 sq. ft., one-bedroom apartments at the Jim Green residence—success in terms of long-term stability of housing, less hospitalization, staying with addiction treatment and improving life skills.

Despite our growth, we very much resist trying to limit the people we serve to accessing only our own services. We always try to link them to other community agencies or supports. This ensures that when (especially in the shelter, but also in the housing) they do leave us, the supports remain in place wherever they may go.

I love to think that we could reduce our role as an emergency shelter provider, but this will only happen when more quality, supportive housing is available to the people who need it most. ■

For more information on Outlook Emergency Services Society, visit [www.lookoutsociety.bc.ca](http://www.lookoutsociety.bc.ca)

## lookout—the evolution

**1971** First emergency shelter opens in Vancouver’s Downtown Eastside (DTES)

**1978** A long-term housing program gradually implemented: Lookout extended support to other residents of the hotel in which the emergency shelter space was leased

**1981** Built first facility housing the now 42-bed emergency shelter as well as 39 supportive, long-stay units

**1990** Outreach Program established to follow up with shelter clients and provide short-term support to residents in SROs and other accommodation

**1992** Long-term support (longer than three months) added to Outreach Program services

**1993** In collaboration with St. James Community Services and the Strathcona Mental Health Team, opened The Living Room drop-in centre in the DTES to provide social and recreational activities and an access point for treatment

**1993** The Jeffrey Ross Residence, a 37-unit, independent-living apartment block, with support for people with disabilities

**1995** A second, winter-only shelter opened in the Marpole area of Vancouver

**1996** The Jim Green Residence provides 67 one-bedroom units, with support, for people who’ve been chronically homeless; includes one emergency-shelter suite

**2001** The North Shore winter-only, cold-weather shelter opens (there had been no shelter on the North Shore)

**2001** Cliff Block, with 16 transitional units and seven supported, permanent housing units opens in New Westminster

**2002** Yukon Housing Centre opens outside the DTES, in central Vancouver, with 36-56 emergency shelter beds (replacing the winter-only Marpole shelter) and 37 transitional studio apartments

**2005** North Shore Residence opens with 25 year-round shelter beds and 25 transitional studio apartments

# Pacifica Housing Services

## Embracing the challenges of homelessness in Victoria

**A**s team leader for Pacifica Housing Services, I provide support, guidance and mentoring to our terrific team of outreach workers and community support workers. Our job is to find housing for people who, for many reasons, cannot find appropriate housing on their own. Not everyone we assist to find housing is subsidized, but in certain cases a combination of subsidy and community support can lead to stability.

We meet people where they're at. This means that we believe in using a welcoming approach. We walk people through the entire process of securing housing, to make sure no barriers get in their way. Our services range from helping them apply for income assistance, going with the person to meet the landlord and helping them fill out standard Residential Tenancy Act application forms—to setting up damage deposits, helping them move and find furniture, and addressing any other barriers they face.

Once a person is housed, we stay connected with that person as needed, to ensure the tenancy remains stable. This is done by our community support worker and outreach program staff, who provide support and edu-

cation to both the landlord and the tenant.

We have ongoing partnerships with private landlords, who have been fantastic in helping us provide housing for people who otherwise couldn't secure a place to call home.

We also have an ongoing partnership with the Vancouver Island Health Authority (VIHA) in providing subsidized, supported apartments to formerly

homeless adults. VIHA funds some community support staff and repair and maintenance, as well as 20 "floating" rent supplements for private landlord settings. This collaboration is helped in that Pacifica shares its office property with staff from the health authority. Ministry of Employment and Income Assistance staff also share our space.

BC Housing provides

the funding for our housing outreach staff. BC Housing also provides subsidies for people who meet criteria related to being homelessness and "at risk." Factors such as mental health issues, substance abuse issues, addictions, behaviour issues, culture of an individual, location (a consideration when, for example, someone is trying to stay away from an area to avoid

**Phil Ward**

*Phil is a Team Leader/ Housing Outreach Worker with Pacifica Housing Services, a division of non-profit housing provider Pacifica Housing Advisory Association. He finds and establishes relationships with private landlords in the Greater Victoria community who are willing to work with Pacifica*

### a case study in community partnerships

**J**oe,\* a person we have supported in the community for many years, had been struggling for years to find suitable housing, staying in various rooming houses and either getting evicted or becoming victimized and having to leave.

After trying a few different apartment settings, Joe finally settled into a privately owned unit and seemed to be doing okay. We provided a community support worker who checked on him weekly and tried to help keep the apartment clean. This became a challenge, however.

Despite our best intentions, Joe couldn't look after himself well when he stopped taking his medications. His mental health worsened, and one day our agency received a call from the police. They said he'd been scaring customers away from a local business by making threatening comments and throwing things off his balcony. We talked with the business owner, who quickly realized that Joe really didn't mean any harm. Still, the issue needed to be resolved.

We called workers from the local mental health team, who quickly facilitated a short-term hospital stay to help stabilize him. Unfortunately, shortly after he was discharged back to the apartment the behaviours escalated again. By this time, the landlord became concerned that the apartment had deteriorated to such a state under Joe's tenancy that repairs were necessary.

All this pointed to the fact that Joe needed more support than we could provide through our services. So, we reconnected with the mental health system, all the while keeping Joe informed about what we were doing and why. He was treated with respect and dignity throughout the process.

Joe went into hospital again, and he is now slated to move to an apartment that has more supports on-site. We believe he will do well there.

Co-operative relationships between Joe, our housing workers, the landlord, mental health staff, the hospital, the business owner and even the police were essential to getting Joe what he needed. We also work in partnership with other related social service agencies in search of solutions to the ever-growing need for more housing.

\* pseudonym





contact with drug-involvement issues) and vulnerability are considered.

We keep a database of people who've done an intake form to describe their housing needs and the barriers they've experienced trying to secure housing. This helps us decide, in a fair process, who is the best fit for new subsidy programs or for vacancies that come up. Our landlord partners call us when they have vacancies instead of advertising in the paper, and we match what they have to offer with a person we feel would be a good fit in that particular setting.

Another way we support both the tenant and the landlord is by hiring clients who have been housed by

our service and are stable in their situation. We hire them to help clean apartments when someone moves out, or to help keep someone housed by assuring the landlord the apartment is being kept clean.

We've heard countless stories from the people we serve about their struggles to find decent housing. The options are limited in a city where the average rent is often more than their entire income assistance cheque. The challenges are huge, but we have had great success with our housing programs thus far: 60% to 70% of the people housed in subsidized, supported units are still housed and are stable in their lives. **i**



## The Youth Supported Independent Living Program Helping at-risk youth with mental illness to succeed

**Eric Sault**

*Eric is Housing Manager and a Youth Supported Independent Living worker for the Canadian Mental Health Association, Simon Fraser Branch*

At the Canadian Mental Health Association's Simon Fraser Branch (CMHA-SF), we run several programs to provide affordable housing and support for people with mental illnesses. The Youth Supported Independent Living (YSIL) program was created in the Fraser North area in 2000 as a pilot project. It has since become one of our regular programs. Making the transition from youth to adulthood can be challenging at the best of times. Teens facing adversities such as mental illness and disruptive home lives, however, are at far greater risk. By providing housing and support to

young people facing mental illness, we help them make the transition to adulthood more manageable.

Kids are not able to live at home for a variety of reasons. There may be abuse, addiction and/or a parent with mental illness who is unable to care for the child. Tensions may involve issues between the youth and their siblings and it may be better for the rest of the children/family if the youth moves out. Some of the youth referred to YSIL have been in foster care and the foster placement has ended. These situations can be extremely stressful for these young people and

their families.

When youth begin to show signs of mental illness, this may increase family tensions to the point where it is no longer possible for the youth to remain at home. Or, the relationship between the parent(s) and the youth may be negatively affecting the mental health of the youth. The combination of having an emerging mental illness and unstable housing puts youth at risk of becoming street involved, getting into drugs, drinking and dropping out of school.<sup>1</sup>

### How YSIL works

Our YSIL program provides young people between the

ages of 16 and 21 with rental subsidies for affordable accommodation—usually a one-bedroom apartment. These apartments are in traditional rental housing.

Since most youth who enter this program have never lived on their own, we provide a youth worker to help them learn life skills important for successful, independent living. These include skills such as paying rent and bills, grocery shopping, cooking, cleaning, balancing work and leisure, and developing support systems in the community.

The YSIL workers assist the youth in finding accommodation. It can be

a challenge for youth, because not many landlords want to rent to people under the age of 19. The YSIL worker usually explains to the landlord that our program is subsidizing the youth's rent and supporting them to live independently while they go to school. Landlords usually want people who are quiet, clean and pay their rent on time. Since the rent is guaranteed, landlords don't need to worry about the youth not paying the rent.

Before a young person is accepted into the program, an occupational and skill assessment is done by Fraser Health's occupational therapist (OT) to determine if the youth is ready to live independently with support. This assessment highlights the young person's strengths, as well as the areas needing attention.

Then the youth meets with the YSIL worker and a mental health clinician to work out an individualized service plan (ISP). The

ISP will map out goals and other specifics in order of importance. The youth can set personal goals such as completing high school and obtaining future employment. And they can be connected with a variety of professional services that will help them achieve their goals.

The actual move-in date depends on how ready the youth is. We have a training apartment which we can use to teach youth how to cook, clean and get comfortable with living on their own. They can stay there for a few nights, checking in with the YSIL worker, to see what it feels like to live on their own. Some youth have lived on their own before or are identified through the OT assessment as having the skills to live independently without the use of the training apartment. Once the youth has started meeting with the YSIL worker, they can begin looking for an apartment right away.

### Respectful relationships lead to success

The success of this program depends on mutual respect and trust between the worker and the client. Many of the youth we work with have been let down by people during their young lives. Learning to trust someone new is not always an easy task for them.

The workers work one-on-one with clients—usually for three to five hours, once or twice per week. The worker may spend more time with them initially to help them secure housing and get their place set up. The workers must be sensitive to the individuals' needs and issues. They must find common ground and meet the youth where they're at. They must be patient, caring and non-judgmental, gradually building a foundation of trust.

With trust, it is then possible to establish a meaningful and produc-

tive relationship between the worker and the client. This unique professional relationship—sometimes developed over the course of several years—can be a very rewarding experience for both the youth and the support worker.

Since its inception, our YSIL program has helped over 25 youth. I have seen several youth in the YSIL program go on to graduate from high school and/or college, obtain employment, enter positive, long-term relationships and even graduate from mental health services completely. The support offered by the YSIL program gives youth with mental illness a chance for success. It provides stability during a time of great change and uncertainty, and gives them the tools needed to move forward in their lives. Most importantly, it can give them hope. **i**

#### footnotes

visit [www.heretohelp.bc.ca/publications/visions](http://www.heretohelp.bc.ca/publications/visions) for Eric's complete footnotes or contact us by phone, fax or email (see page 3)

#### the ysil program

**Who** Serves youth living in the Fraser North health region who have an emerging or established mental illness and who are unable to remain in the care of their families.

**What** Provides a rental subsidy for market accommodation, as well as support from a youth worker.

**Where** The Fraser North health region comprises Burnaby, New Westminster, Tri-Cities (Coquitlam, Port Coquitlam, Port Moody), Maple Ridge and Pitt Meadows.

**Intake** Youth must be referred to the program. They must have an open file with a mental health clinician at the time of referral and must agree to continue seeing a mental health clinician while they are in the program.

**When** Between the ages of 16 and 18¾.

**How long** Youth can remain in the program until the age of 21 if necessary. After 21, the housing subsidy and the support from the YSIL worker end. Most youth transfer to adult mental health services at 19.

**Then what** We begin a housing plan when youth are

accepted into the program. Applications to alternate subsidized housing (i.e., BC Housing) are made, since often there are long wait-lists. This may include getting on the wait-list for Adult SIL if appropriate. Some youth will be able to financially support themselves through employment or a combination of employment and disability benefits. Other options include finding a roommate or moving to a more affordable location. The mental health clinician continues to work with youth who need ongoing support. They can be referred to services such as Adult SIL/Community Living Support (CLS), vocational/educational programs, clubhouse and/or recreation programs if required.

**Funded by** The Ministry of Children and Family Development, Fraser Health and BC Housing.

**Anyone wishing more information can contact Eric Sault at [es-cmha-sf@telus.net](mailto:es-cmha-sf@telus.net)**

For my friends, reaching age 19 meant clubbing, parties and looking at universities. To me reaching age 19 meant losing all the supports that the system had provided and I had relied on since I was 14: my home, my child-care worker and my amazing Ministry of Children and Family Development (MCFD) support team.

My introduction to the Youth Supported Independent Living Program (YSIL) began at age 16. I was in total denial that eventually I would turn 19 and when that day came, I would have to live on my own. It just seemed too scary. My therapist referred me to the YSIL program and everything about it seemed challenging: the disability pension, finding an apartment, living alone and budgeting. But what was most frightening, was accepting this was inevitable and one way or another I was going to have to deal with it. I decided to meet with the YSIL worker, even though I was still convinced that this was not for me. I was caught on the word "disability" mainly because I hated the idea of being labeled. However, while I did not want to leave the security of care provided by the system, I did enjoy the possibility of being able to choose buttercup yellow walls with sky blue trim in a place of my own.

Over the next 2 years, I meant with my YSIL worker once a week, and the idea of having my own apartment brought on

feelings of both fear and excitement. But now I no longer felt like on that dreaded day when I turned 19, that I would be "dropped off a cliff" and left to fend for myself. I began to see YSIL more as a stepping stone between my current support systems and total independence. A program where I was learning budgeting, cooking and identifying and solving problems that arise from when someone lives on their own for the first time—everything from safety to dealing with loneliness.

The realization that they believed I was capable of living alone, also helped me believe I could do it too. I trusted them. I was getting the support I needed to becoming independent! Realizing there was this supportive middle ground was key to me accepting the YSIL program and succeeding. As soon as I realized this and that my YSIL worker would be there for the long run, I was ready to take the plunge! Over coffee, we worked on the dreaded budget forms, the shopping list which was always followed by the what-can-I-afford list, and the search for "the" apartment. I finally found the perfect home, took a deep breath and moved out on my own at 18 years old. I channeled the empty scary feeling into unpacking and decorating, the fear soon turned to housework. I continued to meet with my YSIL worker, working on issues like paying bills, advocating for myself with the MHR [Ministry of Human

Resources, known today as MEIA] and most important, cooking edible food without setting the fire alarm off.

Over the past five years I feel like I have successfully crossed over to adulthood. September will be my last month in YSIL and I'm excited to be starting a new chapter in my life by returning to Douglas College to get my diploma in child and youth counselling. Ultimately I was the one who created the success in my life, but I thank the YSIL program, and its dedicated workers Dan, Lindsay and Paige, for the continual support, guidance, laughter and companionship throughout my journey. **i**



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## Already in Our Backyard

Coast Foundation began providing supported housing in 1972. Jackie Hooper, a mental health consumer, came up with the idea of buying an apartment block to provide housing and a healing and supportive community for people with mental illness. The plan was to take people out of boarding homes and Riverview Hospital and to provide them with their own apartment, a support worker and a housing subsidy.

Jackie shopped the idea around, and Coast agreed to pioneer the concept. Today, Coast owns and/or manages 12 different housing locations in Vancouver that provide apartment accommodation for 309 people with mental illness. Coast also provides supported independent living (SIL) units in market<sup>†</sup> rental housing for 153 people.

Coast's supported housing model ensures that our clients have help from their

housing worker to search for, secure and keep housing. We have found that having a housing worker as an advocate and support is vital for most clients.

Unfortunately, it is still a challenge to place tenants in market housing, despite the fact that a person living with mental illness is as good a neighbour as anyone else. Many Coast tenants actively contribute to their communities by serving on strata (some Coast apartments are

### Rudy Small

*Rudy is the Supported Housing Manager for Coast Foundation Society. He is a Registered Psychiatric Nurse and has worked in mental health for over 30 years. Currently, Rudy manages 20 community housing workers who serve 462 people with a mental illness living in supported housing in Vancouver*

located in condominium complexes) or cooperative boards or by becoming involved in Neighbourhood Watch programs.

One barrier is that the rent subsidy for our clients is too low. Many neighbourhoods in Vancouver don't have any decent apartments for \$750 a month, which is the maximum allowable rent. The \$375 housing portion of disability assistance is topped up with funds from Vancouver Coastal Health, but only to the \$750 rental charge ceiling.

Other major barriers are directly related to discrimination and stigma. Some landlords believe that Coast clients might be dangerous and may scare away other tenants. Some landlords view people receiving Persons with Disabilities assistance as "welfare" recipients, and worry that they won't pay their rent. Landlords are permitted to ask about source of income or to run a credit check. Since most

Coast tenants have never had credit, they must reveal their source of income. Disability benefits and income assistance are managed and distributed through the same Ministry of Employment and Income Assistance offices. Thus, disclosing source of income often serves as a barrier to obtaining apartments.

Much work still needs to be done to educate landlords and neighbours about people with mental illness. At Coast's annual general meeting in 2001, a motion was put forward to change Coast's name from Coast Foundation Society to Coast Mental Health Society. The motion was defeated, because clients and staff did not want to use an agency name that contained the words "mental health." Most of the people who voted against the motion did so because they thought the "mental health" label would prevent people from getting decent housing.

Fortunately, there are a small number of private landlords who are willing to house people with mental illness. For our staff, building relationships with these landlords is an essential part of assisting clients. Landlords who have problems with tenants often feel quite isolated and unsure of what to do. They may take the only course they know: eviction. By getting to know landlords as individuals and by using every opportunity to provide mental health education and information, we usually develop strategies that meet the landlords' needs and expand housing opportunities at the same time.

It is critical that these relationships result in successful experiences of providing housing for people with mental illness. My experience is that when landlords and their tenants are provided with problem-solving support and mediation services, people with mental illness

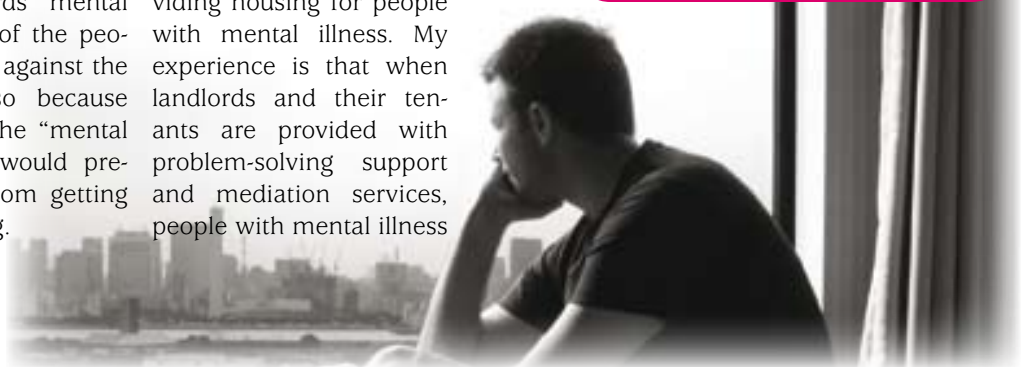
become highly desirable tenants. After people move into their homes, there are rarely complaints.

It is safe to have a neighbour or tenant who has a mental illness. Coast tenants and buildings fit seamlessly into neighbourhoods. When people say, "I do not want housing for people with a mental illness in my neighbourhood or building," they don't realize that "those people"—brothers, sisters, fathers and mothers—are already in their 'backyard.' **i**

#### related resource

for a story from a Coast housing client, check out Jake's online-only Visions interview

**"major barriers are directly related to discrimination and stigma."**



## In from the Shadows, in the North

### AWAC's services for marginalized women and female youth



AWAC—An Association Advocating for Women and Children was created in 1994 by a small group of community activists and social service providers in Prince George. The group was responding to an identified need for more accessible and appropriate services for street-involved women and female youth. These women and girls were living in poverty, homelessness and struggling with addiction, mental illness and exploitation. Many were engaged in survival sex to maintain their addictions. Many were dying violently or alone. All were engaged in a daily battle to survive.

With so many obstacles, the women were rarely able to access safe and supportive resources. Existing

services were mostly based on sobriety and asked too much of women who barely saw past each day. It was clear that vulnerable women in Prince George were in need of a safe place, a refuge from life on the streets.

After gathering together donations of money, time and materials, and securing a very small contract with the provincial government, the Quebec Street 24-hour Emergency Shelter opened in 1995. The shelter offered 19 crisis beds on a 24-hour-a-day, year-round basis for women and female youth. The program provided meals, snacks, coffee, outerwear and personal items for residents, as well as access to laundry and hygiene facilities.

#### Marianne Sorensen

*Marianne has been the Executive Director of AWAC—An Association Advocating for Women and Children in Prince George since 1996. She is active on many community and provincial initiatives to address women's issues, homelessness and community development*





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### Quebec Street Shelter—outreach and love

Our emergency shelter program was created to be very flexible, with a minimum of rules. Basically, the rules consisted of policies designed to maintain safety for clients and staff. In the beginning, women were asked to be sober when they came in. But it soon became obvious that we would not be meeting their needs if that policy continued. The guideline was changed, basing access on behaviour rather than sobriety. This allowed better access for women, while allowing staff to manage high-risk situations.

Whatever the women needed from us was what we tried to provide. I say “tried,” because the needs were great, and at times overwhelming. Knowing that we couldn’t offer everything they needed, we started with what we could easily give: love and acceptance. Lots of it. The staff hugged them, fed and clothed them and in many ways became their mothers, their families.

During the first few years of operation, approximately 250 individuals stayed with us annually. The usual length of stay was about three weeks, but many women stayed for much longer—sometimes for months. Many came to stay a number of times.

We then started building connections with other service providers in the community, to start breaking down the obstacles women often faced in getting needed services. Most of our clients had little trust, and little patience for wait-lists and paperwork. But, in spite of the challenges, we were providing shelter, support, outreach and referral to over 300 women a year.

During our fourth year of service, we created the outreach support program. Clients were still feeling frustrated and discouraged by the barriers to service. Staff were also discouraged by the inability of the community to help these women and girls in ways that might improve their lives. A small amount of funding was secured for a worker who provided clients with support, advocacy and accompaniment to appointments and meetings.

Over time, this program has grown into an important resource, not only for women who access our services, but also for other service providers working with vulnerable women and girls. The outreach worker is often the person who pulls together all of a woman’s support people, so that a strong and practical plan can be put in place to assist her. This has also created much stronger and lasting relationships between agencies.



### AWAC minimal barrier shelter

In the late 1990s, a provincial government program was created to address the growing shelter needs of homeless people during winter months. We were added an overnight minimal barrier shelter to our services, operating from 8:00 p.m. to 8:00 a.m., November to March.

This program enabled us to support women with very difficult-to-manage behaviours—women who were generally very high or intoxicated, or who were experiencing acute mental health symptoms. Without the extra staff to closely monitor these women’s safety, we would not have been able to shelter them.

### A new building—a new era for AWAC

In August 2004—with funding from a number of federal, provincial and other granting organizations—we moved all of our programs into a newly interior-renovated building. The outreach program and both shelter programs now operate year-round.

At the same time, we added a daytime/evening drop-in centre. Through the drop-in centre, we are building a base of activities and social opportunities for all interested women and girls. We also provide bathroom, shower, laundry, telephone and meal services to any woman or girl who comes to us in need.

### Providing skills for independent living

Many of the women were repeatedly returning to our services, unable to break free of the cycles they were trapped in. We wanted to provide these women with a safe environment, where they could learn the skills needed to live more independently.

Our supported housing program has been up and running since March 2007. We have a full house of eight tenants living on the second floor of our facility, supported by staff and community.

Over the years we have been fortunate to develop relationships with many incredible women. We have witnessed their amazing strength and humanity, in the face of circumstances that no one should ever have to endure. Some have moved on to a happier life; sadly, many have been lost.

We continue to open our doors to new faces and old, in the belief that each one has the possibility of a brighter future. Our hope is that, as a society, we will learn to do a much better job of caring for these women and girls who ‘walk in the shadows.’ **i**

#### related resource

for more on housing for vulnerable women, see Diana’s online-only Visions article

“Knowing that we couldn’t offer everything they needed, we started with what we could easily give: love and acceptance. Lots of it.”

**Homelessness Resources**

- **Tool Kit to End Homelessness.**  
www.endhomelessness.org/content/article/detail/1223
- **Community Services Housing Centre.**  
www.city.vancouver.bc.ca/commsvcs/housing
- **Homelessness Nation.org** is a site by and for homeless Canadians. www.homelessnation.org
- **Homeless Hub.** A new Canadian website coming Fall 2007. www.homelesshub.ca
- **PovNet.** Find resources, advocates, homelessness-related news. www.povnet.org
- **BC Mental Health Information Line:** 1-800-661-2121
- **BC Housing** www.bchousing.org
- **BC Non-Profit Housing Association.** www.bcnpha.bc.ca
- **Beyond Shelter.** Background on the 'Housing First' approach. www.beyondshelter.org/aaa\_initiatives/ending\_homelessness.shtml

*this list is not comprehensive and does not imply endorsement of resources*

**Publications**

- **Homelessness Virtual Library.** www.hvl.ihpr.ubc.ca
- **Homelessness: Causes and Effects.** A 2002, 4-volume research report by the BC government. www.housing.gov.bc.ca/housing/homeless/homless\_index.htm
- **Housing for People with Mental Disorders and Addictions.** BC Partners fact sheet. www.heretohelp.bc.ca/publications/factsheets/housing.shtml
- **SPARC BC.** has a number of reports on homelessness in BC on their website: www.sparc.bc.ca

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