City of Courtenay Mayor's Task Force on Breaking the Cycle of Mental Illness, Addictions and Homelessness in the Comox Valley

HOMELESS!

March 1, 2008

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Message From The Mayor of Courtenay

In November 2007, as Mayor of Courtenay, I formed a task force on Breaking the Cycle of Mental Illness, Addictions and Homelessness in the Comox Valley.

The Chair of our committee Mr. Tom Grant, along with other professionals and dedicated citizens from all walks of life, compiled the information contained in the City of Courtenay Mayor's Task Force on Breaking the Cycle on Homelessness, Mental Illness and Addiction in just three months, achieving our initial goal of creating a report within a very short timeline.

The issue of homelessness is complex, and difficult to solve in isolation. We recognize that resolving this issue will require the cooperation and partnership of all levels of government as well as community partners.

I strongly support the recommendations contained in this report and look forward to forming partnerships in order to address these very serious issues in our community.

Thank you.

Yours truly,

Starr Winchester
Mayor
City of Courtenay

Executive Summary

For the last three months the Mayor's Task Force has worked diligently examining the problem of homelessness in the Comox Valley. The Final Report is complete, and indicates there must be a change in direction if we are to solve this serious issue.

We all know how great a place this is to live, with a significant transportation infrastructure and a booming real estate market. Unfortunately, we also have the often-unseen world of homelessness. The task force and other experts estimate that there are 250 truly homeless people here, with at least another 3,100 at risk of becoming homeless. Unexpectedly, eighty-five percent of the homeless come from the Valley. They are not transplants from elsewhere.

There are many reasons why people are homeless. Most jobs here are in the service sector, and as such; do not provide a high income. Average household income is $59,000 per year, which is 18% below the BC and 22% below the Canadian average. What little rental housing is available (0.5% vacancy rate) has been rising in cost faster than most incomes. The majority of homeless have mental illness and/or addictions issues, and many also have other complex medical conditions. The current healthcare system is ill equipped to handle these cases effectively.

The suggested approach to solving this problem is to use a "housing first" model that has been used successfully in many American and some Canadian cities. The first step is to get the homeless housed, and then offer any required treatment and/or supports. The model is client-centered and also focuses on harm reduction. A seamless network of services is needed to provide support to these individuals.

A "Needs Survey" was completed in January 2008 with the assistance of the AHERO (Ad Hoc Emergency Resources Organization). The objective was to determine the needs of the homeless; in order for them to get the help they needed to turn their lives around for the better. Included in this survey were 116 respondents of which 21 were under 18 years old, and the average age was 40.3 years. Of those surveyed, fifty-three percent were female, which is much higher than the norm elsewhere. Thirty of the respondents had a least one child living with them, for a total of 46 children either homeless or at risk of homelessness. Twenty percent described themselves as being of aboriginal descent. This preliminary analysis identified that the highest need was around affordable housing.

It is estimated that each homeless person costs the system more than $50,000 per year, and that figure only takes into consideration healthcare and corrections services.

If we don't do something about this issue, there will be more than 900 homeless by the year 2012 (based on a conservative 30% annual growth rate).

More than $4.5 million could be saved annually by implementing a program to end homelessness.

There are four key strategies that are essential to success:

1. End homelessness through permanent supportive housing,
2. Proactively serve the needs of the homeless,
3. Stop homelessness before it begins; develop prevention measures,
4. Implement a comprehensive system of client-centered housing, services, supports, and treatment.

One of the key recommendations of the Task Force calls for the establishment of a “Comox Valley Commission to End Homelessness”, that would operate under the direction of the new Comox Valley Regional District Board. In the short term the action plan includes:

- Forming a housing development team (HDT),
- Initiating assertive community treatment (ACT) teams,
- Establishing a prevention team and preparing a detailed implementation plan, including a communications program to keep the public informed as to the Commission's progress.

The five-year plan calls for the housing of the 250 homeless, and an additional 500 units of affordable housing for some of the 3,100 considered ‘at risk’. The associated capital costs are estimated to be $52.4 million over the next 5 years. Of that, $17.3 million would be needed to provide various levels of supported housing to the 250 currently homeless. Operating costs for this endeavor will be roughly $5 million per year.

Many stakeholders will have to work together to achieve this largely attainable goal of eliminating homelessness in our community. BC Housing, all of the local governments, the Vancouver Island Health Authority (VIHA), community groups (such as Lush Valley, Salvation Army, Dawn-to-Dawn, etc), business people, financial institutions, citizens of the Comox Valley and homeless people themselves will all have to participate.

Introduction

To the outsider, the Comox Valley has all the appearances of an idyllic locale. Situated as it is in the splendid scenery of eastern Vancouver Island on a small coastal plain verging on Georgia Strait to the east and the imposing Beaufort Range to the west, it appears to be a place that would beckon anybody to take up residence. And it is. The population has grown phenomenally in recent years.

Composed of an almost poetic blend of forest, agricultural land, and a business/service industry, the Comox Valley consists of three municipalities, Courtenay, Comox and Cumberland. As well, there exists a populous rural area, and a large recreational aspect, both active and potential. This, Vancouver Island's third largest community, with a population of roughly 65,000, would seem to have it all.

Well served by transportation links, including WestJet's regular flights between the new Comox Valley Air Terminal and Edmonton and Calgary, as well as a superlative highway connection north and south, there is nothing to impede travellers and potential new residents from directly connecting with the Comox Valley.

Such connections have led to amazing changes in the past few years, and a significant building boom that shows no signs of abating. New neighbourhoods have sprung up throughout the three municipalities, including single residences as well as townhouses and condominiums. So far it all looks extremely positive and inviting. Indeed, it is inviting, a fact to which significant population growth will bear witness.

A Nasty Secret

Yet, not very well hidden behind the striking façade of the greater community there lies an unpleasant reality that remains unbeknownst to many, but is only too real to those impacted, and those who labour arduously to assist those impacted. That reality is the world of the homeless and the "at risk" of homelessness population of the community.

You've seen them. We all have. They gather in front of St. George's United Church at noontime; they sometimes panhandle on the streets, periodically evoking cries of: "Get a job!" They drift through the downtown core and into the side streets. They provide a vivid reminder that all is not necessarily well in a community we might like to think is pristine.

Many of us assume that homelessness is surely a 'big city' phenomenon to be found, most notably, in such urban centres as Vancouver and Victoria, but this is not the case. Homelessness knows no such boundaries. Suffice it to say that the Comox Valley has an inordinate number of people who are either literally homeless, or who have a huge potential to be without warm and safe housing in the near future. Or else, they are just 'making-do' at the moment in inadequate suites, or 'couch-surfing' with obliging friends or relatives.

This report will focus on two major components of the homeless and potentially homeless populations: the approximately 250 absolutely homeless persons, as well as the minimum of 3,080 persons who are who are considered to be at risk for future homelessness because of the inadequate level of shelter subsidy that is available through the income assistance program.

This report will also consider a third group that stands in jeopardy of going homeless in the future; the underemployed and the so-called 'working poor, as well as those subsisting on Employment Insurance payments.

The summarized findings of the *Courtenay Mayor's Task Force on Homelessness* are to follow. There we will look at the realities of Comox Valley homelessness, wants and needs, economic realities and potential solutions to a grievous situation for too many in the community.

A Slice of Comox Valley Life in the Raw

Three different women, ages 40, 28, 25 were in the (Lilli) house with three children each. They stayed 40, 52 and 65 nights each. What prevented them from leaving was the lack of affordable, adequate housing. Generally speaking, landlords don't want kids in rentals. Eventually one of the above-mentioned women went back to the family home, one moved into a two-bedroom apartment and the third found housing outside of town, which created transportation challenges. A fourth woman with three children is living in a summer cottage. The landlord's wife doesn't want them there, making her situation very unstable. In more than one of these cases, the MEIA worker was insisting that a three-bedroom apartment be rented for three children and an adult. When asked if the MEIA was going to provide the shelter funds to pay for a three bedroom apartment, the answer was no. An apartment was secured, but the worker was lied to, putting the woman and her children at risk of losing assistance.

Personal Income Realities Of The Comox Valley

There is wealth in the Comox Valley. It's predominantly wealth possessed by older established families, successful entrepreneurs, professionals, or by newer members of the community who have done well elsewhere and have come here to settle.

Otherwise, the community is one under economic duress. Major industries, such as Field Sawmill, and the Comox District Free Press (both companies who compensated their employees well) have gone in the past 15 years, and nothing comparable has been enticed to replace them. The largest employer is CFB Comox, and there is also a sizeable professional sector. Otherwise, the Valley is predominantly service and clerical in terms of employment offerings. Such employment does not pay well, and the level of pay is well below the level for comparable jobs in other communities, even on Vancouver Island.

Tourism is big, but again, except for owners and upper management, few make an adequate salary from this venture, which impacts them in terms of available income for home ownership or meeting rent payments.

The Valley has a large agricultural sector, but the majority of farm jobs are at minimum wage or less.

While many Valley residents formerly sought and found employment in the forest industry, mining and the fishery, these sectors are all depressed and offer little or no opportunity locally.

Local Wages are Inadequate

Due to an influx of newcomers there has been a notable housing boom that currently shows no sign of abating. Current homeowners and mortgage holders have seen their properties accrue mightily in the last half decade. That's good news for those who are so situated and who have a source of income that permits them to maintain that status.

On the other hand, there is a significant portion of the population that cannot keep a household together financially. Often, in what should be their peak earning-years, people are either forced to leave (witness our diminishing school population) or they must live in substandard accommodation. In some cases, when unable to secure basic housing, people resort to "couch-surfing" with friends or relatives, or living in tents or their vehicles. They are literally a step away from the streets, and many do indeed end up on the streets.

With no notable, union-wage paying industry, and with the forestry and fishing options under duress, the rate of pay in the Comox Valley is substandard to other communities in the province (even on Vancouver Island), and three per cent lower than the national average. This takes a huge toll.

Income Estimate Comparison			
	Comox Valley	BC	Canada
Avg. Household Income	**$59,136**	**$69,968**	**$72,015**
Avg. Family Income	**$68,162**	**$78,470**	**$81,104**
Per Capita Income	**$25,920**	**$28,388**	**$28,782**
Avg. Employment Income Male (PT)	**$40,207**	**$46,218**	**$47,382**
Avg. Employment Income Male (FT)	**$53,595**	**$60,781**	**$60,548**
Avg. Employment Income Female (PT)	**$25,182**	**$29,582**	**$29,858**
Avg. Employment Income Female (FT)	**$37,604**	**$43,174**	**$42,303**

Source: 2007 Financial Post Canadian Demographics

Do the above figures indicate the Comox Valley is a financially depressed area? By any conventional standards, indeed it is. Since we sit well below the provincial average, despite all that is shiny and new on the surface, we are in a similar position to other popular retirement and tourism destinations, such as Hawaii or Palm Springs. As is the case in such places, many householders in this community are working at more than one low paying job. Likewise it is the norm for both adults in a family to be working at one or more jobs to gain sufficient income to meet their basic needs.

The obvious answer to this quandary is to attract industry and technology to the community so that, at the very least, current provincial standards of income could be met.

Housing First

Two significant concerns prompted the establishment of the Mayor's Task Force on Homelessness in the Comox Valley. The first and most obvious of these is sheer compassion for the community's dispossessed. It is unacceptable that in an affluent time in a relatively affluent community some of our citizens are unable to access safe and warm accommodation.

The second concern is a fiscal one. The way the Comox Valley deals with its homeless is expensive. Studies indicate here, as they do in other communities, that by providing a viable means of housing to the homeless, we would be saving a significant amount compared to what we are spending with our current approach to homelessness.

The Courtenay Mayor's Task Force on Breaking the Cycle of Mental Illness, Addictions and Homelessness Expert Panel indicated that utilizing the "Housing First" model was a key element in addressing the issues.

Origin of the Philosophy

The principles and approaches that lie at the core of the Comox Valley's plan to alleviate homelessness find their roots in a basic philosophy developed by US social housing expert Philip Mangano, who was commissioned to find a solution for the dire homelessness picture in a number of American cities, large and small.

Mangano's philosophy calls for 10 steps to which a community must commit in order to be successful. Those communities that subscribed to "*The 10-Year Planning Process to end Chronic Homelessness,*" *(see:* http://www.usich.gov/slocal/Innovations-in-10-Year-Plans.pdf) have been overwhelmingly impressed by the results.

> *"A 10 year plan to end homelessness in Portland, Oregon, for instance, has seen a 70 per cent reduction in the number of chronically homeless people on its streets in the first two years of the strategy. Employing the 'Housing First' model – which combines immediate housing with specialized outreach services – Portland saw its homeless population fall from 2,355 to 1,438, with a particularly dramatic reduction among a subset of 1,284 people who were considered chronically homeless."*
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> ***As cited in the Report of the Steering Committee, Victoria Mayor's Task Force***

On the Canadian side of the border, the City of Calgary has developed an extensive program that follows many of these *Best Practices* principles. As is stated in the Calgary report:

"The social costs of homelessness are many and well understood. We know that people with mental illness and addictions get worse when they are un-housed and unable to receive treatment, and they often end up in ambulances and emergency wards… But, we've also begun to realize that homelessness is exacting a terrible economic toll. Our own analysis shows it costs taxpayers more to manage homelessness that it would to end it."[1]

The largest study of homelessness on Vancouver Island was the one recently completed by the City of Victoria. The Comox Valley plan claims a direct connection with the philosophies outlined by Victoria, but also incorporates the models provided by other communities in Canada and the US.

While the Comox Valley study owes some points of reference to the Victoria study, ours is unique in a number of ways, including the fact that all three elements of our study are cohesive and represent unanimity in the findings and approaches of the Steering Committee, Expert Panel and Gap Analysis Team.

Late last year, *Victoria Times-Colonist* columnist Jody Paterson ran an excellent series on homelessness. It captured the crux of the problem, whether it's in Victoria, the Comox Valley, or virtually any city or town.

> *So we needn't waste any more time pointing fingers, and we certainly shouldn't be waiting for an election to solve anything. What we need to do now is get on with it. Hospitals were closed. Cheap housing was no longer built. Welfare benefits were slashed to the bone. Children with a lifetime of problems were pushed out into the world with no support. Governments got out of the business of helping citizens without even considering the long-term impact of withdrawing care from those who needed it.*
>
> ***Jody Paterson, Jan. 27/08, Times Colonist***

[1] 'Calgary Committee to End Homelessness, *Calgary's 10 Year Plan to End Homelessness* (Calgary, Alberta: City of Calgary,[2007]), http://www.endinghomelessness.ca/default.asp?FolderID=2178 (accessed February 2008).

Issues Causing and Impacting Homelessness

- *Federal withdrawal from social housing* – The federal government began withdrawing from the social housing sector in the early 1990s after having been actively involved for several decades through the Canada Mortgage and Housing Corporation (CMHC). The government's plan was for the private sector to take over. This didn't happen because investment returns were too small.

- *Housing costs rose, earning power didn't* – The costs of housing in the Comox Valley have risen much faster than the incomes of low and middle-income earners.

- *Policy changes to federal transfer payments* – In 1996 the federal government announced a new policy around transfer payments to the provinces that were provided to offset the costs of providing social programs. Previously, provinces had been required by Ottawa to maintain funding to social services at a specified level. Now provinces had the freedom to set their own levels, and most provinces responded by cutting social spending.

- *Changes to BC's income assistance policy* – In the mid 1990s BC launched an aggressive strategy to reduce the number of employable people on income assistance. Further policy changes were introduced in 2002. Between 2001 and 2005, more than 105,000 people lost their welfare benefits. The two-year "independence" test introduced in 2003 is a particular challenge to those with chronic mental illness, addiction and other ongoing barriers. Additionally, to be eligible for disability income assistance, people have to 'prove' they have a permanent disability.

The Comox Valley's 'Reality'

The Comox Valley population is not large as compared with other centres; this makes the community's homelessness problem seem especially disconcerting.

In response to growing concerns, the Mayor's Task Force took a direct page from other successful plans and developed a process following the "Best Practices" model that begins with full emphasis on the "Housing First" component.

When this project (with a tight timeline) was established in November of 2007, the three 'teams' – Gap Analysis Team, Steering Committee and Expert Panel – generously contributed pro bono expertise, time and energy to develop a plan geared specifically to the Comox Valley.

The reason for going with the *Housing First* philosophy is very simple. It works. It addresses the initial problem for the chronically homeless, and it saves the community considerable money in the long run.

How It Works

Worldwide, successful interventions in supporting homeless residents are based on the following "Best Practices":

- *Housing first*. An approach that houses homeless residents and then is followed by supported treatment options.
- *Client-centered approach*. Services are most successful when they are adapted to individual client needs rather then organized around a facility, the providers or other efficiencies.
- *Flexibility*. Working with people "where they are at" rather than forcing people to meet service requirements.
- *Low barrier programs*. Access to these types of programs do not require a person to be in treatment or abstain from the use of substances.
- *Harm reduction*. Reducing the risks and harmful effects of substance abuse and addictive behaviours are beneficial to the individual as well the communities/neighbourhoods in which these practices occur.
- *Assertive Community Treatment (ACT)*. Community-based, multidisciplinary teams that provide 24-hour support, treatment and rehabilitation services to clients where they live and work.
- *Seamless network*. Making it easy for mental health and addiction clients to access multiple services and supports.
- *Emphasize choice*. Client-centered strategies have much higher success rates for recovery and community integration. This practice relates to offering various alternative options rather than a single approach for everyone. Client-centered strategies have been commented on above.
- *Prevention*. Strategies to assist the "at-risk of homelessness" population are in place to break the cycle of homelessness.

Recommendations from the Mayor's Task Force Expert Panel are founded on these "Best Practices".

Bringing About Change

One of the primary incentives in bringing about change, aside from the obviously compassionate one, is financial. The community will, in fact, be saving some $4.25 million annually by getting people off the streets and into safe, warm housing. It costs more to 'manage' the homeless than to house them. Currently the projected annual costs of the homeless' public service usage for the Comox Valley Regional District is roughly $13.3 million.

With intervention and the provision of adequate housing, the annual cost would be a little over $9 million. This is a 32 per cent drop, or savings of $4.2 million.

What are our current homeless shelter realities? The findings of the Task Force Gap Analysis Team Needs Survey indicate the following:

- Very few services are currently available to this sector of the population. In comparison to other areas on Vancouver Island and throughout BC, the Valley is under-served in many areas, beginning with supported housing. Virtually no new rental housing has been built in the last 20 years.

- A number of community groups do provide critical services, including the weekday soup kitchen at St. George's United Church, the Comox Valley Food Bank, and various drop-in centres. However, there is no ongoing outreach program at the present time. The Comox Valley Nursing Centre does some primary medical outreach and operates a drop-in-clinic five days a week.

- There is no continuum of housing available. There is a shortage of shelter beds. Those that are available through the Salvation Army are restricted in terms of the type of client they will accept. In addition, the homeless client is limited to a stay of only three days due to space limitations. In that regard, the current shelter needs to be replaced. It is not suitable in terms of physical layout and location to provide a 24/7 operation, which is what the provincial government would prefer. With major residential and commercial development ongoing, there are fewer and fewer places for the homeless to go.

The Chronically Homeless

The needs survey estimated the numbers of chronic homeless in the Comox Valley at around 250.

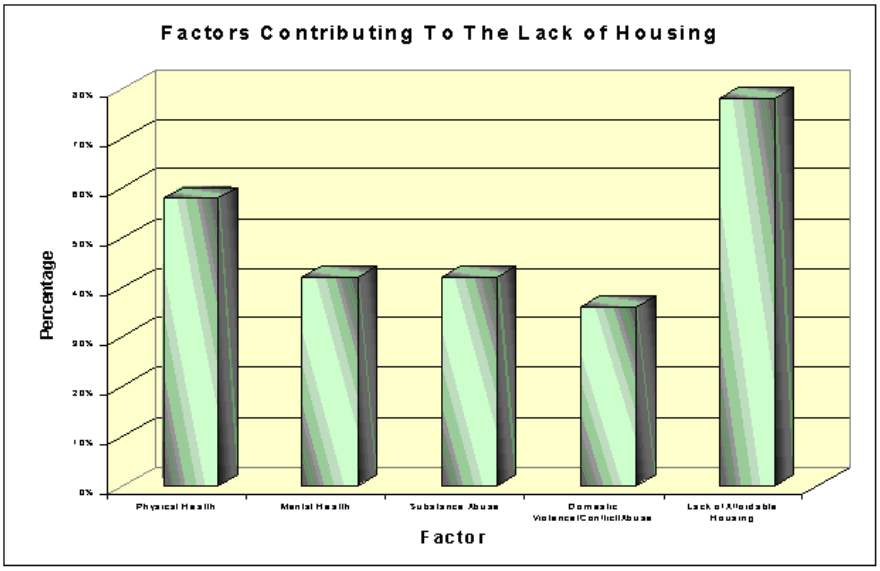
The majority are local (about 85 per cent), and it is believed that some 25 per cent of these people are aboriginal. The aboriginal sector is a population in flux, as its members tend to arrive and then often leave. Roughly 50 percent are

women – some with children though these numbers vary. In Victoria the number is closer to 30 percent.

Why are these people homeless? Mental illness is identified as the leading problem, but addiction to drugs and/or alcohol is also a large problem. In a recent homeless survey, over a third of respondents identified themselves as having both mental health and substance abuse difficulties. As cited in their January 2008 report *Reducing Homelessness: Proposals for Housing and Support Services in the Comox Valley*, Comox Valley Mental Health and Addictions Services (CVMHAS) states as follows:

"With a vacancy rate of .05, one of the lowest in the province, there is an overall shortage of affordable housing in the Comox Valley and even fewer housing options for low-income earners with mental health and/or substance use problems. Due to their illnesses, many of these individuals are often involved with the legal system, have impaired vocational functioning, have poor money management skills, problems with family and/or social functioning and may experience other barriers, such as learning disabilities and illiteracy. When a supported housing program does become available, they are often ineligible due to the requirement that tenants/clients abstain from alcohol and other drugs. In the Comox Valley we need housing that does not require total abstinence and one that incorporates a supportive and harm reduction approach. In addition, it is important to not only address the above population but also to develop a housing program that addresses people whose early recovery is fragile. In this way, housing becomes a stable foundation on which mental health and substance use problems can be addressed and the process of bridging individuals to community rehabilitative services can be initiated."[2]

[2] 'Comox Valley Mental Health and Addictions Services', *Reducing Homelessness: Proposals for Housing and Adjunct Services in the Comox Valley* (Courtenay, BC: Vancouver Island Health Authority,[2008]) (accessed February 2008).



The CVMHAS report ties in succinctly with the *Housing First* philosophy that has guided the work of the Task Force.

At Risk Population

In addition to the chronically homeless, the Comox Valley also has a large at-risk group that totals approximately 3,100 people (including but not limited to people on income assistance and employment insurance as well as the working poor), or roughly five per cent of the total population. This group is largely composed of individuals and their dependents receiving income assistance, who would need to spend 65 per cent of their income on shelter. This would leave little for food, clothing and other essentials.

> *"I am one of the fortunate ones but I'm only one welfare cheque away from being homeless. Unfortunately, most homeless do not fill out these forms (the AHERO Survey forms, see Page 21). Most are deemed 'employable' although most have other issues: mental illness, depression, transportation, telephone, to name only a few."*
>
> ***Male, age 51***

The Working Poor

With average gross incomes in the Valley being at least 15 per cent lower than the provincial average, the working poor make up a large body within the community. While there has been an increase in employment in the construction sector due to the current building boom, virtually all the new jobs

created in the past half-decade lie in the service and hospitality sectors. Those are often entry-level jobs with few opportunities for advancement and higher wages. In one household, even if a couple are both working at such jobs, the concept of buying a house is out of reach for most. In the case of singles, it's virtually impossible. Meanwhile, rental rates are rising faster than incomes and show no signs of levelling off.

For these people, paying rents that are more than 50 per cent of their gross income leaves little for food and other necessities. According to the BC chapter of Dieticians of Canada, it takes approximately $715 per month to feed a family of four. Consequently, low wage earners may face a deficit each month. This has other implications including poor nutrition for families, which means that children especially do not receive proper nutrition. This will lead to health problems as they grow older and will end up costing society more in the future.

Reality of the Working Poor

Dionne Woods and her life partner live in what she describes as a "$546 a month box" at the Washington Inn. "I guess, to be polite, you could call it a bachelor pad," she says. "But, there's no other place for people at our level."

Dionne is candid about being identified because, as she says, maybe it will make people sit up and pay attention. She would rather not live where she does, and she doesn't like the fact there is a bar and the new bingo palace all connected with, or in close proximity to the Washington.

"*A lot of these people turn to gambling," she says. "That's not a good thing, but it's a hoper for them, so it's understandable."*

Dionne works full-time at a service station, and also she and her partner produce an on-line magazine that helps pay the bills, but their income does not put them near to being able to acquire a home of their own, or even pay rent at the level that is available for more inviting accommodation.

"*There's a lot of us working at minimum wage, and with no health coverage," she says. "I just had surgery and the pharmaceuticals I need now aren't covered. It's lousy. I work really hard, and so do a lot of us.*

And here we live in the best place in the world, but our food, rents and gas are all more expensive and wages in this community are terrible."

Meet The Homeless

There is no single reason that some members of our society end up homeless. Reasons such as lack of formal education, decrease in primary industry, misfortune, abuse, mental challenges, emotional challenges, ill health, Fetal Alcohol Syndrome, and addiction are all factors. People's stories are as varied as they are individually.

So, who are these largely nameless men and women who are the subject of this report? Much expertise and a lot of energy have been devoted to the homelessness crisis in the Comox Valley. It is hoped that we can find various means of bringing a better quality of life to all our citizens. These people are *our* citizens.

A fact worth noting is that research indicates that up to 65 per cent of people do find their way out of homelessness by themselves. However, the truly vulnerable, as described below, often have a large combination of barriers.

The profiles were created from the findings of the three committees in the Mayor's Task Force: the Expert Panel, Gap Analysis Team, and Steering Committee. Contributing a great deal of the information to the committees were: Comox Valley Mental Health and Addictions, VIHA, the Salvation Army, the AHERO organization members, the medical community, the Nursing Centre, Dawn to Dawn, and others.

That stated, the prototypical homeless male and female (with variations on the key elements to be found with each individual) resemble the following two people**:**

He Is:

- *41 years old:* Taken as an average from the age demographic of Comox Valley homeless.

- *Impoverished for various reasons*: He may have grown up in poverty; he may have met with a health crisis, domestic crisis, and employment crisis.

- *Suffering from a physical disability, mental illness or addiction*: The physical disability may have arisen from accident or injury, chronic condition, or lifestyle -precipitated health condition. Many homeless are suffering from Hepatitis-C or HIV, both which pertain to lifestyle. Mental illness may be of a chronic nature, or it may have manifested itself later. Addiction may have arisen as a result of life in the streets, or as a means of coping with a mental illness, or it may stand alone but has led to lack of employment or spotty work record, punctuated by stays in recovery facilities, hospitals and jails.

- *Victim of a difficult childhood*: He may suffer from Fetal Alcohol Syndrome or Effect, have been abused, sexually and/or physically. He lacks supportive relationships within his family. He may have been in a multiplicity of foster homes.

- *Lack of formal education:* He is not well equipped to take a role in the modern workforce; if he is employable it is only at the most rudimentary levels. Furthermore, the lack of a stable home means he has little chance to make himself job-ready in appearance, and has virtually no means to travel to either a job site or even to a job interview.

> *"It would be good to have a safety-net, after treatment, for example. To have a resource centre and helpers to access housing, employment and training programs. This would also be good for those being released from jails. People out of recovery centres and jails have no help, and don't know where to get help. They usually end up back in trouble."*
>
> ***Male, age 32***

She Is:

- *39 years old.* Taken as an average from the age demographic.

- *Impoverished for many reasons:* Often the victim of domestic violence, from which she has been forced to escape. As with the male, she may also have grown up in poverty, then became pregnant or married at an early age. Her poverty is not exclusive to herself, but also extends to the children she cares for.

- *Suffering from a physical disability, mental illness or addiction:* Many of the same criteria apply here as do for the homeless male. If she is suffering from addiction the paucity of subsidized treatment/recovery options in this community tends to compound the problem because she has very few options other than recovery programs such as AA or NA. Formerly there was a day program in the Valley for addicted females, but that has long-since gone. There is limited access in this regard at Lilli House.

- *Victim of a difficult childhood:* Often the product of a broken, fatherless or violent home of origin, she has become pregnant at an early age to escape the situation. In many cases she has been sexually abused: often by a family member. Early cohabitation or marriage has often been a situation as dysfunctional as the one in which she grew up.

- *Lack of formal education:* Due to lack of any sort of support system she left home at an early age and did not complete her education. And, as in the case of the male, the lack of housing has made it difficult for her become job-ready. Furthermore, if she has to care for young children she must often refrain from working in order to care for them. Her educational deficits combined with a possible addiction to drugs and/or alcohol may contribute to her being a homeless person.

- *In the majority:* Whereas in the case of other jurisdictions, like Victoria or Calgary, the majority of homeless are male, often by a considerable margin, 51 per cent of the Valley's homeless are female. This fact attests to the lack of opportunity or meaningful work available for women. It is not unheard of for a homeless woman to end up as a sex-trade worker, or trading sex for shelter, rendering herself even more vulnerable.

"I went to the Transition House in October 2005 for three weeks and three days. The Salvation (Army) shelter for three days, two times. I stayed in St. George's Church overnight once in October 2005 and set off the alarm. I stayed one night in the CRA. I then stayed as a guest with a person at the Courtenay Hotel for October, November and December 2005, and then January to April 2006."

Female, age 38

The Needs Survey for the Mayor's Task Force indicates that female homeless people are in a slight majority in the Comox Valley. For them the paucity of a continuum of housing is a sort of double-whammy. If they have children, it is essential that they find safe shelter. Unfortunately, they are often refugees

from family violence and sometimes are forced by circumstance to go back to an unhealthy and even dangerous situation. Their choices are very limited.

The Comox Valley Transition Society, which operates a shelter for homeless and "at risk" women, sees many of these women first-hand, and reports that their situation is dire.

More Truths About Homeless Women

Between June 1, 2007 and Dec 17, 2007 139 women and 66 children stayed at Lilli House, the Transition Society shelter. The Comox Valley Transition Society considers all of these women homeless. For many it is a brief stay. Others are seeking to free themselves from the abusive relationships and are looking for safe, adequate and affordable housing.

Several women presented with no history of violence, with homelessness being the primary issue. The stays ranged from 1 to 76 nights.

A significant number of women using the services have mental health or substance abuse challenges. And in this period of time three women were turned away because of unmanageable substance abuse.

In addition 35 women stayed at Lilli House in the Addictions Program.

Many of the women who stayed at Lilli House chose to relocate to another community rather than risk becoming homeless in the Comox Valley, because of the lack of adequate and affordable housing.

Other women were Transition House "hopping", choosing this facility rather than being ill housed or homeless.

In similar context, consider the following findings, from the Canadian National Clearinghouse on Family Violence, as offering a strong indication of the need for a continuum of housing, not only to protect women, but children as well.

The lack of affordable housing has been identified as a barrier that prevents abused women and their children from "moving on" after short-term stays in a family violence shelter. Trends recorded in one major Canadian city seem to indicate that women are having increasing difficulty to obtain subsidized housing upon leaving a shelter. Statistics Canada data indicates that approximately one-third of victims who flee violent homes remain homeless or unstably housed for prolonged periods.

Family Violence and Homelessness: A Review of the Literature By Sylvia Novac, Ph.D., for the National Clearinghouse on Family Violence.

Health Issues

Most of us appreciate that we have access to necessary medical care. We have family physicians, we have health plans and for the truly fortunate, health insurance and benefits that are included with our employment.

For the homeless, this is not the case. The Comox Valley is experiencing a shortage of family physicians. For many this is an inconvenience; for the homeless it is disastrous and even life threatening. Their needs are different from those who are adequately housed, and their access to services is compromised.

What Are the Health Issues For the Homeless?

The Nursing Centre, which has been in existence for 10 years and which has provided the prototype model for such facilities in other communities, sees many homeless first-hand. This is due to the limited access to medical services such people experience.

- Such clients may be unreliable about making and keeping appointments.
- The Comox Valley medical community has established an "informal policy" of not accepting another doctor's patients. If you have left another GP's practice, you will be unable to find another physician.
- Street-involved clients or those with complex health issues, including addiction (both past and current) are often "fired" either for not showing up for appointments or for presenting challenges for service provision needs.
- They then become medically 'orphaned' and access to primary health care is limited.
- Currently, walk-in medical clinics provide only limited care, as they typically cannot address the complex health issues that so often plague the street person. Psychosocial, nutritional, and housing needs cannot be addressed in the clinics.
- Shared interdisciplinary care is also not an option for the homeless. Many of the physicians working at the walk-in clinics advise us that they do not have hospital - admitting privileges, thereby limiting the services they can offer to medically orphaned patients. Referrals to specialists are not an option, as clients need a family doctor.

What Are the Options?

The open access drop-in clinic at the Comox Valley Nursing Centre and the outreach-nursing clinic at AIDS Vancouver Island (AVI) provide nursing services to this population. However, there are significant limitations:

- The service offers a nursing component only; there is no access to physicians.
- The AVI outreach is limited to one-half day a week.
- Physical space limits the array of services that can be offered. For example there are none of the following: dietician/food service, social worker, Mental Health And Addictions Services, clinicians, pharmacist, dentist, or laboratory services.
- Limited staffing resources do not allow for extended hours of service.
- Family physicians have minimal contact even for those clients who have a primary care physician.

Existing Opportunities

AHERO (Ad Hoc Emergency Resources Organization) represents a number of community agencies that offer services to those who are marginalized or street involved. Included in the membership of AHERO are the Wachiay Friendship Centre, MEIA, AIDS Vancouver Island, the Transition Society, Red Cross, Salvation Army, St George's United Church lunch program, the Comox Valley Food Bank, and other agencies. They meet monthly to identify gaps but there is limited opportunity to actually work from a central location to make for easy no-barriers access for clients.

The Communicable Disease program resourced through Public Health Nursing currently tries to link with the AVI outreach on Wednesday and is committed to offering appointments for testing and counselling in a timely way. Staff resources are a limitation.

The mobile outreach van operated by AVI has been funded intermittently through the Ministry of Employment and Income Assistance (MEIA) or The United Way. The van offers warm food, clothing, blankets, and support from an outreach worker and volunteers, Tuesday and Thursday evenings and Sunday afternoons. They facilitate referrals to other agencies and build a bridge to daytime services. The van typically parks at the Washington Inn and the Maple Pool Campground as well as other ad hoc "camping" sites to which they have been invited.

The Chronically Homeless

Many factors render it difficult to develop fully accurate numbers representing the size of the Comox Valley's chronically homeless population. Periodic surveys can provide only estimates, and are acknowledged as being 'undercounts' for many reasons. The population is somewhat transient, many are wary of being included in a survey; therefore there is a singular lack of comprehensive data.

With that understood, it was still necessary for planning purposes of the Mayor's Task Force to estimate the magnitude of the homeless population. This was accomplished by reviewing estimates from a variety of organizations that serve homeless persons, and the 2006 Comox Valley Homelessness and Housing Survey carried out by the Comox Valley Ad Hoc Emergency Resources Organization (AHERO). Based on a review of these figures, the Task Force's Expert Panel arrived at consensus-based planning targets.

Estimates of the Population

- Based on the application of provincial estimates to the Comox Valley population, it is probable that 116 to 232 people with serious addictions and mental illnesses live on the streets.

- The Mayor's Task Force on Homelessness and AHERO Needs Survey of January 2008 identified 103 persons who were homeless, or without a home at the time of the survey. Seventy per cent of these respondents had mental health/addictions problems.

- Adult Addiction Community Treatment Program identified 125 homeless persons among their clients in the most recent 12-month period.

- The Salvation Army Emergency Shelter estimated 340 homeless persons among shelter users during the most recent 12-month period. Two hundred and fifty-three users of the shelter have mental health and addictions problems.

- Comox Valley Transition Society housed 139 women and 66 children at Lilli House and 35 women in the Lilli House Addictions program during the most recent 12-month period. All of these women are considered homeless insofar as they would have nowhere else to live if they were not at Lilli House. Fifty percent of women and children served at Lilli House leave with either no housing to move into, or whose housing situation is uncertain for the future, or are at immediate risk of further homelessness.

- Wachiay Friendship Centre Homelessness Prevention/Intervention Centre currently has 367 Aboriginal clients, most who are at risk for homelessness.

- The Courtenay District Office of the Ministry of Children and Families is financially supporting 15 youths who would be homeless without their support. All have a range of emotional and behavioural problems including substance abuse, sexual exploitation, criminal activities, self-destructive activities, mental health impairment, school absence or no family support.

- There are currently 1,500 cases that represent 3,083 persons receiving income assistance through the Ministry of Employment and Income Assistance, all of who are considered to be at risk for homelessness because of the level of shelter subsidy, which is available through the income assistance program ($375 per month for a single person). It is estimated that there are an additional 1,500 people considered at risk or in unstable housing.

Planning Targets

Based on the figures reviewed above, the Task Force agreed to plan for between 200 and 300 absolutely homeless persons, with a mid-point planning target of 250. As well, planning includes a minimum of 3,080 persons on the provincial social assistance program who are at high risk of homelessness. This number does not include the working poor or persons on Employment Insurance.

Health Problems

Based on provincial estimates that were developed by the Centre for Applied Research in Mental Health and Addictions at Simon Fraser University, it is expected that the prevalence of mental health and addictions problems among the core group of 250 homeless persons will be as follows:

- 200 persons (80 per cent) will have serious mental illness and/or addictions problems
- 75 persons will have concurrent mental illness and addictions problems
- 37 will have serious mental illness without serious addictions
- 88 will have addictions without serious mental illness

It should be noted that a large proportion of the homeless population also experience a high prevalence of other chronic and acute illnesses and disabilities - seizures, chronic obstructive pulmonary disease, chronic pain, arthritis, hypertension, anemia, respiratory tract infections, skin and foot problems, tuberculosis and other infectious diseases. These can be concurrent with mental health and addictions problems.

The Comox Valley Nursing Centre provides Outreach Nursing Services to 14 homeless men through AIDS Vancouver Island. In addition, the Centre supports a peer counselor who in turn, supports a number of homeless men. Shelter was found for 11 men in a six-week period in October and November 2007.

Among CVNC clients, chronic health issues and marital breakdown were key factors contributing to male homelessness. When relationships break down and there is also a concurrent chronic illness and under-employment, homelessness often becomes an issue.

It is estimated that between five and 10 homeless persons are very frequent users of the mental health services, emergency services and policing services, accounting for an unusually high proportion of contacts.

It is estimated by the Centre for Applied Research in Mental Health and Addictions at Simon Fraser University that for each absolutely homeless person it costs $54,833 per year for health care and correctional institutions alone.

Gender

Fifty-three percent of the homeless and high-risk populations in the Comox Valley are female. This was notably higher than the one-third female to male ratio noted in other surveys. After a review of a variety of local agency statistics, the Panel concluded that the fifty-three percent estimate appeared to be a consistent figure.

Family violence is a major contributor to homelessness among women. After leaving Lilli House, many women have to leave the community because of a lack of affordable housing, and half of the women leaving the addictions program have nowhere to go. Some end up in the sex-trade in order to finance food and shelter.

Children are also a significant factor with the female homeless. In a survey of twenty respondents that the Comox Valley Family Services Healthy Families program carried out in December 2007, three respondents indicated that they had been homeless at sometime during their pregnancy or while caring for their children and five reported that they knew someone who was currently homeless while pregnant or caring for young children.

Aboriginal People

Although accurate counts of the homeless Aboriginal population in the Comox Valley are not available, the Panel supports an estimate that at least 25 per cent of the homeless population is of Aboriginal descent. This is a relatively fluid population as members of Aboriginal communities from outside of the Comox Valley come into the area for varying periods of time. Since Aboriginal people compose less than half of one per cent of the Valley's population, these numbers are disproportionately high.

Age

The Mayor's Task Force and AHERO reported an age range of 15 to 73 years with an average age of 40. This was consistent with the age range reported by the Comox Valley Transition Society Services for women. Thirty-five per cent of females and 15 per cent of males of the survey respondents (absolute homeless and "at risk") reported that they had children living with them.

Youth under 19 experience a unique barrier to housing insofar as landlords require the signature of an adult on any lease. Youth also require additional supports because of their lack of experience in maintaining a household.

Homeless and Unstably Housed People Estimated by Age and Housing Category in the Comox Valley

Housing Category	Adults			Youth	Children	Total
	Males	Females	Transgender			
Homeless	97	29	0	22	12	159
Unstably Housed	35	27	1	12	17	91
Total	131	55	1	34	29	250

Current shelter options for the homeless

Options for the chronically homeless include the following:

- ***The Salvation Army Shelter*** provides 11 beds for men and six beds for women.
- ***Lilli House (Transition Society)*** has 11 emergency shelter beds (six for women, five for children) available to those escaping abuse, as well as one detox bed for women. This is the only available bed of its kind in the Comox Valley.
- ***The Comox Valley Recovery Centre*** has 20 residential treatment beds and five detox beds for adult males only.
- ***Six primary emergency food support programs*** exist, including: Comox Valley Food Bank, St. George's Pantry, St. Vincent de Paul, the Salvation Army, Courtenay Foursquare Church, AIDS Vancouver Island Cold Weather Outreach.
- ***Ten units for short-stay housing*** are available to mental health clients at the Washington Inn Studio Apartments.

This Is Costly

While we might think that the financial implications of this problem seem insurmountable for the community, we must bear in mind that our current approach takes a huge annual economic toll. Band-aid approaches to homelessness end up costing a great deal more than investing in more long-term solutions.

To cite an example of the cost: A University of California study involved following 15 chronically homeless San Diego residents for 18 months. While those conducting the study initially thought that the annual tab for the 15 might work out to around $20,000 each, they were astonished to find that the expenditure worked out to 10 times that amount for each individual.

Let's look closer to home. With the proper supports in place, the Comox Valley could experience a savings of 32 per cent of what it is currently spending on health care for the homeless. It could save a further 66 per cent of its expenditure on incarceration in correctional institutions for those who run afoul of the law, either for drug infractions, public drunkenness, and other relatively minor transgressions.

Projected Annual Costs of the Homeless Public Service Use

Public Service Sector	Pre-Intervention	Post-Intervention	Cost Avoidance	Percent Change
Health Care	$13,290,250	$9,071,250	-$4,219,00	-32%
Correctional Institution	$418,000	$141,000	-$277,000	-66%
Total	$13,708,250	$9,212,250	-$4,496,000	-33%

However if concerted steps are put into place, then the savings to the community for the current population of 250 chronically homeless works out to roughly $4.5 million dollars per year.

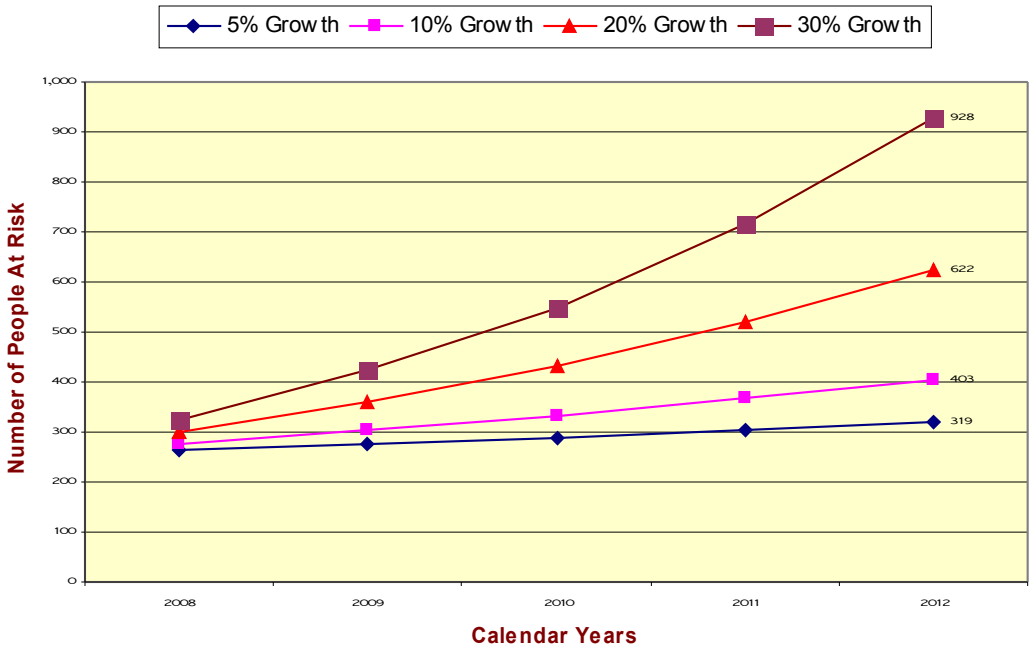
How Bad Can It Get?

It would be both unfair and untrue to suggest that nothing is being done to address the needs of the homeless and "at risk" in the Comox Valley, for as we have seen, vast numbers of professionals and volunteers have expended and continue to expend vast energies in dealing with the problem. Likewise, huge amounts of money go towards dealing with the plight of the homeless.

However, the primary issue remains that there is no suitable accommodation for the men, women, and even children who are relegated to life on the streets.

The following two graphs look at different scenarios. The first shows what will happen if we do not change the current process and develop acceptable levels of housing, and the second, shows what will happen if change is brought about. The second scenario is the one the Mayor's Task Force is seeking.

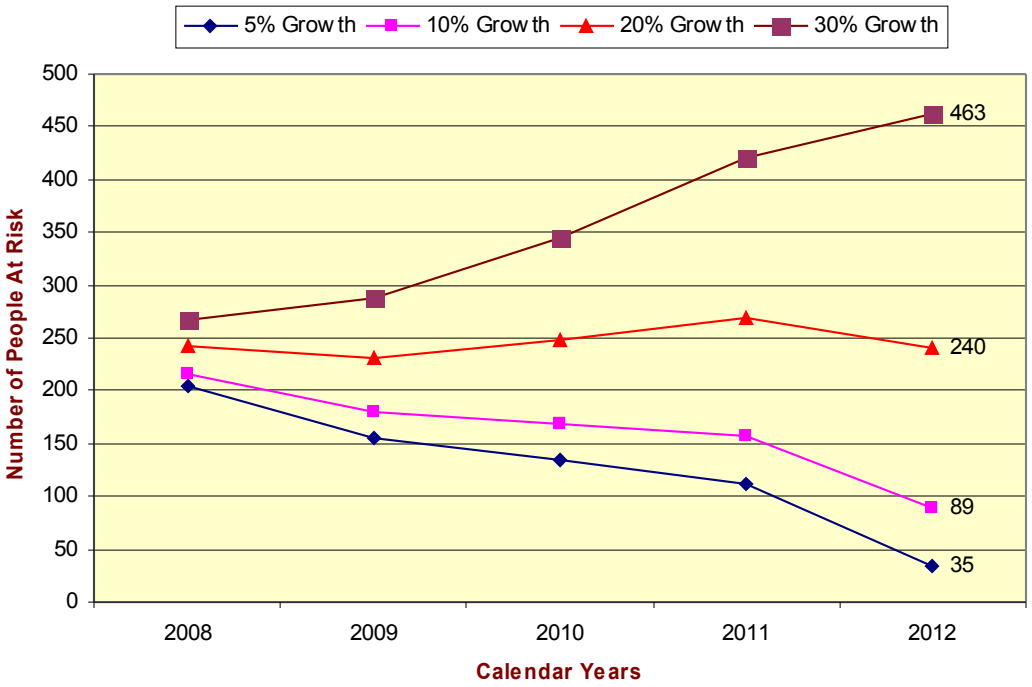
Size Of The Population At Risk of Homelessness
Under Four Different Growth Scenarios
Status Quo



As you see in the first graph, with no intervention, and a 30 per cent population growth rate in the community, we can expect 928 people living homeless on our streets. That is nearly a thousand displaced persons. Even at a 20 per cent increase rate, there will be 622. And at 5 per cent growth, it will be 319. Considering current population trends, 5 per cent is unlikely.

But, if housing recommendations are implemented, the number by 2012 will be 463. This is still unacceptable, but vastly preferable to the dire outcomes that may unfold if we continue in our current manner.

Size Of The Population At Risk of Homelessness
Under Four Different Growth Scenarios
Recommendations Implemented



By adopting the *Housing First* plan of the Task Force, change can be effected that will address not only the actual problems of homelessness per se, but all the concurrent issues.

Taking The Count

It is no small task to arrive at exact numbers for the chronically homeless in the community. The members of the Gap Analysis Committee and volunteers from assorted groups and agencies that carried out the survey (70-80 people) readily assert that there are understandable “glitches” in the survey process.

It has been noted that there are natural limitations, including refusals by those approached to take part. Some had already been surveyed in the past, some wished to retain their privacy (despite the fact that anonymity was assured.) At the same time, it is believed that the sample attained is highly representative of the whole, especially in terms of wants and needs.

At the same time, the survey results also offered some questions for which there are no ready answers. For example, the Aboriginal population of the Comox Valley sits at less than half of one per cent, yet the Aboriginal representation in the homeless survey sits at up to 25 per cent. The question remains, therefore, why is there a higher degree of Aboriginal homeless than is reflected in their actual numbers as local residents. The assumption is, therefore, that many surveyed have to be from elsewhere on Vancouver Island, or elsewhere in the province.

A bigger question, perhaps, is why the male/female ratio in the Comox Valley is at complete odds with the surveys in other cities that have been completed?

Again, there are no ready answers to why the females constitute 51 per cent of the overall homeless. However, it was suggested that women are more likely than men to take part in such a survey. Furthermore, it may be that the wants and needs of the two sexes are different. Women, some with children, need safe shelter. Men who are often single and childless (though not always) seek access to food. Otherwise, many men are prepared to ‘sleep rough’ in temporary encampments or elsewhere, as long as they are able to access meals. Finally, some of the disparity between the Valley’s female homeless numbers and Victoria’s includes the fact that a number of women in Victoria who would otherwise be homeless are involved in the sex trade.

There are some representations missing from the survey, including the sick, and those people with a problematic rental history.

2008 Homeless Needs Survey	Total Surveyed	132	100%	At 250
Members of the Mayor's Task Force and other volunteers carried out the accompanying survey of the Comox Valley's homeless in January 2008. While it doesn't include all of the homeless, it does include those who agreed to participate. Others declined for a host of reasons, some of them well founded, others just a matter of disinclination. However, the figures are also projected through to the 250 deemed absolutely homeless in the Comox Valley It is immediately apparent, the wants and needs vary significantly, but high numbers in certain categories indicate the prevalent needs, such as housing (the highest category, at nearly 70 per cent, as well as work (47 per cent), telephone or mailbox, 41 per cent, and so forth. The survey also shows that while 34 per cent were completely homeless, 54 per cent were unstably housed. **Average monthly income of 86 respondents was $904 – An annual income of $10,848.**	***Total Included in Analysis***	***116***	***88%***	***220***
	Total Homeless	103	89%	222
	Total Absolutely Homeless	40	34%	86
	Total Unstably Housed	63	54%	136
	Total of Aboriginal Descent	23	20%	50
	Total Females	***62***	***53%***	***134***
	Average Age for Females	39.5		
	Females With Children	22	35%	89
	Total Males	***54***	***47%***	***116***
	Average Age for Males	41.3		
	Males With Children	8	15%	37
	Total Children With a Person Included in the Analysis	***46***		
	Total Children with a Homeless Person	7		
	Total Children at Risk of Being Homeless	39		
	People Wanting Help to Find and Keep Housing	***80***	***69%***	***172***
	People Wanting Affordable Housing	74	64%	159
	People Need a Damage Deposit	42	36%	91
	Outreach Worker/Advocate	45	39%	97
	Need a damage deposit	42	36%	91
	Internet Access	31	27%	67
	Need a Job	33	28%	71
	Low cost Cheque Cashing /bank account	37	32%	80
	Mental Health Supports	37	32%	80
	Child Care	12	10%	26
	Internet Access	31	27%	67
	Personal Housing Reference	38	33%	82
	Phone/Mailbox	40	34%	86
	Shower/Laundry	41	35%	88
	Transportation to See Housing	39	34%	84
	Need Help Finding Work, Supports (Top 12)	***54***	***47%***	***116***
	Clothing	35	30%	75
	Training	34	29%	73
	Transportation	34	29%	73
	A resume	30	26%	65
	To know what jobs are available	29	25%	63
	Help getting motivated	27	23%	58
	Need a Driver's License	26	22%	56
	Education	26	22%	56
	Help getting ID	24	21%	
	Dental Care	23	20%	50
	Need a Permanent Address	23	20%	50
	A phone/voicemail	22	19%	47

The Survey

The volunteers with the Needs Survey Team approached potential survey participants by identifying themselves and asked the individuals about their current housing status and whether they considered themselves to be either in an unstable housing situation, or homeless.

In the questionnaire, *Unstable housing* is defined as being housing that is:

- Not affordable: More than 50 per cent of income is spent on rent.
- An eviction notice has been issued and there is no other available housing option.
- Overcrowding: More people living in the home than available rooms.
- Housing conditions do not meet basic health and safety standards.
- Living in a violent/abusive situation in the home.
- Not able to stay in, or return to the home whenever the occupant chooses to.

Participants were then asked to think back to the previous Monday and to indicate if they were in a shelter, hospital or other public facility. Other questions inquired about whether the person had children staying with them, was of aboriginal descent, and where they stayed at night: with friends (couch surfing), family, own house or apartment, campground, or other.

> *"BC is home to a new tribe of mentally ill people. They're nothing like the people who live in the Riverview psychiatric hospital for all those years. They are a new generation who are fractured by powerful combinations of mental illness, drug use, homelessness and severe physical breakdown. . BC appears to be at the high end. Homelessness, which experts say acts like a corrosive agent on vulnerable brains, and widespread use of psychosis-inducing drugs like crack and crystal meth are propelling increasing numbers of the province's most fragile people into clinical psychiatric territory."*
>
> ***Frances Bula and Lori Culbert,***
> ***Vancouver Sun, Feb. 15/08***

Those polled were asked to indicate which Comox Valley services they used at least once a month and to suggest how many times per month they used them. Services included: Food Bank, shelter, community meal, community centre, advocate, job search centre, library and/or hospital.

Respondents were then asked if they needed help: to find and keep safe, affordable housing; to get social assistance; to find a job; and then to specify what sort of help they would need in those regards.

Finally, they were asked to elaborate on their personal story should they choose to do so. For many of the queries, respondents were given the option to not respond to a specific question. See Appendix F for Needs Assessment Survey.

Moving Into Action

This general survey of the Comox Valley's homelessness is of value in that it indicates the particular needs of this community. They must be acted upon or they are of little value other than as a demographic profile.

In this case, the Mayor's Task Force has been charged with taking action and making a sincere attempt to address the issues and invoke change. As has been stated before in this report, inaction is costly.

The Cost of Inaction:

- It costs taxpayers more than $50,000 per year to support each homeless resident in British Columbia.
- With a homeless population growth factor estimated at 30 per cent, compounded for each year of inadequate housing stock and supports, the Comox Valley's homeless population could double by 2010 and more than triple by 2012.
- Without proper access to health services, homeless residents rely on emergency and acute care health services. A large proportion of people admitted to hospital by Vancouver Island Health Authority have a mental health or substance abuse related problem.
- A study conducted by the Province of BC in 2001 showed that the cost of service under the status quo was 33 per cent higher than the cost of housing and supporting individuals.

Size of the Valley Homeless Population Under Four Growth Scenarios: Status Quo

Year	5%	10%	20%	30%
2007	250	250	250	250
2008	250	275	300	325
2009	275	300	375	425
2010	295	340	425	550
2011	300	375	510	710
2012	319	403	622	928

Where Do We Go From Here?

Following the models that have been adopted by such places as Portland, Oregon, and that are under serious consideration by Victoria, and as advised by the Expert Panel and Steering Committee of our own study, the Comox Valley must develop a client-centered housing option.

Ongoing Problems

It is reasonable to suggest that if mental illness and serious substance abuse problems are so prevalent, more effective treatment must be available. If we can provide a continuum of housing for SAMI (Substance Abusing/Mentally Ill) individuals, we will then be able to assess the needs in respect to their afflictions, and treat them accordingly. If they are out on the streets, then they become lost to those charged with helping them.

It is uncertain whether SAMI individuals are prepared to quickly adjust to a form of independent living, as may be suggested by the Housing First model. The Housing Continuum approach looks to providing vitally needed services first, with a progressive move towards housing.

Many studies reflect this difference of opinion in approach, including the following one from Simon Fraser University:

"Our review of housing and support models for people with SAMI was informed by the notion of a 'housing continuum', ranging from street-outreach services, to shelters, to short-term or transitional housing, to low barrier housing, to longer-term permanent housing.

"Although we focus on low-barrier and permanent housing, the housing continuum is a useful conceptual framework; it highlights the issue of 'continuity of care' across different phases of the continuum as well as the complexity of providing housing and supports to the diverse spectrum of persons with SAMI.

"The traditional continuum model suggests that individuals progress in a step-wise fashion from emergency and transitional programs with more intensive support and monitoring to more permanent, independent living situations.

"As an alternative to the continuum model, many housing advocates and researchers have argued for a housing first model, that by-passes transitional housing. Proponents of this model argue that independent housing should be offered immediately in order to prevent homeless people from becoming caught in the shelter system and the cycle of chronic homelessness. There is considerable debate as to the effectiveness of the continuum versus housing first model of supported housing."[3]

[3] PhD Michelle Patterson and PhD Julian Somers, *Housing and Supports for Adults with Severe Addictions and/or Mental Illness in BC* (Burnaby, BC: Simon Fraser University Faculty of Health Sciences,[2007]), http://www.healthservices.gov.bc.ca/library/publications/year/2007/Housing_Support_for_MHA_Adults.pdf (accessed February 2008).

The Housing First model, accepted by the three components of the Mayor's Task Force, looks towards a blending of the two depending on the needs of the individual. By accepting a 'harm reduction' approach, sobriety does not necessarily become a barrier to housing- affected individuals.

The United Nations refers to homelessness in terms of absolute and relative. People who are absolutely homeless are living outdoors – on the street, in parks, under bridges – and are literally without shelter. The term absolute homeless also refers to people who rely on emergency shelters and hostels for temporary accommodation.

People who are relatively homeless are considered at risk of homelessness because they are paying too much of their income for rent and/or living in unsafe, inadequate or insecure housing. Often, people in these households are one step away from homelessness. People renting hotel or motel rooms by the month, living in rooming houses or 'couch surfing' (temporarily staying with friends and family) are usually considered at risk of homelessness.

Local responses to homelessness: a planning guide for B.C. communities
Co-published by Ministry of Municipal Affairs

Taking Action

Vision Statement

The Comox Valley will be a safe, strong healthy community for all and will seek to create a supportive environment and build opportunities to address social, physical, economic inequities for its residents.

Best Practices/Guiding Principles

- **Client-centered delivery systems approach**: Services to people who are homeless will be delivered within the context of unconditional positive regard throughout the continuum of service delivery. A collaborative systems approach will be used to reach the most effective strategies, while securing adequate resources.

- **Culturally sensitive and appropriate program service delivery**: Services for populations such as immigrant and aboriginal people living with mental health and substance-use issues must be respectful and responsive to the needs of the individual.

- **Supported Housing First:** People who are homeless will be provided immediate access to housing.

- **Flexibility:** Housing will be designed to include the solution-based options likely to succeed with each individual and will have non-restrictive access requirements.

- **Low barrier programs:** Programs that do not require clients to be abstinent or in treatment for mental illness have been shown to be more likely to attract clients, to motivate them to begin making changes, to retain them in treatment and to minimize attrition and drop-out rates. Stringent criteria have proved to be threatening and inclined to keep addicted or mentally ill potential clients from seeking needed treatment.

- **Proactive Engagement, Treatment and Relapse Prevention:** Emphasis will be placed on outreach, frequent contact with clients, relationship building and individualized services. Community-based, multidisciplinary Integrated Service Teams and Forensic Assertive Community Treatment (FACT) and Assertive Community Treatment (ACT) Teams will provide 24-hour support, treatment, and rehabilitation services to clients where they live and work, rather than in an agency setting.

- **Prevention:** Prevention strategies will help to ensure that people—particularly youth and emerging adults — do not become homeless. Targeted efforts to secure and maintain housing for families, strategies to keep children in school, and poverty alleviation measures will serve to decrease the potential for homelessness.

- **Building Community:** The recognition that many currently homeless people may make important contributions to our community if they can find a place in society once again must be recognized. Specific attention to increasing access to multiple services and supports throughout the continuum of care must be supported.

- **Assertive Community Treatment (ACT):** This recommends establishing community-based multidisciplinary teams to provide 24-hour support, treatment and rehabilitation services to clients where they live and work. A need that has been identified by virtually all the studies arising from the Mayor's Task Force is to regularly monitor the vulnerable homeless.

This is especially applicable to individuals who have been jailed, hospitalized or accepted into recovery programs. Once they leave the doors of the aforementioned, they are on their own. If they are in substance recovery, it is recommended that they access programs as AA or NA, but there is no follow-up support.

The team, consisting of individuals with professional backgrounds in social work, substance abuse, treatment counseling, vocational rehabilitation, nursing, psychiatry and those from the faith community who also interact with the homeless in the Comox Valley would be responsible to assist clients in seeking a full-range of medical, psychosocial and rehabilitative services including:

- Assistance in finding and keeping a home.
- Supportive counseling and psychotherapy.
- Substance abuse services.
- Psychiatry and pharmacological treatment.
- Interpersonal life skills development.
- Assistance in accessing entitlements.
- Vocational support.
- Mental illness education for clients and families.
- Peer support services.
- Crisis response.

An evaluation of ACT services in Ontario found a 62 per cent reduction in hospital admissions after one year of services and an 83 per cent reduction after six years. Other studies have shown that ACT is effective in helping homeless clients with severe mental illness and substance use problems achieve stable housing, reduce substance use, improve symptoms and increase ties to their community.

Centre for Applied Research on Mental Health and Addictions, Simon Fraser University

All three committees of the Mayor's Task Force on Homelessness share a common vision as described by the Steering Committee, and it is in this overall view that we must look at the specific steps needed to bring about change.

The Steering Committee of the Mayor's Task Force on Homelessness endorses the Expert Panel's recommended service delivery model, the Gap Analysis targets and strategies, and recommends a comprehensive approach to end chronic homelessness, including:

1) Ending homelessness through permanent supportive housing;
2) Proactively engaging, serving and treating our homeless population;
3) Developing prevention measures;
4) Implementing an integrated, comprehensive system of client-centered housing, services and Treatment.

The Process

In a time frame of slightly more than two months, the members of the three committees of the Mayor's Task Force have produced a workable document.

The result is a blueprint that will guide the process and direct actions that will benefit not only the chronically homeless of our community, but also for those "at risk" of homelessness, and the working poor.

All three committees of the Mayor's Task Force on Homelessness are on the same page. This solidarity is exhibited in the Vision Statement prepared by the Steering Committee, and it is in this overall view and with specific objectives that steps will be taken to bring about change.

Implementation Plan

In keeping with the philosophy established by the Vision Statement criteria, four significant stages towards a solution for were established by the Steering Committee. They compiled the data and recommendations of the Expert Panel, and then presented them for approval to the Gap Analysis Team.

I. End Homelessness Through Permanent Supportive Housing

The desired outcome in this strategy is as follows:

- Reduction of the number of homeless people
- Expansion of existing housing stock
- Access for most vulnerable clients
- Coordinated access to housing for vulnerable clients through a housing 'registry' and coordinated services plan
- Formation of a professional Housing Development Team/Committee (HDT)
- Aboriginal housing support defined
- Long-term strategy to include integrated low-income housing in all Comox Valley developments
- Improved quality of life of all citizens. Improved sense of public safety.

The goals of this component are divided into a number of time-sensitive categories, including Early, Six-month, Year one, Year two, Years three and four, and finally Year five.

Early:

- Within 60 days a Housing Development Team (HDT) is formed and tasked with the mandate of identifying solutions for establishing an increase in available housing stock availability through existing untapped stock and added stock.

Six Month:

- 15 people are housed (pilot project) in expanded existing stock.
- A project plan to implement an integrated registry is finalized within 180 days.
- Initial partnership discussions with Comox, Courtenay, Cumberland and the new Comox Valley Regional District are enacted.

Year One:

- An additional 33 people are housed for a first year total of 48.
- Housing Registry "integration project" is operational, including emphasis on 'most vulnerable' people.

- Well-defined partnership with Comox Valley Aboriginal Housing Support Strategy is developed.
- CVRD embraces role in 'active plan' to direct the HDT in this mandate.

Year Two:
- An additional 161 people are housed for a total of 209 people in years one and two.
- Implementation of Housing Project plans in partnership with BC Housing to add 'new' stock to the registry pool of the Comox Valley.

Years Three and Four:
- An additional 358 are housed for a total of 567 in years one to four.

Year Five:
- An additional 185 are housed for a total of 752 in years one to five.
- A solid and sustainable long-term plan is operational and meeting new demands.

Initial actions to be undertaken to set Stage One into motion will include:
- Establish a Housing Development Team (HDT) to guide and oversee development of additional housing stock/units.
- Move chronically homeless residents into housing.
- Promote rental stability.
- Promote regulatory changes to increase housing stock.

II. Proactively Connecting, Engaging, Serving and Treating the Homeless

The desired outcome of this strategy step is to establish low barrier housing units for the Valley; to establish a Supported Independent Living Program (SILP) to engage more clients in permanent supportive housing; to have a gender-specific Transitional Housing Facility operational, providing a higher degree of support services to clients seeking permanent housing.

Programs:

- Well-integrated detox programs in community to provide significant reductions in problems related to client substance withdrawal.
- Frozen meal program initiate and providing nutritional meals to all vulnerable clients as a part of the 'delivery services' from VIHA/MHA.
- Occupational Food Preparation training is readily available for clients enabling them to seek new employment opportunities.
- All clients are able to engage in higher-level, self-directed management of their living conditions through life skills training.
- Vulnerable clients are well supported and monitored though their recovery period in a facility that alleviates stress and burden to families and community.

Again, this strategy follows a relatively strict time frame in order for it to establish the dynamic needed. The time-sensitive goals are as follows:

Early:

- Input of *VIHA 2008 Report* to Mayor's Task Force for integration with all stakeholders.
- Initiate Assertive Community Treatment (ACT) teams formation and mandate following the establishment of a commission to oversee this endeavour.

Six Month:

- Functional ACT teams working with Housing Development Team (HDT) to move people into permanent housing.

Year One:

- Establishment of Low-Barrier Housing Program in conjunction with HDT.
- Development and implementation of the Supportive Independent Living Program (SILP).
- Integrated service delivery model to the overall. *End Homelessness in the Comox Valley* project.

Year Two:

- Transitional Housing Facility or Facilities to be established in the community for gender specific support to vulnerable clients.
- Development and implementation of the Frozen Meal Program.
- Integrate programs into establishment of One-Stop Access Health Centre for vulnerable clients.

Year Three:

- Implementation of the Cleaning and Lifeskills Programs.
- Establish a long-term medical detoxification facility in the Comox Valley.

Years Four to Ten:

- Sustained development of all programs to reflect the changing nature of the client and community needs.

The vital action steps to be undertaken early in this strategy include:

1) Implementation of Assertive Community Treatment Teams to assist the transition of vulnerable clients into housing.
2) Establishing a Supported Living Program with effective rental subsidies to provide support for individuals trying to access long-term quality housing.
3) Establishing a six-bed Transitional Housing Facility for gender specific support to vulnerable clients needing medical and emotional supports.

4) Establishment of home, social and day detoxification programs.
5) Establishment of a frozen meal program and cleaning/lifeskills program.
6) Build and establish a medical detoxification facility in the community.
7) Provide well-developed support services to the combined efforts of the Task Force on Homelessness in the Comox Valley.

III. Stop Homelessness Before it Begins

The sought-after outcome of this stage in the process is to reduce the number of individuals or families who are at risk for homelessness; to streamline access to services; to incorporate early intervention strategies; to establish an emergency prevention program.

Six Months:

- Prevention team established and functioning.

Year One:

- Early intervention strategy developed and operational.
- Emergency Prevention Fund program implemented.

Years Two-Four:

- Increased access to income to maintain stable housing.
- Enhanced access to employment.
- One-stop access to services.
- Zero persons discharged into homelessness from hospitals, recovery/treatment centres, corrections facilities, emergency shelters or foster care.

Year Five:

- Increased housing opportunities and access to support services for homeless and/or at-risk youth.

The action plan includes the following:

1) Establishment of a Prevention Team to guide and oversee development and implementation of measurable prevention strategies.
2) Establishment of an Emergency Prevention Fund that responds to crisis situations that could lead to homelessness.
3) Develop and implement Early Intervention Strategies that include landlord support, tenant training and support and tenancy relationship intervention and mediation.
4) Create opportunities for most vulnerable to increase income in order to gain permanent housing.
5) Provide practical supports required to secure employment or employment assistance.

6) Implement a One-Stop access to housing and support services for people either experiencing homelessness or at risk.
7) Work collaboratively with government and non-profit agencies to develop strategies to house all people who are being discharged from facilities or who are 'aging' out of the system.
8) Partner with the Housing Development Team to develop youth emergency shelter beds, transitional housing and foster care discharge housing.

IV. Implementing an Integrated, Comprehensive System of Client-Centred Housing, Services and Treatment

The desired outcomes in this fourth and final step are manifold and comprehensive. They include the following:

- Securing funding to implement the recommended model from the Expert Panel.
- Provide assistance to people who are absolutely or chronically homeless as demanded by their level of need. This includes providing increased opportunity for productivity and social inclusion by this group.
- The people directly impacted by homelessness will be actively involved in decision-making via a dedicated, client-centered approach to the issue.
- An increased awareness of homelessness and housing insecurity by citizens and elected civic leaders in the Comox Valley.
- Councils will endorse ending and preventing homelessness by (1) establishing and financially supporting a regional committee to oversee a comprehensive strategy, and (2) embedding the 'elimination of homelessness' within a CVRD staff job description.
- All Official Community Plans (OCPs) within the Comox Valley will include 'eliminating homelessness' in their policies, bylaws and processes.
- Inclusive zoning and land use planning and practices will include provision of future building(s) and the necessary units required to ensure everyone is housed.
- Cost savings are realized by reduced system expenditures otherwise incurred as a result of absolute or chronic homelessness (for example, housing and the continuum of services and treatment, including health care, judicial, policing and social costs.)
- Strategic direction will be aimed toward the prevention of homelessness with the absolute emphasis to seeking solutions after homelessness.

As with the other steps in the process, the effectiveness of this aspect can only be assured if a time-schedule is adhered to.

Early Goals:

- Within 60 days, establish an interim Community Commission to End Homelessness.

- Adopt the recommendations of the Expert Panel Integrated Service Teams.
- Establish a centralized coordination mechanism to implement the action plan.
- Within 20 days from the establishment of the Commission the action teams are organized.
- Within 30 days Community Information Sessions will be held on the Mayor's Task Force recommendations.
- Within 80 days a Communications Plan is developed and operational.
- Within 120 days a process is established to design and implement an operational model to meet the goals of integrated service delivery in support of community priorities for health and housing.
- Also within 120 days an asset review (financial and human resources) of community will be undertaken.

Six Months:

- Review Interim Community Commission, identify gaps and mediate those gaps.
- Review operations of Action Teams and implement change where needed.
- Ongoing funding providers are identified and a database is established.
- Review success of Communications Plan and identify and implement change where needed.
- Review success of Community Information Sessions and implement changes where needed.

Year One:

- Fully constituted Commission to End Homelessness to lead efforts and deliver on the Action Plan is established and in operation.
- Review of operations of the Commission is ongoing.
- Ongoing funding is established.
- Review success of the Communications Plan and implement changes where needed.
- Operational structure is defined and implemented.
- Review successes of operational model and implement changes where needed.
- Review asset structure and make alterations and additions.

Year Two and forward:

- Work of the Commission is ongoing.
- Review status of funding providers.
- Review successes of Communications Plan and identify and implement changes where needed.
- Community Information Sessions are ongoing.
- Integrated Service Delivery model is reviewed on an ongoing basis.

- Ongoing scrutiny of Asset Review structure and changes implemented where needed.

Action:

1) Develop Project Charter including a comprehensive Financial Strategies facet.
2) Effective administration, coordination and implementation.
3) Public engagement.

Accountability:

1) Civic, regional, provincial levels of government, including foundations, private donors, corporations and service providers.
2) Municipal and regional elected officials, leaders of business organizations, representatives of the faith community, and nominated representatives from the non-profit sector.
3) Majors Task Force members and community champions.
4) Citizens of the communities as well as people who have experienced homelessness.

The Health of the Community of the Homeless

A vital component of any homelessness strategy for the community is the physical and mental health of those afflicted by homelessness. That is why the establishment of an improved system of health delivery must be implemented if any headway is to be made. In this, the Expert Panel created a plan for a One-Stop Health Access Centre that would serve all of the needs of the homeless person and help to address some serious deficits that currently exist.

One-Stop Health Access Centre in the Comox Valley

Issue

Many mental health and addiction clients are lost in the process of navigating the health and mental health care systems. Clients living with complex chronic health challenges, compounded by homelessness and poverty, are also challenged to find appropriate services. A 'One-Stop Health Access Centre' would serve to reduce the significant barriers that prevent marginalized members of society timely access to services.

Background

The Comox Valley is experiencing a shortage of family physicians. This shortage is compounded by the challenges of serving clients who are street 'involved' and have complex health issues including addiction, past or current.

These clients become medically 'orphaned' and access to primary health care is limited.

Currently walk-in medical clinics provide limited care, as they typically do not address complex co-morbid health issues. The psychosocial, nutritional, and housing needs cannot be addressed in these clinics. Shared interdisciplinary care is also not an option. Many of the physicians working at the walk-in clinics do not have hospital admitting privileges, thereby limiting the services they can offer to medically orphaned patients. Referrals to specialists are not an option, as clients need a family doctor.

The AHERO organization represents a number of community agencies that offer services to those who are marginalized or street involved. Members of agencies such as Wachiay Friendship Centre, Ministry of Employment and Income Assistance (MEIA), AIDS Vancouver Island (AVI), Transition Society, Red Cross, Salvation Army, Affordable Housing Society, St George's United Church, Mental Health and Addiction Services (MHAS), Food Bank, Dawn to Dawn: Action on Homelessness Society meet monthly to identify gaps, but there is limited opportunity for these services to be provided from the same location to make for easy no-barriers access for clients.

Victoria's Cool Aid Society provides an excellent role model for a One-Stop Health Access Centre. Cool Aid is partially funded by VIHA and has been in existence for 40 years. Aside from the vast array of primary care that is provided, it is this Centre's Homeless counts that led to Victoria's Mayor's Task Force on Breaking the Cycle of Mental Illness, Addictions and Homelessness.

Proposed Service

There is an urgent need to provide primary health care for people who do not have medical coverage, or who live in the downtown core, many of whom suffer from mental health and addiction illnesses and/or other chronic health problems.

A One-Stop Health Access Centre would endeavour to create an environment of trust and mutual respect between the staff and the clients it serves, an important building block to quality health care for this population. Through a collaborative team-based approach, services at the Centre would be designed to reduce the significant barriers to health services facing those who are street involved and/or homeless.

Integral to the Centre is a location in the downtown core and the open access of a welcoming environment and walk-in services with expanded hours of operation. One of the primary points of referral for a proposed Assertive Community Team (ACT) would be the One-Stop Health Access Centre. The

result would be service delivery where people are located whether on the streets, in other social agencies, in drop-in centres, or shelters.

This contact outside the Centre would foster the necessary trust for clients to then more fully utilize the Centre and the services offered, thereby reducing the use of Emergency services for non-urgent issues.

A highlight of the unique service delivery at the Centre would be shared care, with multiple points of entry and referral into accessing comprehensive primary health care. Services provided would be those of nurses, physician, mental health and addiction counsellors, pharmacist, psychiatrist, dentist, and nutritionist under one single roof. In addition, the Centre would offer education and partnerships with Universities to health care practitioners interested in inner-city health care.

Outcomes

- Improved access to a comprehensive array of services through multiple entry points and enhanced links with primary care physicians. This supports VIHA's position that there is "no wrong door" for accessing services and supports a seamless continuous system of care.
- Enhanced access of treatment for addictions and mental health disorders by reducing the stigma often experienced by going through the mainstream health care system.
- Reduced need for Emergency Room visits and in-patient hospitalizations.
- Improved access to harm reduction strategies by clients in the community.
- Improved community service integration services between agencies such as Mental Health and Addiction Services, Nursing Centre, Adult Day therapy program, Wachiay Native Friendship Centre, Transition Society, AIDS Vancouver Island, RCMP, St. Joseph's Hospital (Emergency Crisis Intervention), Comox Valley Recovery Centre, North Island Liver Service, and Public Health Nursing.

Accountability

For the foregoing process, which is the end result of a huge effort by all who took part, to be effective and more than just window-dressing it is essential that many diverse elements should be working towards the same end, which is to ensure the implementation of housing plans and initiatives developed by the Mayor's Task Force.

Various stakeholders will have significant roles to play with a plan that is intended to be informative and a working document. In this regard the overall accountability goes to Mayor Starr Winchester, or to the Task Force, if so designated, with long-term responsibility and oversight being assumed, ideally, by the Comox Valley Regional District.

Furthermore, it is hoped that there will be a joint accountability between all involved agencies and groups to share information, plans and resources for the eradication of the Comox Valley's problem of homelessness. Cooperation is the key in the creation of programs and the acquisition of needed resources, with a joint approach to lobbying for funding and other necessary resources.

The Stakeholders

- *BC Housing*: To provide resource leadership through funding, Registry Integration, and "effective model" plans for new housing stock developments and provide for ancillary support services to the rest of its accountability partners to ensure effective "new stock" and existing stock utilization for homeless clients.

- *Local Municipalities*: To promote the formation of the HDT. Provide political leadership and Bylaw Amendments necessary to enable goals to be met in an expeditious manner. Identify properties and facilities that aid the achievement of the goals noted. Budget some funds for staff and resources needed to respond to the goals noted for "best use" of lands and developments.

- *Comox Valley Regional District:* Oversight and coordination of the HDT as it walks out the mandate to nurture housing development and availability. Coordination of Municipal Responses with Provincial Support Services for effective use of funds and resources in the Region.

- *Vancouver Island Health Authority (VIHA):* Provide guidance to the HDT as it responds with housing to ensure all health needs of the homeless clients are taken into account.

- *Non-Profit Housing/Services Providers:* Active participation in the planning and implementation processes to meet housing development and management goals. Use of the Housing Registry, interactive with social services providers to ensure "best practices" for tenant/landlord relations.

- *Faith Based Organizations:* Integration of individual vision, programs and resources into the goals and action plans of the Task Force and its subsequent delivery models to eliminate homelessness in the Comox Valley Region.

- *Financial Institutions:* Provide new opportunities to assist developers and service providers finance plan and programs that extend beyond funding available from government sources.

- *Developers/For-Profit Housing Providers:* Active participation in the planning processes and in providing new stock within all developments or a fund towards the development of new stock in lieu thereof.

- *Federal and Provincial Government Representation:* Communicate the process in motion in the CVRD to appropriate government service bodies to ensure "open doors" for resources such as funding and staff training. Actively support all phases of the critical path for success.

- *Comox Valley Citizens:* Be engaged in the solution, through education, volunteer support and sensitivity to the opportunity to effectively changes people's lives for the better of the whole community by nurturing real hope. Lobby governments for needed programs and funds. If the public plays an active role, then the chances for success are much greater.

What Is The Cost?

Mayor's Task Force on Homelessness 5 Year Capital Plan for Housing				
	Type of	**Number**	**Cost**	**Total**
	Units	**Of Units**	**Per unit**	**Cost**
Year 1 Goal:				
•Build/acquire supported housing	Housing First	35	$70,000	$2,450,000
•Build/acquire supported housing	Residential	10	$70,000	$700,000
•Build/acquire supported housing	Family Care	3	N/A	$0
		48		**$3,150,000**
Year 2 Goal:				
•Build/acquire supported housing	Low Barrier	38	$70,000	$2,660,000
•Establish new emergency shelter	Shelter	5	$70,000	$350,000
•Transitional crisis housing	"	8	$70,000	$560,000
•Build/acquire supported housing	Group Home	35	$70,000	$2,450,000
•Build/acquire 75 units	Affordable	75	$70,000	$5,250,000
		161		**$11,270.000**
Year 3 Goal:				
•BC Housing health services prog	"	13	$70,000	$910,000
•Build/acquire supported housing	Congregate	35	$70,000	$2,450,000
•Build/acquire another 125 units	Affordable	125	$70,000	$8,750,000
		173		**$12,110,000**
Year 4 Goal:				
•Build/acquire supported housing	Satellite/supported	35	$70,000	$2,450,000
•Build/acquire another 150 units	Affordable	125	$70,000	$10,500,000
		173		**$12,950,000**
Year 5 Goal:				
•Build/acquire supported housing	Block Apartments	35	$70,000	$2,450,000
•Build/acquire another 150 units	Affordable	150	$70,000	$10,500,000
		185		**$12,950,000**
	5 Year Plan Total	**752**		**$52,430,000**
	Average Per Year			$10,486,000
For the shelter in Year 2 costs, the sum cited only covers the incremental cost of new beds, not the shelter itself				

At first glance, nearly $52.5 million seems like a hefty sum. And it is, by any standard. But, it must be appreciated that this is spread out over five years, and

as earlier figures have indicated, it ends up costing considerably less than the status quo costs of caring for the homeless.

As mentioned earlier, the annual savings of getting people off the streets in terms of health care input was about $4.4 million per year for the targeted population of 250. This plan includes an additional 502 units to address the needs of the other 3,100 who are considered to be at risk of homelessness.

Where Are the Dwellings?

The inventory of available and suitable housing in the Comox Valley is sparse and one of the first steps will be to acquire existing structures and turn them into supported housing, so that the first step can be undertaken quickly.

As of this writing, the only privately owned low-income housing for singles in the community is the Washington Inn. Despite the fact it was recently sold, the new owner has assured the building will not be redeveloped and turned into condos.

At pre-sale the Washington's two apartment buildings (one with 300-square-foot units renting for $425 per month, and the other with 415-square-foot units at $525 per month) could be handled by low-income and income assistance tenants. However, there are no guarantees that the new owners will maintain that rental rate.

Task Force chair, Tom Grant says that he is pleased that the building will not be torn down (as was rumoured) and that it will still be available as housing. However, there is no guarantee that the new owner will not raise the rents.

"If he (the new owner) goes market rent, and if the market will support $600 a month and the people who are living there can only afford $400. Well, we're going to have more homeless people, aren't we," says Grant. "So, there's a deep concern, but I guess on the other hand, I think we're happy that it's not going to be torn down and developed into condos or anything like that."

In its current legal status, the property is zoned to allow single family, duplex and multi-family residences, as well as various commercial uses.

Other than that, with no new rental accommodations having been constructed in a number of years in the community, the pickings are slim. That is why the task force hopes to have caveats in place for developers so that rental accommodations become part of the mix in future developments. Some developers have already expressed interest in erecting large rental structures offering small single-residency occupancy apartments, if they can get past zoning hurdles.

Projected Capital Costs to Implement Recommended Levels of Supported Housing Beds/Units For The Comox Valley Region

February 29, 2008

Housing/Support Model	Recommended Levels	# Of Units Needed	Per Unit Capital Cost ($)	Capital Cost ($)To Implement Recommented Levels	25% Of Per Unit Capital Cost ($)To Implement Recommented Levels
Residential Care	**5%**	**13**			
Licensed Care Facilities	4%	10	$70,000	$700,000	$175,000
Family Care Facilities	1%	3	N/A		N/A
Low Barrier Housing	**15%**	**38**			
High-Level Support	5%	13	$70,000	$875,000	$218,750
Low-Level Support	10%	25	$70,000	$1,750,000	$437,500
Permanent Supported Housing	**70%**	**175**			
Group Homes	14%	35	$70,000	$2,450,000	$612,500
Congregate Housing	14%	35	$70,000	$2,450,000	$612,500
Satellite/Supported Apartments	14%	35	$70,000	$2,450,000	$612,500
Block Apartments	14%	35	$70,000	$2,450,000	$612,500
Housing First	14%	35	$70,000	$2,450,000	$612,500
BC Housing Health Services Program	**5%**	**13**	**$70,000**	**$875,000**	**$218,750**
Transitional/Crisis Housing	**3%**	**8**	**$70,000**	**$525,000**	**$131,250**
Refusers (Emergency Shelters)	**2%**	**5**	**$70,000**	**$350,000**	**$87,500**
Total	**100%**	**250**	**N/A**	**$17,325,000**	**$4,331,250**

Housing/Support Model Definitions:

[1] Licensed Care Facilities – Under Community Care and Assisted Living Act, SMI unable to live independently, 24-hr care, onsite intensive supports, 6-25 residents.

[2] Family Care Homes – Privately owned, not licensed but must meet Health Authority Standards, SMI unable to live independently but require support in a family setting, Max. 2 clients per home, Onsite supports.

[3] Low-Level Support – Highly disruptive with complex health issues, Cannot access or maintain housing in the market, Min. 1 staff 24/7, add overnight if challenging.

[4] High-Level Support – Highly disruptive with complex health issues, Cannot access or maintain housing in the market, Min. 2 staff 24/7 for less than 30 units, additional staff if more than 30.

[5] Group Homes – Clients share communal home, Offsite home support, Short-term (less than 2 years).

[6] Congregate Housing – Bachelor suites, Communal food services on site, On site home support services, Long-term (over 2 years).

[7] Satellite/Supported – Self-contained subsidized private market units, Offsite home support, Long-term (over 2 years).

[8] Block Apartments – Self-contained subsidized private market 1 bedroom. Units, Onsite or offsite home support, Long-term (over 2 years).

[9] Housing First – House clients first, then connect them to supports.

Notes:

[1] Reflects a range from low (regular case management) to high-level support (e.g., Assertive Community Treatment)

[2] Transitional/crisis housing was not a focus of this report and thus have not been included in the costing analysis; however, transitional and crisis housing is a recommended portion of the overall housing and support mix (3%).

[3] The distribution for homeless this area is based upon the fact that everything is currently at capacity.

[4] 25% of capital costs will be funded up from through grant contributions.

[5] Units will become operational on average at mid-year.

[6] Enhanced services will divert services from existing programs resulting in a $25,000 in annual savings per person served.

After Word

The purpose of this report is to provide a working document for the community - all segments of the community who will work together with the goal of reducing and perhaps ultimately eliminating homelessness in the Comox Valley.

What Changes Can We Anticipate?

When the community plan is identified and implemented, we can anticipate:

- Significant savings in taxpayer supported systems stemming from reduced use of such services as emergency rooms, ambulances and EMT services.
- Savings in other service systems, including shelters, psychiatric services and corrections, the use of which will be reduced once supportive housing is in place.
- Enhanced quality of life for the homeless and unstably housed.
- Increased resources to address other homeless subpopulations such as youth, families and aboriginal people.
- Increased community solidarity as a result of working together towards common goals.

Implementing the Plan

The final step is to execute the strategies identified in the report by moving into action:

- Use of the plan to guide activities; update the plan as situations change or as other needs are identified.
- Regularly evaluate the community progress in incorporating elements of the plan.
- Continue to be innovative and stay informed about similar actions in other communities.
- Continue to encourage ongoing stakeholder and community input.
- Continue to build new partnerships with sectors of the community not previously involved.

Mayor's Task Force Committee / Panel Members

Starr Winchester: Mayor of the City of Courtenay. Director, Comox Valley Regional District. Struck Task Force on Homelessness in the Comox Valley in November, 2007.

Tom Grant: Chair of Mayor's Task Force on Homelessness, semi-retired businessman, Rotarian, Chair of Dawn to Dawn: Action on Homelessness Society

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Peter Birch: BA, BSW. Team Leader, Youth Services, Ministry of Children and Family Development. Member of Youth Services Team, Courtenay. Background in Child and Youth Care and Protection in Victoria, Toronto, Vancouver, Revelstoke and Campbell River.

Helen Boyd: R.N., M.A. (Counselling) Registered Nurse & Mental Health Therapist. Board Member of Dawn to Dawn: Action on Homelessness Society. Consultant to VIHA proposals entitled Reducing Homelessness: Proposals for Housing and Support Services in the Comox Valley.

Ted Brooks: Co-chair of Gap Analysis Panel. Businessman, member of Ad Hoc Emergency Resources Organization (AHERO). Chair of Finance and Administration committee for ElderCollege. Former director of Comox Valley United Way and the Comox Valley Airport Commission.

Rick Brown: Comox Valley resident and Director of Service Delivery for Ministry of Employment and Income Assistance, Vancouver Island/Powell River Region.

Leigh Carter: Communications/media relations for task force. General manager, corporate communications for Comox Valley Regional District. Over 20 years corporate communications professional experience, several in news media before that.

Diane Collins: Program Manager, John Howard Society with 26 years experience in the corrections/social services field in the Comox Valley.

Dr. Charmaine Enns: Co-Chair expert panel. Medical Health Officer of the North Island.

Patricia Foster: RN, MSN. Thirty years of experience in First Nations outpost and community settings. Clinical interest in chronic health issues and ethics.

Steve Garoupa: Rehabilitation and Housing Coordinator, Mental Health and Addiction Services, VIHA

Chris Goble: Clinical Educator for Adult Addictions - VIHA Mental Health Addictions Services. Masters degree in Education [Counseling]; Canadian Certified Counselor.

Ken Grant: Councilor – Town of Comox

Inspector Tom Gray: O.I.C. Comox Valley Detachment, R.C.M. Police. 35 year veteran of policing. Dedicated to the ideal of safe homes and safe communities for the Comox Valley.

Cathy Hubberstey: Supervisor of the local Ministry of Employment and Income Assistance (MEIA) office.

Betty-Anne Juba: Comox Valley resident and business owner. Chair of the Comox Valley Affordable Housing Society and President of LUSH Valley Food Action Society.

Roger Kishi: Program Director, Wachiay Friendship Centre

Heather Ney: Executive Director, Comox Valley Transition Society

Mike Pennock: Population Health Epidemiologist

Michael Pitcher: Comox Valley resident, business owner and Chairman of the Northgate Foursquare Church 'Homes for Families' Project.

Hendrik Roelants: BA, BSc. Member of the Mayor's Task Force on Homelessness and Co-chair of Gap Analysis Panel. Decision support consultant for Vancouver Island Health Authority Mental Health and Addiction Services. A founding board member of the Dawn to Dawn: Action on Homelessness Society.

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Mike Stewart: retired, former supervisor at Ministry for Children & Families. Comox Valley resident and board member of Dawn to Dawn - Action on Homelessness Society

Dr. Mark Tapper: Co-Chair expert panel**.** North Island Site Chief, Mental Health and Addiction Services, VIHA, for Comox Valley, Campbell River and Mt. Waddington.

Pam Vickram: MA, MSW, RSW. Manager - Mental Health & Addiction Services Campbell River and Comox Valley.

Shawn Wilson: Chair of Steering Committee; Community Services Director, Salvation Army, running Outreach and Shelter programs for the homeless. Current President of Crossroads Crisis Centre in Courtenay.

Phyllis Wood: RSW, Positive Wellness Counsellor/Health Promotion/Harm Reduction - AIDS Vancouver Island.

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Appendix A

Strategy						
1. End Homelessness through permanent supportive housing						
Outcomes						
	•Reduction in the number of homeless people •Expansion of existing stock •The most vulnerable clients will have access •Coordinated access to housing for vulnerable clients through a housing "registry" and coordinated services plan •Formation of a professional Housing Development Team/Committee (HDT) •Aboriginal housing support strategy defined •Long-term strategy to include integrated low-income housing in all Comox Valley developments •Improved quality of life of all citizens; Improved sense of public safety					
GOALS	***Early***	***Six-month***	***Year 1 Goals***	***Year 2 Goals***	***Years 3-4 Goals***	***Year 5-10 Goals***
	♦ Within 60 days of the formation of the **Commission to End Homelessness** a **Housing Development Team (HDT**) is formed and tasked with mandate to identify solutions for establishing more housing stock availability through existing untapped stock (S.T.) and added stock (L.T.)	♦ 15 people are housed (pilot project) in expanded existing stock ♦ A project plan to implement an integrated registry is finalized within 180 days ♦ Initial partnership discussions with Comox, Courtenay, Cumberland and the CVRD developed	♦ Additional 33 people housed for a first year total of 48 ♦ Housing Registry "integration project" is operational including emphasis on the *most vulnerable* people ♦ Well-defined partnership with CV Aboriginal Housing Support Strategy is developed ♦CVRD embraces role in "action plan" to direct the HDT in its mandate	♦ An additional 161 people are housed for a total of 209 people in 1 and 2 years ♦ Implementation of Housing Project plans in partnership with BC Housing to add "new" stock to Registry pool in CV	♦ An additional 358 are housed for a total of 567 in years 1-4	♦ A solid and sustainable long-term plan is operational and meeting new demands ♦ New stock is housing 752 plus clients

Action	
	1.Establish a Housing Development Team to guide and oversee development of additional housing stock / units 2.Move chronically homeless residents into housing 3.Promote rental stability 4.Promote regulatory changes to increase housing stock

Strategy						
2. Proactively Connecting, Engaging, Serving and Treating our Homeless Residents						
Outcomes						
	Housing •Low Barrier Housing units functioning in the Comox Valley •Supported Independent Living Program (SILP) engages more clients in permanent supportive housing. •Gender specific Transitional Housing Facility operational providing higher degree of support services to clients seeking permanent housing **Programs** •Well integrated Detox Programs in community to provide significant reductions in problems related to client "substance withdrawal" •Frozen Meal Program initiated and providing nutritional meals to all vulnerable clients as a part of the "delivery services" from VIHA/MHA •Occupational Food Preparation training is readily available for clients enabling them to seek new employment opportunities. •All clients are able to engage in higher level, self-directed management of their living conditions through Life Skills training. •Vulnerable clients are well supported and monitored through their recovery period in a facility, which alleviates stress and burden to families and the community.					
GOALS	***Early***	***Six-month***	***Year 1 Goals***	***Year 2 Goals***	***Years 3 Goals***	***Year 4-10 Goals***
	♦ Input of the **VIHA 2008 Report** to Mayor's Task Force for integration with all stakeholders ♦ Initiate Assertive Community Treatment (**A.C.T. teams)** formation and mandate	♦ Functional **A.C.T. teams** working with **Housing Development Team (HDT)** to move people into permanent housing ♦ Establishment of **Home, Social and Day Detoxification Programs**	♦ Establishment of **Low-Barrier Housing Program** in conjunction with the **HDT** ♦ Development and Implementation of the **Supportive Independent Living Program (SILP)** ♦ Integrated service delivery model to the overall "End Homelessness in the Comox Valley" project	♦ **Transitional Housing Facility**(s) established in CV for gender specific support to vulnerable clients ♦ Development and Implementation of the **Frozen Meal Program** ♦ Establishment of a "**One-Stop Health Access Center**" for vulnerable clients ♦ Provide for a central **Help Center** to assist all clients in easily accessing information and services.	♦ Implementation of the **Cleaning & Life-Skills Programs** ♦ Establish a Long-term **Medical Detoxification Facility** in the Comox Valley	♦ Sustained development of all programs to reflect the changing nature of the client and community needs
Action						
	•Implementation of Assertive Community Treatment Teams (ACT) to assist the transition of vulnerable clients to housing					

	•Establish a Supported Independent Living Program (SILP) with effective Rental Subsidies to provide *effective* support for individuals to access long-term *quality* housing. •Establish six-bed Transitional Housing Facility (THF) for gender specific support to vulnerable clients needing medical and emotional supports •Establishment of Home, Social and Day Detoxification Programs •Establish the Frozen Meal Program and Cleaning/Life Skills Program in the Comox Valley •Build and establish a Medical Detoxification Facility in the Comox Valley •Provide well developed support services to the combined efforts of the Task Force on Homelessness in the Comox Valley •Establish a "One Stop Health Center" facility in the Comox Valley with an easy access Help Center to provide ready access to all services and support.

Accountability

- **VIHA/MHA** provides experienced service provider models to the overall efforts of the task Force and its recommendations for ending homelessness in the Comox Valley
- **VIHA/MHA** housing proposals are integrated into Task Force Recommendations and subsequent mandates for **the "delivery teams".**
- **Municipal, Provincial and Federal** bodies providing funding and support services to VIHA to sustain programs
- **Community Businesses:** provide effective opportunities to partner with VIHA for Life-Skills Training Programs
- **Comox Valley Citizens:** Active participation in consultative programs to ensure validation and support to VIHA projects

Strategy					
3. Stop Homelessness before it begins with effective Prevention Strategies					
Outcomes					
	•Reduction in the number of individuals or families who are at risk of homelessness. •Streamlined access to services through a centralized "Help Center" located in the "One Stop Health Access Center" •Early Intervention Strategies •Emergency Prevention Program				
Goals	***Early***	***Six-month***	***Year 1 Goals***	***Year 2 – 4 Goals***	***Year 5 - 10 Goals***
	♦ Prevention Team concept included in "ground teams" (HDT; ACT; Prevention) under the "Commission to Eliminate Homelessness"	♦ Prevention Team established and functioning effectively	♦ Early Intervention Strategy developed and operational ♦ Emergency Prevention Fund program implemented	♦ Increased access to income to maintain stable housing ♦ Enhanced access to employment ♦ A centralized "Help Center" operational to provide ease of access to all levels of support and services ♦ Zero persons discharged into homelessness from hospitals, treatment centers, correction facilities, emergency centers or foster care	♦ Increased housing opportunities and access to support services for homeless and "at risk" youth
Action					
	1.Establish **Prevention Team** to guide and oversee development and implementation of measurable prevention strategies. 2.Establish **Emergency Prevention Fund**, which responds to crisis situations, which could lead to homelessness. 3.Develop and Implement **Early Intervention Strategies** which include landlord support, tenant training and support and tenancy relationship intervention and mediation. 4.Create opportunities for most vulnerable to increase income in order to gain and retain permanent housing. 5.Provide practical supports required to secure employment or employment assistance. 6.Implement a centralized "**Help Center**" access to housing and support services for people experiencing or at risk of homelessness. The concept involves jointly housing the proposed VIHA One-Stop health centre with a like centre offering homeless services 7.Work collaboratively with government and non-profit agencies to develop strategies to house all people who are being discharged or are aging out of the system. 8.Partner with the **Housing Development Team** to develop youth emergency shelter beds, transitional housing and foster care discharge housing.				

Outcomes	Funding to implement the recommended model from the Expert Panel is achieved.
	Assistance is provided to people who are absolute or chronically homeless in order to meet their required level of need, including the increased opportunity for productivity and social inclusion.
	A dedicated client-centered approach will involve people in the process of decision-making, who are or who have experienced homelessness.
	Increased awareness of homelessness and housing insecurity by Citizens and elected Civic members of the Comox Valley.
	Increased capacity to collaboratively address social, economic and health inequities specific to vulnerable population groups will occur at a community, municipal and regional level.
	City Councils will endorse ending and preventing homelessness in the Comox Valley by; •establishing and financially supporting a Regional committee to oversee a comprehensive strategy, and, •embedding 'the elimination of homelessness' within a Regional District's staff job description.
	All OCP 's within the Comox Valley will include 'eliminating homelessness' within their policies, by-laws and processes.
	Inclusive zoning and land use planning and practices will include the provision of future building(s) and the necessary units required to ensure everyone is housed.
	Cost savings are realized by reduced systemic expenditures otherwise incurred as a result of absolute or chronic homelessness (e.g., housing and the continuum of services and treatment including health care, judicial, policing and social costs).
	Strategic direction will be aimed toward the prevention of homelessness with the absolute emphasis to seeking solutions after homelessness occurs.

Goals	**Immediate Goals**	**6 Month Goals**	**Year 1 Goals**	**Year 2+ Goals**
	Within 60 days, Establish an Interim Community Commission to End Homelessness •adopt the recommendations of the Expert Panel Integrated Service Teams •establish a centralized coordination mechanism defined to implement the Action Plan	Review Interim Community Commission, identify gaps, and mediate gaps.	Fully constituted Commission to End Homelessness to lead efforts and deliver on the Action Plan is established and in operation	On-going

	Within 20 days from the establishment of the Commission – action teams organized	Review operations and implement change where necessary	On-going	
		On-going funding providers are identified and a data base is established	On-going funding is established	Review and augment as required
	Within 80 days Communications Plan developed and set into operation.	Review success and identify and implement changes where required	Review success and identify and implement changes where required.	Review success and identify and implement changes where required
	Immediate Goals	**6 Month Goals**	**Year 1 Goals**	**Year 2+ Goals**
	Within 30 days, Community Information Sessions will be held on Mayor's Task Force Recommendations	Review success and identify and implement changes where required	Operational structure defined and implemented	On-going
	Within 120 days a process is established to design and implement an operational model to meet the goals of integrated service delivery in support of community priorities for health and housing.		Review success and identify and implement changes where necessary	On-going
	Within 120 days, Conduct an asset review (financial and human resource) of Community		Review – make alterations and additions.	On-going
Action	1.Develop Project Charter including a comprehensive Financial Management Strategies (a job of the commission) 2.Effective Administration, Coordination and Implementation 3.Public Engagement			

Stakeholders and Proposed Roles in Accountability Process

- **BC Housing**: Provide resource leadership through funding, Registry Integration, and "*effective model*" plans for new stock developments and provide for ancillary support services to the rest of its accountability partners to ensure effective "new stock" and existing stock utilization for homeless clients
- **Local Municipalities**:
  1. Establish the Housing Development Team (HDT), ACT and other Delivery Service teams to implement the action plans of the Mayor of Courtenay's Task Force. Ensure clear, well-coordinated mandates are instilled in each team.
  2. Promote the formation of the *"Comox Valley Commission to Eliminate Homelessness*" to oversee the governance and effective unity of these teams.
  3. Provide political leadership and Bylaw Amendment to enable goals to be met in an expeditious manner. Identify properties and facilities that could aid the achievement of the goals noted.
  4. Budget some funds for staff and resources needed to respond to the goals noted for "best use" of lands and developments.
- **C.V. Regional District**:
  1. Coordination of Municipal Responses with Provincial Support Services for effective use of funds and resources in the Region through the formation of the "*Comox Valley Commission to Eliminate Homelessness."*
  2. L.T. Oversight and coordination of these "on the ground" Teams as they work out the mandate to nurture housing development/availability.
  3. Integrate all municipal "*homelessness"* response programs into a regional response to be stewarded by the "Commission"
- **Van. Is. Health Auth. (**VIHA): Provide support services and guidance to the CV Commission as it responds with housing to ensure all health needs of the homeless clients are taken intro account and fully met.
- **Faith Based Organizations:** Integration of individual vision, programs and resources into the goals and action plans of the Task Force and its subsequent delivery models to eliminate homelessness in the Comox Valley Region.
- **Non-Profit Housing/Services Providers:** Active participation in the planning and implementation processes to meet housing development and management goals. Use of the Housing Registry, interactive with social services providers to ensure "best practices" for tenant landlord relations.
- **Developers/For-Profit Housing Providers:** Active participation in the planning and implementation processes to ensure effective provision of new stock within all developments and the establishment of a fund towards the development of new stock in lieu thereof.
- **Comox Valley Business Community:** Identify opportunities to work in concert with the Task Force and service providers to engage more "at-risk" clients in meaningful employment.
- **Financial Institutions:** Provide new opportunities to assist developers and service providers finance plan and programs that extend beyond funding available from government sources.
- **Provincial and Federal Government Representation:** Communicate the Task Force findings and action plans for the CV Region to the appropriate government service bodies to ensure "open doors" for resources such as funding and staff training. Actively support all phases of the critical path for success.
- **CV Citizenry:** Be engaged in the solution, through education, volunteer support and sensitivity to the opportunity to effectively changes people's lives for the better of the whole community by nurturing real hope. Lobby governments for needed programs and funds.
- **Homeless and "At Risk" Clients:** Engaged in all elements of the implementation of plans and programs to nurture and sustain their re-integration into the community

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