"...People in my situation...you don't have a home...What do I do?"

HOMELESS IN THE FRASER VALLEY

Report on the 2011 Fraser Valley Regional District Homelessness Survey

By:

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Fraser Valley Regional District

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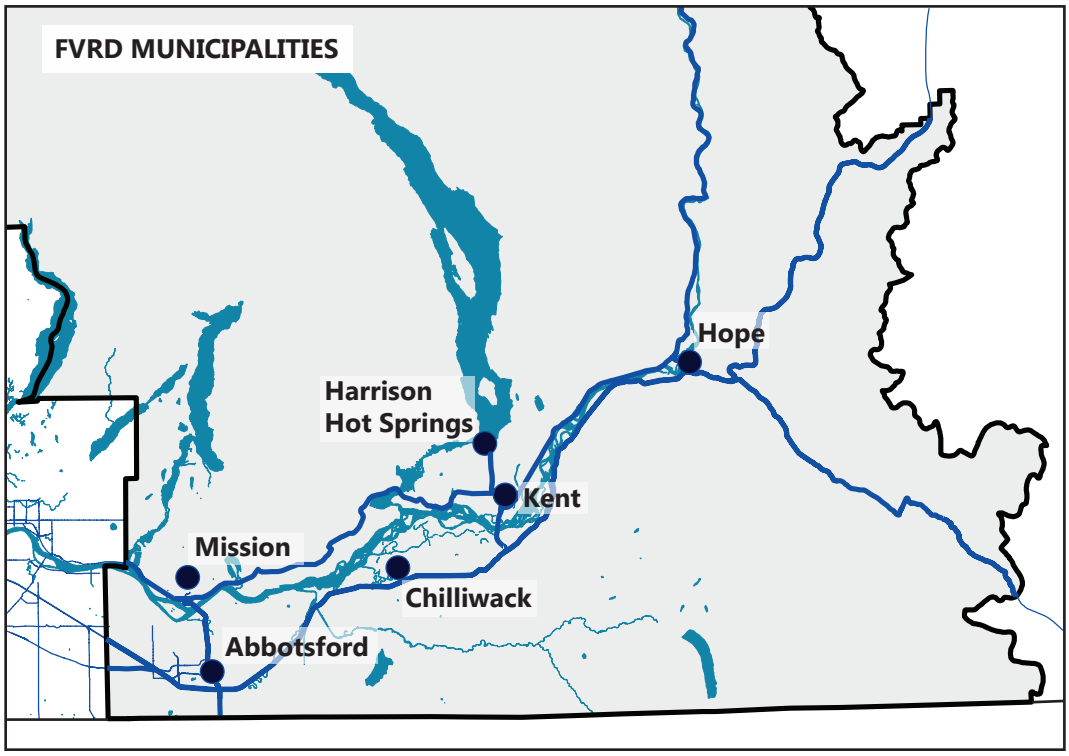

Fearless they wander the streets
Disappearing into the night,

Cold damp concrete
They call it home,

The pains in their stomach
Reminds them of better times,

Sleep in not their right
but only a temporary escape,

Three meals in a day,
Maybe three in a week!

Many think they want a hand out,
When all they want is a hand up.

If we look real hard
what do we see?

Is it someone we know?
Could it be me?

~Les Talvio~

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF CHARTS

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EXECUTIVE SUMMARY

BACKGROUND

This 2011 report on homelessness in the Fraser Valley Regional District (FVRD) documents the process and findings, with analysis, of a 24-hour survey conducted March 15 and 16, 2011 in the communities of Abbotsford, Mission, Chilliwack, Agassiz–Harrison Hot Springs, Hope, and Boston Bar–North Bend.

The successful completion of the survey was made possible through the work of more than 100 volunteers, monetary contributions from the FVRD, and in-kind contributions, mainly through staff time, from collaborating community agencies.

These are:

- Salvation Army, Abbotsford
- 5&2 Ministry, Abbotsford
- Abbotsford Community Services
- Mission Community Services Society
- District of Mission, Social Development and Planning
- Pacific Community Resources Society, Chilliwack
- Chilliwack Community Services, Youth Outreach
- Fraser Valley Regional District
- Agassiz-Harrison Community Services
- Hope and Area Transition Society
- Mennonite Central Committee, British Columbia
- Mission Community Services
- Cyrus Centre, Abbotsford
- Women's Resource Society of the Fraser Valley

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

Selected Key Findings

- 345 persons were found to be homeless:
  - 117 in Abbotsford
  - 54 in Mission
  - 111 in Chilliwack
  - 20 in Agassiz–Harrison Hot Springs
  - 43 in Hope
- In 2008, the number of homeless persons interviewed was 465.
- The number of homeless persons interviewed has decreased substantially in Abbotsford and Mission, but the numbers in Chilliwack, Agassiz-Harrison, and Hope have increased.

- Homelessness in the Upper Fraser Valley is linked to:
  - inadequate affordable housing
  - inadequate income levels (poverty)
  - drug addiction
  - mental health issues
  - relational breakdown
- Just over one third (34.0%) of homeless persons experience long-term homelessness (one year or longer).
- The number of persons counted in emergency shelters in 2011 is slightly lower (41) than in 2008 (48). The total emergency shelter capacity in the FVRD at the time of the survey was 64 beds.
- The number of women counted in transition houses was 34. This is higher than the 21 counted during the 2008 survey. The total transition house capacity in the FVRD at the time of the 2011 survey was 65 beds.
- The number of youth shelter beds has gone down from 8 in 2008 to 5 in 2011.
- There remains a need for transition (second-stage) housing and long-term, if not permanent, housing with support for those persons who live with mental illness and/or addiction to substance use.
- The proportion of women within the homeless population increased from 32.1% in 2008 to 45.0% in 2011.
- The largest proportion of homeless respondents in 2011 (37.2%) falls within the age bracket of 35–54, with a substantial proportion (25.6%) within the age category 25–34.
- The respondents who self-identified as Aboriginal/Métis make up 28.2% of the homeless persons surveyed.
- Almost three quarters of the respondents (74.8%) indicated that they live alone.
- Welfare as a source of income was reported by 42.8% of respondents, whilst 12.4% indicated that their source of income was employment, mostly part-time and temporary.
- Just under half of the respondents (46.4%) reported a health related problem; of these, 53.0% reported having multiple conditions.
- 37.1% reported an addiction problem and 20.5% reported a mental health problem, with 15.0% reporting “dual diagnosis or concurrent disorder”—i.e., both addiction and mental health issues.
- Almost three quarters (73.9%) of respondents reported that they have used community based services in various combinations over the past 12 months.
- 68.6% of respondents reported that they had had a good meal during the week of the survey.

CONCLUDING CONSIDERATIONS

Homelessness Prevention

With regard to homelessness prevention in the FVRD, a two-year rent assistance pilot project is being implemented by Mennonite Central Committee, British Columbia (MCC BC), in collaboration with Abbotsford Community Services, Mission Community Services, Pacific Community Resources Society (Chilliwack), Agassiz-Harrison Community Services, and Hope and Area Transition Society. The findings of this pilot project, which will end in March 2012, will determine how to proceed with rent assistance as one way of preventing homelessness. It needs to be noted that prevention of homelessness also connects with making affordable and social housing available, expanding rent supplements that are currently provided by BC Housing, and addressing the housing affordability issue as it relates to living wage levels.

Emergency Shelters

Emergency shelters do not seem to be the most effective and efficient way to deal with chronic homeless persons who live with mental health issues, substance use addiction, or both. This subpopulation needs long-term or permanent supportive housing, or housing with supports. There is a view among some service providers in the FVRD that the current emergency shelter provisioning is not equipped and resourced to deal successfully with this subpopulation. Leading housing and care practices for homeless persons living with mental health challenges and substance use addiction are multifaceted interventions with ongoing support that require integrated and accountable universal services from government housing and health care. This level of service is, to some extent provided but could be provided more effectively through a partnership arrangement between government and social economy sector organizations.

Housing First

The literature is clear that effective treatment for homeless people with concurrent disorders requires comprehensive, highly integrated, and client-centred services, as well as stable housing. Housing is essential both during and following treatment. There is growing evidence that supported housing is essential, regardless of treatment. Safe and secure housing with an integrated service team is a key factor that makes it possible for residents/program participants to address their substance use issues by becoming abstinent, reducing their substance use, or reducing the negative impacts of their use. It is imperative to understand that in the context of providing housing to chronically homeless people, housing becomes the platform from which services are delivered to facilitate social inclusion. In this regard, the concept of “housing first” seems to represent a significant value shift in how housing is provided to people with concurrent disorders.

By utilizing the approach of “no-barrier” or “minimal-barrier” housing, a conscious effort is made to ensure that nothing will get in the way of keeping a roof over someone’s head. This means that although the client may have an addiction issue that is not approved of, housing will not be refused and all necessary support will be provided to reduce the harm that may come from using addictive substances. The reasoning is that support and care remain in place, which is necessary for the relationship to remain intact; this in turn will contribute to the building of trust, with the belief that through continuing support and care, the person will come to a decision point in favour of choices toward a healthier lifestyle. Furthermore, the reasoning is that keeping people housed and providing ongoing support based on empathic therapeutic relationships will prevent people from going back to the street again or ending up in housing settings where they will be evicted and wind up on the street.

RECOMMENDATIONS

1. That community efforts, building on the work undertaken and progress achieved in FVRD communities over the past five years, be focused on establishing a more coherent and more comprehensive intervention to implement housing and care, based on the housing-first and no-barrier/low-barrier approach.

The aim of this should be to provide housing with supports, inclusive of assertive community treatment (ACT) teams, to homeless persons in FVRD communities who live with mental illness and/or addiction to substance use.

2. That the province continue to work with FVRD communities to address ongoing homeless challenges.

1. INTRODUCTION

1.1 Survey Background

Although homelessness is very visible in metropolitan areas such as Victoria, Vancouver, Calgary, Edmonton, Regina, Winnipeg, and Toronto, it is no longer a problem restricted to high-density urban cores. Although less visible, homelessness in the Upper Fraser Valley has been empirically confirmed in 2004 and again in 2008 (van Wyk & van Wyk, 2005, 2008).

Following on the 2004 and 2008 homelessness counts, the 2011 Fraser Valley Regional District (FVRD) homelessness survey was conducted via a collaborative effort involving the following organizations:

- Fraser Valley Regional District
- Mennonite Central Committee, British Columbia
- Salvation Army, Abbotsford
- 5&2 Ministry Abbotsford
- Cyrus Centre, Abbotsford
- Women's Resource Society of the Fraser Valley
- Mission Community Services
- District of Mission, Social Planning Department
- Pacific Community Resources Society, Chilliwack
- Salvation Army, Chilliwack
- Chilliwack Community Services, Youth Outreach
- Agassiz-Harrison Community Services
- Hope and Area Transition Society

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

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

1.2 Survey Objectives

The objectives of the survey were to:

- Determine whether homelessness is increasing or decreasing in the region;
- Provide reliable data to support the work by the FVRD in addressing housing and homelessness in the region, through research, data and several housing forums;
- Continue to increase awareness and understanding of homelessness; and
- Inform all levels of government, policy makers, and community based organizations about the extent of local homelessness and the need for both provincial and federal investment in social housing in FVRD communities.

1.3 Research Outcomes

Understanding the quantitative aspects of homelessness is an important step in addressing this socio-economic phenomenon. At a general level, it is expected that the research findings will enhance understanding among service providers, civic, provincial and federal politicians, civil servants, community volunteers, the general public, and others about homelessness as a socio-economic problem, and contribute to the design of additional interventions to reduce homelessness. Furthermore, it is expected that the research findings will continue to increase community capacity, including growing community collaboration and mobilization of resources, to respond constructively to the phenomenon of homelessness. More specific outcomes include:

- Knowledge building in partnership with communities;
- Facilitation of effective public support and community action in response to homelessness;
- Enhanced understanding of the causes and effects of homelessness; and
- Increased community capacity, marked by greater collaboration among service providers, researchers, all levels of government, the for-profit sector, and the not-for-profit sector, to continue to respond constructively to the issue of homelessness in the Upper Fraser Valley.

1.4 Defining Homelessness

A precursor to quantifying the extent of homelessness is defining what it means to be “homeless”. This term, which may appear to be nebulous, upon further inquiry demonstrates the ambiguous and politically charged nature of defining what is considered to be homelessness, and under what circumstances. Various definitions of homelessness produce various responses from policy makers, politicians, activists, and community workers, who are constantly engaged in examining the semantics of what it means to be homeless in Canada. This process of definition influences how we as a society respond to homelessness, since definitions become “tools that justify action or inaction, depending upon who is doing the defining” (Layton, 2008, p. 41).

The United Nations (2005) has distinguished two categories or degrees of homelessness: primary and secondary. **Primary homelessness** includes persons living in the streets without a shelter. **Secondary homelessness** includes persons with no place of usual residence, who move frequently

between various types of accommodations, including dwellings, shelters, transition homes, or other living quarters.

Drawing upon the international constructs of homelessness by agencies such as the United Nations, Canadian researchers for the Toronto Mayor's Homelessness Action Task Force defined homelessness "as a condition of people who live outside, stay in emergency shelters, spend most of their income on rent, or live in overcrowded, substandard conditions and are therefore at serious risk" (City of Toronto, 2000, p. 58).

In British Columbia, a recent report on housing and support defined homeless people as those who "live rough" (i.e., outside in parks, alleys, doorways, parked vehicles, parking garages, etc.), as well as those living in shelters. The study also included invisible homeless people—those living in substandard housing, including shacks and cabins without running water, transitional housing, and housing in major disrepair (Patterson et al., 2008, p. 17). Each of these definitions illustrates the continuum of homelessness, ranging from the extreme of absolute homelessness to being inadequately housed. As stated by Frankish et al. (2005):

> Homelessness can be viewed along a continuum, with those living outdoors and in other places not intended for human habitation as the extreme, followed by those living in shelters. . . . Homelessness also includes people who are staying with friends or family on a temporary basis. . . . Those at risk of being homeless include persons who are living in substandard or unsafe housing and persons who are spending a very large proportion of their monthly income on housing. (p. 24)

For the purpose of this study, two major factors were considered in defining homelessness: the importance of maintaining consistency with similar research in Metro Vancouver so that useful comparisons could be made, and the desire to include the variety of situations in which homeless persons can be found.

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

1.5 Methodology and Ethical Considerations

A 24-hour snapshot survey method was used to enumerate as accurately as possible the number of homeless people in the FVRD. The survey was conducted on March 15 and 16, 2011, and coincided with a similar survey conducted in Metro Vancouver. Following the research methodology utilized in the 2004 and 2008 FVRD surveys and prior research in other communities, this survey included nighttime and daytime components for data collection.

1.5.1 Nighttime survey component

The nighttime component focused on the enumeration of persons at shelters, safe houses, and transition houses during the selected night of the count. For this purpose, staff at these locations were enlisted to administer the questionnaire.

Preparation for the nighttime component included:

- Compiling a list of all emergency shelters, safe houses, transition houses, and other temporary emergency accommodation in the respective communities. Each of these places was contacted, and one person was enlisted to be responsible for administering the survey form and submitting completed survey forms to the Community Coordinator in each community.
- Providing orientation to the research project and training in the use of the survey questionnaire to the volunteers who agreed to assist with gathering of survey data.

1.5.2 Daytime survey component

The function of the daytime component was to find homeless people who had not stayed in shelters, safe houses, or transition houses the previous night. Coordinated by the Community Coordinator, this task was carried out by trained volunteer interviewers who visited pre-identified locations throughout the day of March 16, 2011, looking for homeless persons and screening out those counted the night before in shelters and transition houses. The pre-identified locations included meal program sites, drop-ins, and other services, as well as outdoor congregation areas.

Preparation for the daytime component included:

- Compiling a list of all service providers, facilities, and outdoor locations (e.g., pan-handling spots, malls, parks) where homeless people were likely to be found during the day.
- Demarcating communities into various areas to ensure manageable survey areas, and allocating trained volunteers to the areas.
- Working with various service providers (e.g., shelter services, drop-in centres, meal programs) in each community to enlist their support for and participation in the survey process.
- Providing training to interviewers to ensure that research participants were approached in a respectful manner and that the survey was done ethically.

1.5.3 Methodological challenges

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

Enumerating homeless persons poses longstanding difficulties. Layton (2008) explains that the problem of counting homeless people, even those who live rough in outside locations, is that the

single most important survival tactic is being invisible. This makes it practically impossible to reliably count homeless persons.

For example, it is difficult to measure the extent of homelessness in certain subpopulations, such as women with children, who are often invisible homeless persons since safety concerns affect coping strategies that rarely include the visible aspects of homelessness, such as sleeping in public places. Women and children will often couch surf, relying on friends or families, turning to emergency shelters only as a last resort. Therefore, the invisible nature of certain segments of the homeless population makes enumeration difficult.

The following factors are potential reasons for an undercount of homeless people in the FVRD in 2011:

1. Although the Community Coordinators consulted with service providers and homeless people to identify places where homeless people may be commonly found, it cannot be claimed that each and every possible place was identified.

2. Not all homeless people necessarily visited these identified locations on a given day.

3. The number of homeless persons should also be looked at in relation to the phenomenon of recovery houses. Although not included in the survey, given the agreed definition of homelessness, a voluntary count in 2008 of recovery house residents yielded a result of 181 persons. It is currently not known what the number is in 2011. Exactly how many of these residents do have a home of their own to go to once they leave the recovery homes is not clear. Suffice to say that once these residents leave the recovery houses, some may become part of those who have no alternative but to live homeless.

4. By-law enforcement to discourage the establishment of homeless campsites, and law enforcement to reduce trading in prohibited substances, might also from time to time have an impact on the number of homeless people present in a community. These methods or tactics for the most part result in displacement of homeless people. Rarely, if ever, do they result in people being housed.

Given the above mentioned reasons and the unavailability of an ethical method that can produce a 100% reliable number of homeless people, the homeless estimate that was arrived at through this survey represents only the number of homeless people who were identified by the interviewers over a 24-hour survey period on March 15 and 16, 2011. Although this number is in all probability an undercount of the number of homeless people residing in the FVRD, it nevertheless does provide a guideline for planning purposes.

For purposes of further comparison, estimates derived from snapshot surveys may be compared with HIFIS data (Homeless Individuals and Families Information System) where available. In the absence of HIFIS data, researchers can also rely on what is called a period prevalence estimate, which is obtained by arranging with various services providers in the communities under study to keep accurate records, using a standardized form, of the number of homeless people who make use of their services over a period of time, e.g., one year, six months, or three months.

1.5.4 Ethical considerations

In keeping with the principles of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, it is recognized that “the end does not justify the means.” In other words, carrying out the survey should not harm any of the people involved (both interviewers and interviewees)

physically, emotionally, or financially. The survey should in no way compromise the dignity of the persons surveyed, or jeopardize their ability to receive services.

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

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

2. EXTENT OF HOMELESSNESS IN 2011 IN THE FVRD

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

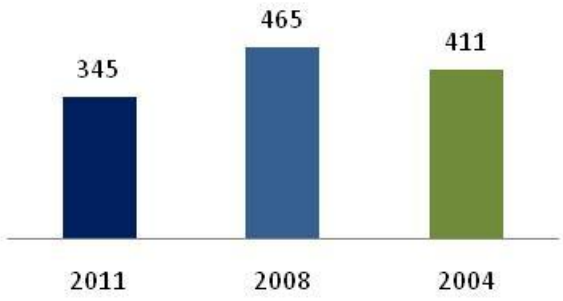
The communities in the FVRD included in the survey were Abbotsford, Mission, Chilliwack, Agassiz–Harrison Hot Springs, Hope, and Boston Bar–North Bend. The total number of homeless people surveyed during the 24-hour period, March 15 and 16, 2011, in the FVRD was 345 persons, distributed across the region in both urban centres and smaller communities, as shown in Table 1.

TABLE 1: Number of Respondents Surveyed by Community

Community	2011 n	2011 %
Abbotsford	117	34
Mission	54	16
Chilliwack	111	32
Agassiz-Harrison	20	6
Hope	43	12
Boston Bar/North Bend	0	0
Total	345	100.0

Comparing this result with the 2008 survey indicates that the overall number of homeless persons surveyed in the FVRD is down by 25.8% since 2008. In 2008, 465 homeless persons were counted, and 411 in 2004. The decrease in the number of homeless persons between 2008 and 2011 was not uniform across the region.

CHART 1: FVRD Homeless Count Totals 2004-2011

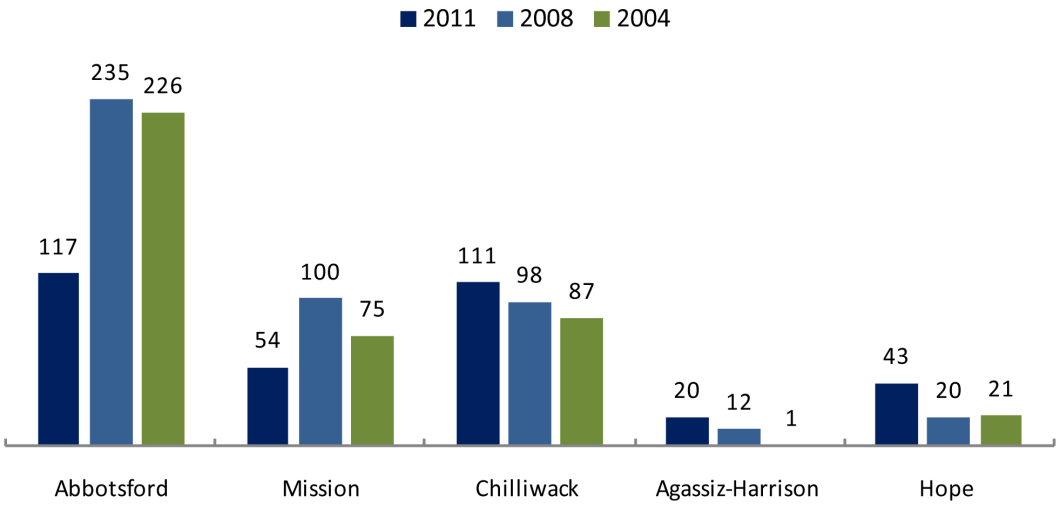


As shown in Chart 2, the decrease in the number surveyed is substantial in Abbotsford, where the number dropped from 235 to 117, a significant 50% reduction. Similarly in Mission, the number counted dropped from 100 to 54, representing a 45% reduction. However, further east into the FVRD,

the number in Chilliwack increased from 98 to 111, in Agassiz–Harrison from 12 to 20, and in Hope from 20 to 43, representing 13.3%, 69%, and 115% increases, respectively.

In an attempt to explain the overall reduction, the reduction in Abbotsford and Mission specifically, and the increase in Chilliwack, Agassiz–Harrison, and Hope, the following can be advanced as possible factors contributing to the change. Since 2006, the Ministry of Social Development has been funding Homeless Outreach Programs in Abbotsford, Mission, Chilliwack, and Hope. The purpose of the outreach programs is to connect homeless persons with services and housing. It is plausible to think that these outreach programs must contribute to a reduction in homelessness in these communities. Another factor at play, specifically in Mission, could be the opening of a second-stage housing project offering 44 beds (32 for men and 12 for women).

CHART 2: Municipal Homeless Count Totals 2004-2011



Another factor specifically in Abbotsford that could have played a role in the reduction of the number of homeless people interviewed relates to the Abbotsford police's newly implemented crime prevention policy, coupled with enforcement by the city's by-law department that prevents homeless camps from being erected and "taking root". Anecdotal reports from service providers indicate that for the past year or so, there have been far fewer homeless camps in Abbotsford. From this a plausible conclusion could be drawn that, at least in the case of Abbotsford, through a new crime prevention strategy coupled with a stricter enforcement of by-laws, homeless people in Abbotsford have become less visible or have been "encouraged to move on". This, however, does not detract from the efforts taken by Abbotsford City Council, supported by its Social Development Advisory Committee, to provide more shelter space and more affordable housing units.

Regarding the increase in numbers further east into the region, it could possibly be argued that the increase is (based on anecdotal evidence from service providers) a result of what is happening in Abbotsford through that city's perceived stricter by-law enforcement approach and its crime prevention strategy. It is common knowledge that there is a connection between homelessness and addiction to substance use. If addiction to substance use is seen first and foremost as a matter of crime, then a crime prevention strategy could result in homeless persons becoming less visible in a community, especially in smaller communities with relatively smaller homeless populations and surrounded by acreages, farmland, and wooded areas, coupled with options to cope with homelessness in neighbouring communities.

2.2 Reasons for Homelessness

Every homeless person has an individual story of their path into homelessness. Although research in the past has explored the personal dynamics that contribute to homelessness (including addiction and mental illness), Canadian studies have shifted towards understanding the structural/systemic factors that contribute to homelessness.

As Buckland et al. (2001) explain:

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

Thus, the assertion can be put forward that politics, economics, and social issues have all played a role in the dramatic increase in homelessness in Canadian cities.

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

TABLE 2: Reasons for Being Homeless

Reason Given	2011 n	*2011 %
Inadequate income	94	39.5
Rent too high	92	38.7
Family Breakdown/Abuse/Conflict	23	9.7
Health	11	4.6
Other	18	7.5
Total Response	238	100
NR	107	
Total	345	

**percent does not include non-responses*

Just over three quarters of the respondents (78.2%) claimed that the reason for homelessness related to the issue of affordability, i.e., inadequate income and unaffordable rent, which is an example of a structural cause. A further 9.7% of respondents cited family breakdown/abuse/conflict as the reason for homelessness, followed by health reasons at 4.6%, and “other” reasons at 7.5%.

It is evident from the survey results that while personal issues may precipitate homelessness in the Fraser Valley, systemic structural factors play a significant role. Research has shown that there are often precipitating factors including job loss, loss of permanent housing due to eviction, family breakdown, or illness (Buckland et al., 2001, p. 4). Homelessness can result when precipitating factors are compounded by structural and systemic factors such as shifting provincial or federal policy. Based on an interpretation of the growing body of knowledge on homelessness in Canada, it is safe to assert that homelessness is indeed a complex phenomenon and that a variety of factors, in various combinations, contribute to homelessness.

2.2.1 Politics & Policy

A major structural component of housing and homelessness is government policy and funding which has shifted significantly over the past twenty years.

The 1930s saw Canada's first national housing legislation to help ease housing shortages and to promote job creation through the stimulation of the private housing market. Over the next six decades, Canada continued to play a strong role in ensuring the viability of the housing sector for all Canadians. In the early 1990s, however, the Canadian government sought to end its financial involvement in areas of provincial jurisdiction, including housing. In 1992, the federal government terminated the funding of the federal cooperative housing programs (Begin et al., 1999), and in 1993, it froze funding for social housing programs, resulting in no federal money to build new social housing until 2001.

As Irwin (2004) states, "Canada now has the dubious distinction of being the only Organization for Economic Cooperation and Development country without an ongoing national housing program—even though Canada is a signatory to the Universal Declaration of Human Rights, which states that everyone has a right to an adequate standard of living, including housing" (p. 7).

Not only did the federal government terminate spending, but in 1996 it announced plans to download national housing programs to the provinces and territories. From 1993 to the early 2000s, British Columbia and Quebec were the only provinces that continued to fund new social housing projects. Yet even with additions to social housing stock, there has been an average waiting list of 10,000 applicants for social housing in British Columbia (Irwin, 2004, p. 7).

The dismantling of federal housing policy and initiatives has resulted in a complete halt to the construction of federal social housing units that in the past had provided low-income Canadians with affordable housing. The fact of fewer available units has contributed substantially to the national housing crisis.

Municipalities are often left to deal with the social and health consequences of homelessness, without the funding and expertise of national or provincial authorities. As Layton (2008) explains,

> As federal and many provincial governments were . . . downloading responsibility for housing to municipalities, a common refrain was heard: municipal government is closest to the people and is best able to determine its specific housing needs. There's a large element of truth to that, of course, but municipalities don't have the financial resources of provincial and federal governments. So, they are stuck with the problem without being given the resources for the solution. (322–323)

Without a national housing policy, Canadians who find themselves homeless are at the mercy of a system that is ad hoc, piecemeal, and not proactive.

2.2.2 Economics

One of the most common reasons for homelessness is probably one of the simplest to understand—"homelessness is the fallout of the twin problems of affordability and supply" (Kauppi, 2003, p. 15). Studies have repeatedly shown that the single biggest cause of homelessness is financial—that people who are homeless cannot afford housing. As Buckland et al. (2001) state, "generally speaking, one shared characteristic of homeless persons is that they have very limited, if any, financial resources. Low income and inability to pay market rents is likely a particularly major cause of homelessness" (p. 10).

The Canadian Mortgage and Housing Corporation (CMHC) has extensively studied the dynamics of housing affordability, comparing housing costs to a household's ability to meet those costs. The Shelter Cost to Income Ratio (STIR) is a measurement that CMHC has developed to determine the expenditures of Canadian households on housing. STIR is calculated by measuring the before-tax household income spent on shelter costs. According to their research, a benchmark of less than 30% for the STIR is commonly accepted as the upper limit for defining affordable housing (CMHC, 2008). In other words, affordable housing should cost 30% or less of a household's income.

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

TABLE 3: Average STIR of Households in Core Housing Need

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

Source: CMHC (Census based housing indictors data)

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

In many Canadian cities, low-cost rental units have been lost to gentrification and redevelopment, decreasing the inventory of safe, good-quality, affordable homes even further (CMHC, 2003b). The combination of current housing market conditions with the federal government's 1993 decision to halt spending on the construction of new social housing units has resulted in a housing crunch that has left Canada's most vulnerable populations precariously housed.

The CMHC (2008) has identified people living alone, female lone parents, renters, immigrants, and aboriginals as being statistically more likely to be part of the population that experiences unaffordable housing. It is also known that social assistance recipients make up a very high proportion of high-risk renter households (Buckland et al., 2001). In British Columbia, sweeping changes in income assistance have been blamed for causing homelessness (Klein & Pulkingham, 2008).

Rules and regulations that govern social assistance benefits can also make it difficult for homeless individuals to find permanent shelter. In this regard, Buckland et al. (2001) state: "Frequently, the exhaustion of financial assets is an a priori condition of receiving any financial assistance, yet this creates an additional hurdle for homeless individuals who cannot otherwise accumulate enough resources to cover first and last month's rent" (p. 13–14).

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

2.2.3 Deinstitutionalization

A contributing dynamic with respect to homelessness is the deinstitutionalization of and lack of discharge planning for mental health patients and inmates. A study in London, Ontario found that discharge from psychiatric wards to shelters or the streets is a real problem; the researchers conservatively estimated that such discharges occurred at least 194 times in 2002 (Forchuk et al., 2006). Forchuk et al. argue that patients with mental illness being discharged without an appropriate housing plan are critically vulnerable to homelessness and place a strain on shelters that often leads to rehospitalization and pressure on public resources. Buckland et al. (2001) argue that "deinstitutionalization has not been accompanied by adequate community supports, and that supportive housing is essential to meet the needs of the homeless and mentally ill people" (p. 16).

Offenders discharged from correctional facilities without adequate housing can potentially contribute to homelessness. Studies have found that "when prisoners being released have few outside supports and do not have access to comprehensive and situationally relevant discharge planning, they have a high probability of being released to a situation of homelessness, which in turn increases their likelihood of re-incarceration" (CMHC, 2007b, p. 2). Currently, on any given day, approximately 1000 people are living in the FVRD within the Province's probation system. Although federal inmates are required to have basic plans in place for housing, the lack of long-term affordable housing stock remains an obstacle for them. In the provincial correctional institutions, discharge planning is generally

not undertaken and inmates are routinely discharged to the street.[1] The absence of housing plans for offenders reentering a community can "result in ex-prisoners being concentrated in the most problematic parts of the community where there are high rates of crime and disorder and an absence of support services" (Griffiths et al., 2007, p. 22).

2.2.4 Social factors

As argued earlier, homelessness is often the result of structural/systemic conditions that place vulnerable populations at risk. There are, however, individual precipitating factors that will often be the breaking point resulting in homelessness. Buckland et al. (2001) explain:

> The main argument is that economic and social welfare changes, when coupled with demographic pressures, have created a class of people who live in marginalized housing conditions—the 'proto-homeless'—and that adverse events cause these people to fall into homelessness. These events include eviction, domestic conflict, and loss of job or welfare support. (p. 19)

Issues of mental illness and/or drug abuse have often been cited as overlapping risks for homelessness. Goering et al. (2002) found that 64% of first-time shelter users in Toronto had a history of drug abuse and 64% had other psychiatric problems. Of those who had previously been in shelters, 71% had drug abuse histories and 69% had other psychiatric problems.

A study conducted in British Columbia on housing and support for adults with severe addictions and/or mental illness (SAMI) drew a connection between the cyclical and long-term nature of their illness(es) and their difficulty in gaining and sustaining employment. This difficulty results in precarious economic circumstances. As Patterson et al. (2008) explain:

> Without a regular income, many depend on a patchwork of provincial and federal benefit programs for disabled persons. However, entitlement programs, designed to provide assistance to meet basic needs, are often inadequate. Moreover, SAMI individuals often experience difficulty gaining access to and establishing eligibility for these programs. Once eligibility is established, loss or interruption of benefits may also become a precursor to episodes of homelessness. (p. 20)

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

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

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[1] Information obtained at a meeting of the Affordable Housing Working Group of the Abbotsford Social Development Advisory Committee, September 16, 2008.

more complicated, requiring a comprehensive approach that extends beyond merely providing a roof over one's head.

2.3 Duration of Homelessness

The respondents were asked to indicate how long they had been homeless. Those who had been homeless for a year or longer constituted 34.0%, whilst 17.6% indicated they had homeless for more than six months but less than a year, 31.6% for more than a month but no longer than six months, and 16.8% for less than a month (see Table 4).

TABLE 4: Duration of Homelessness

Duration	2011 n	*2011 %
less than 1 month	40	16.8
1 month – less than 6 months	75	31.6
6 months – less than 1 year	42	17.6
1 year +	81	34.0
Total Response	238	100.0
NR	107	
Total	345	

**percent does not include non-responses*

Based on the above, it can be argued that just more than half (51.6%) of the respondents were experiencing relative long-term homelessness. Therefore, there are people in the Upper Fraser Valley who experience chronic homelessness. This situation of long-term or chronic homelessness is in line with the assertion of Begin et al. (1999) that the duration of homelessness is a contributing factor in the continuum of homelessness, characterized by the following three subgroups.

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

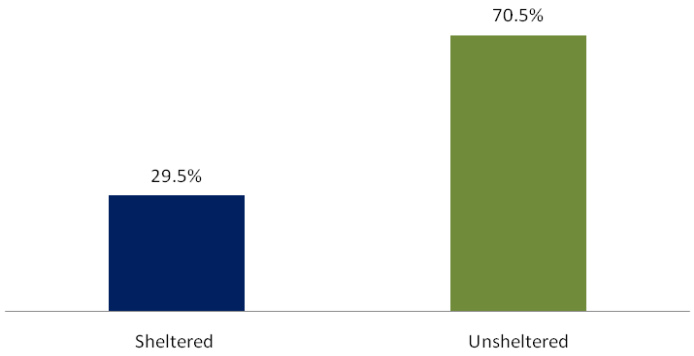
The ***cyclically homeless*** includes individuals who have lost their dwelling as a result of some change in their situation, such as job loss, a move, a prison term, or a hospital stay. This group must from time to time use safe houses or soup kitchens, and includes women who are victims of family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

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

2.4 "Sheltered" and "Unsheltered" Homeless Persons

The number of homeless persons surveyed in shelters was 41 (15.5%) and those surveyed outside totaled 75 (28.4%). This included those who slept in their cars/campers. Those who reported that they were sleeping at the homes of friends/family (couch surfing) totaled 111 (42.1%).

CHART 3: Total Sheltered and Unsheltered Persons



Sheltered: shelter (youth and general) & transition house
Unsheltered: outside, car/camper and couch surfing

The number of homeless people surveyed outside of shelters remains high, namely 186 persons or 70.5% of the respondents, in comparison to 199 (48.7%) in 2008 and 158 (43.4%) in 2004. The proportion of respondents surveyed in shelters is 15.5% (41), compared to 11.7% (48) in 2008 and 6.0% (22) in 2004. The number of persons counted in transition houses is 34 (12.9%), compared to 21 (5.1%) and 42 (11.5%) in 2008 and 2004, respectively.

TABLE 5: Accommodation on Night of Survey

Place Stayed	2011 n	*2011 %
Transition House	34	12.9
Shelter	41	15.5
Youth Shelter	3	1.1
Outside	55	20.8
Car/Camper	20	7.6
Friend's place	111	42.1
Total Response	264	100.0
NR	81	
Total	345	

**percent does not include non-responses*

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

TABLE 6: Reasons for not staying in Shelter/Transition House

Reason	2011 n	*2011%
Turned away	21	11.7
Stayed with friend/family	90	50.3
Dislike	27	15.1
Did not know about shelter	7	3.9
Couldn't get to shelter	9	5
Slept in car/camper	20	11.2
No shelter in community	5	2.8
Total Response	179	100
NR	166	
Total	345	

percent does not include non-responses

2.5 What Will End Homelessness for You?

The majority of respondents (82.1%) reported that they were not satisfied with their current living arrangements. When asked what would end their homelessness, respondents indicated that access to more affordable housing was the most common barrier to them finding a home.

TABLE 7: What will end homelessness for you?

Response	2011 n	*2011 %
Affordable Housing	71	38.0
Employment	34	18.2
Higher Income	33	17.6
Overcoming Addiction	17	9.1
Other	30	16.0
Like it	2	1.1
Total Response	187	100
NR	158	
Total	345	

percent does not include non-responses

2.6. Shelter and Transition Beds in the Upper Fraser Valley

The total number of shelter beds in the Upper Fraser Valley in 2011 is 64, compared to 41 in 2008 and 28 in 2004.

- Abbotsford – 27 emergency shelter beds (15 for men and 5 for women, plus an additional 7 [5 for men and 2 for women] if required)
- Chilliwack – 13 emergency shelter beds (8 for men, 3 for women, and 2 for youth)
- Hope – 2
- Mission – 22 (15 for men, 5 for women, 1 family room, and 1 mobility room)

The total number of beds in transition houses in the Upper Fraser Valley is 65, compared to 60 in 2008.

- Abbotsford – 13 beds
- Aldergrove – 10 beds
- Mission – 10 beds
- Chilliwack – 24 beds (Ann Davis 14; Xolhemet 10)
- Hope – 8 beds

The total number of safe house beds for youth is 2, compared to 8 in 2008 and 0 in 2004.

It is important to note that there are limits on the number of days people can stay at these facilities. This arrangement does not facilitate either the complicated “road” toward self-sufficiency or linking someone to an integrated arrangement for service provision. The desired outcome of self-sufficiency for those for whom it is possible cannot be achieved overnight and is dependent on long-term supports.

3. WHO ARE THE HOMELESS?

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

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

Based on information obtained from respondents during the 2011 homelessness survey, the following can be reported regarding a profile of homeless people in the Upper Fraser Valley.

3.1. Profile of Homeless People in the Upper Fraser Valley

The following information, obtained from homeless people surveyed on March 15 and 16, 2011 in Upper Fraser Valley communities, is discussed in this section:

- Gender
- Age
- Ethnicity
- Community of origin
- Street community and mutual support
- Source of income
- Health problems
- Usage of medical services and other services

3.1.1 Gender

The gender distribution of homeless people surveyed in the Upper Fraser Valley in 2011 has changed from the 2004 and 2008 surveys (van Wyk & van Wyk, 2005, p. 12; 2008, p. 29). The 2011 survey found that the proportion of women has significantly increased, to 45.0%, with men constituting 55% (see Table 8).

TABLE 8: Gender of Surveyed Respondents

Gender	2011 n	2011 %
Male	190	55
Female	155	45
Total	345	100

CHART 4: Respondent Gender - 2004 to 2011

The shift in the number of homeless females was most pronounced in Chilliwack. The 2011 survey encountered more females (52.0%) than males (48.0%). This is up significantly from 2004 and 2008, when the proportion of females was 32.6% and 32.1%, respectively.

The reason for this shift is unclear. The gender breakdown of the homeless persons surveyed in 2004 and 2008 did not differ significantly from available data regarding homelessness in Canada. Women constitute one third to one half of the homeless in major urban areas across Canada (Lenon, 2000, p. 1; Neal, 2004, p. 1; Wove, Serge, Beetle, & Brown, 2002, p. 9). It was indicated in the 2008 report (van Wyk & van Wyk, 2008, p. 28–29) that the 2008 finding that 32.1% of the respondents were women could have resulted from an underrepresentation of women, as there may be more homeless women who are not on the streets for reasons of safety and security. Also, as stated earlier, it is difficult to measure the extent of homelessness in certain subpopulations (e.g., women), and therefore homelessness among women is more hidden than among men.

As indicated above, the reason for the increase in the proportion of women among homeless persons in the FVRD, specifically Chilliwack and further east, is unclear. This change is different from the findings of previous studies here and elsewhere in Canada. The proportion of males to females should be monitored in future surveys in the FVRD to determine whether or not this is a new trend.

3.1.2 Age

Similar to the 2004 and 2008 surveys, the biggest proportion of homeless respondents in 2011 fell in the 25–54 age group. However, at 62.8% this represents a decrease from 2008 and 2004, when the proportion of homeless respondents in the 25–54 age group was 70.4% and 69.7%, respectively (van Wyk & van Wyk, 2008 p. 29–30; 2005 p. 12–13).

A significant proportion (28.9%) of respondents were 24 years or younger, with 18.8% or 52 persons 19 years or younger. The proportion of persons under the age of 25 is higher in the homeless population than it is for the region's population as a whole, as shown in Chart 5. Table 9 shows that the largest proportion of respondents (25.6%) was in the 25–35 years cohort. A significant number of the respondents (21.7%) were 35–44 years old. There were 23 (8.3%) respondents in the 55–75+ age group. This latter group is dealing both with homelessness and with the physical and psychological

challenges involved in the process of growing older. With the overall population aging, it is anticipated that this group will expand.

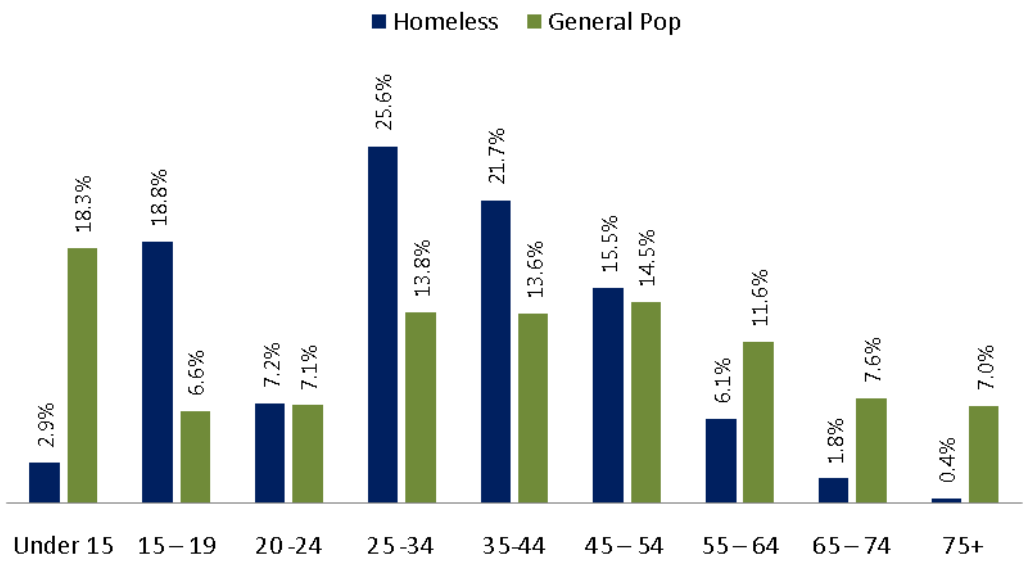
TABLE 9: Age of Surveyed Respondents

Age	2011 n	*2011%
Under 15	8	2.9
15 – 19	52	18.8
20 – 24	20	7.2
25 – 34	71	25.6
35 – 44	60	21.7
45 – 54	43	15.5
55 – 64	17	6.1
65 – 74	5	1.8
75+	1	0.4
Total Response	277	100
NR	68	
Total	345	

**percent does not include non-responses*

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

CHART 5: Age Distribution of Homeless in Relation to General Population



3.1.3 Ethnicity

Ethnicity is the cultural heritage or identity of a group, based on factors such as language or country of origin. The respondents were asked to indicate their ethnic background. For more detail, see Table 10.

TABLE 10: Ethnic Background of Surveyed Respondents

Ethnicity	2011 n	*2011%
Canadian/Caucasian/English	115	61.2
Aboriginal/First Nation/Métis	53	28.2
Other	20	10.6
Total Response	188	100
NR	157	
Total	345	

**percent does not include non-responses*

More than half of the respondents (61.2%) indicated that they are Canadian/Caucasian/English. A significant proportion (28.2%) of the respondents self-identified as Aboriginal/First Nation/Métis. In 2008, the proportions "Canadian" and "Aboriginal" constituted 53.7% and 32.1%, respectively. Of those who self-identified as Aboriginal, 14 (26.4%) were in Abbotsford, 5 (9.4%) in Mission, 15 (28.4%) in Chilliwack, 5 (9.4%) in Agassiz–Harrison, and 14 (26.4%) in Hope (see Table 11).

The literature indicates that the Aboriginal homeless have special needs that must be considered—e.g., cultural appropriateness, self-determination, and traditional healing techniques (Beavis, Klos, Carter, & Douchant, 1997). It fell outside the scope of the 2011 survey to make further determinations in this regard. Suffice to say that the notion of providing culturally appropriate services for Aboriginal persons likely remains valid and requires further analysis.

Table 11: Aboriginal/First Nation/ Métis Homeless Respondents by Community

Community	2011 n	2011%
Abbotsford	14	26.4
Mission	5	9.4
Chilliwack	15	28.4
Agassiz-Harrison	5	9.4
Hope	14	26.4
Total Response	53	100

3.1.4 Community of origin

The origins of homeless persons in the Region appear to be changing, with more respondents indicating they come from Metro Vancouver and other locations than from within the FVRD. In 2011, only one third of the respondents (33.4%) indicated that they were originally from FVRD communities, with 23.2% indicating that they came to the FVRD from communities in Metro Vancouver, followed by 12.1% from the "rest of BC", 5.1% from Vancouver Island, 23.2% from the "rest of Canada", and 3.0% from "other" regions, mainly from other countries. These responses differ from findings based on the

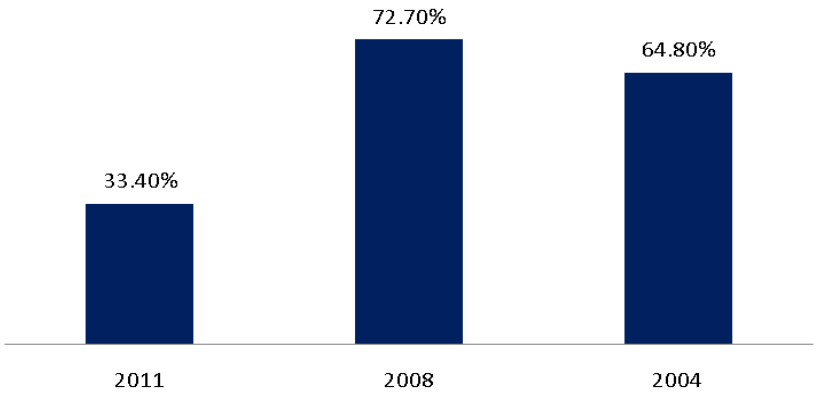
2004 and 2008 surveys, when the percentage of respondents from FVRD communities was 64.8% in 2004 and 72.7% in 2008 (van Wyk & van Wyk, 2004, p. 14; 2008, p. 33).

Table 12: Where do you Call Home?

Home community	2011 n	*2011%
Other FVRD	66	33.4
Metro Vancouver	46	23.2
Rest of BC	24	12.1
Rest of Canada	46	23.2
Vancouver Island	10	5.1
Other	6	3.0
Total Response	198	100
NR	147	
Total	345	

**percent does not include non-responses*

CHART 6: FVRD Origins of Homeless Population



3.1.5 Street community and mutual support

Based on the survey findings, it can be reported that almost three quarters (74.8%) of respondents indicated that they lived alone, while 23.5% lived with someone else—e.g., a partner/spouse, a friend, or children. It could perhaps be argued that those who live with others do find social support through this arrangement, and that this is a way to counter social isolation. In a previous study (van Wyk & van Wyk, 2005), it was reported that, based on information obtained through focus groups and qualitative interviews, homeless people do look out for each other, and that there are "rules of engagement" (p. 19). They respect one another, and they know who not to fool around with. Young women indicated that they learned quickly to keep a male companion with them.

Others in the same study reported "that they don't trust anyone and that homeless people steal from one another and attack one another" (van Wyk & van Wyk, 2005, p. 19). As MacKnee and Mervyn (2002 p. 301) report, because of "basic survival needs, relationships among street people are frequently characterized by distrust and suspicion". This can be juxtaposed with the aforementioned picture of rules, respect, and coexistence. This may be why a substantial number (74.8%) of homeless people in the Upper Fraser Valley have opted to live alone (see Table 13).

TABLE 13: Living Alone or with Others

Company	2011 n	*2011%
Alone	181	74.8
With pet	4	1.7
With partner/spouse	17	7
With friend	23	9.5
With children	12	5
Other Relatives	2	0.8
Partner, Spouse and Children	3	1.2
Total Response	242	100
NR	103	
Total	345	

**percent does not include non-responses*

3.1.6 Source of income

Welfare was indicated by 42.8% of respondents to be their source of income, followed by 11.0% receiving disability allowances. This compares with 4.8% and 28.4% who reported welfare as their source of income in 2004 and 2008, respectively (van Wyk & van Wyk, 2005 p. 25; 2008 p. 35). The percentage of respondents who indicated employment as their source of income is 12.4% for 2011. In 2004 this was at 29.2% and in 2008 at 21.3%. A significant proportion (18.6%) reported no source of income. This number is almost 6% higher than in 2004. Homeless persons typically hold unskilled, seasonal, and lower-paying jobs. The level of income associated with this type of employment makes it challenging to save money for emergencies, such as periodic or seasonal unemployment, or to secure the kind of economic stability that would prevent homelessness (van Wyk & van Wyk, 2005, p. 26). The number of respondents reporting welfare as a source of income dramatically increased from 4.8% in 2004 to 28.4% in 2008 and then to 42.8% in 2011. This increase is the result of the Homelessness Outreach Programme, in partnership with the Ministry of Housing and Social Development in Abbotsford, Mission, and Chilliwack, The programme connect homeless persons with services in the community and with supports provided by the Ministry of Social Development.

TABLE 14: Source of Income

Source	2011 n	*2011%
Welfare	101	42.8
Disability Benefit	26	11.0
Employment	29	12.4
EI/CPP/WCB/OAS/GIS	13	5.5
Binning	10	4.2
Family/Friends Support	9	3.8
No Income	44	18.6
Other	4	1.7
Total Response	236	100
NR	109	
Total	345	

**percent does not include non-responses*

3.1.7 Health problems

Survey respondents were asked to report on their health problems; 23.5% of respondents reported a medical condition, 18.9% reported a physical disability, 37.1% indicated they live with an addiction, and 20.5% with a mental illness. In addition, 46 respondents replied that they live with an addiction and a mental illness. If this category is added to those who reported living with an addiction and those living with a mental illness, then the proportion of respondents living with a mental illness is 35.5% and the proportion living with an addiction is 52.1% (see Table 15). It could be argued that substance abuse contributes to medical problems such as tuberculosis, hepatitis, and HIV. Respondents were not asked to specify the nature of their mental illness, but it is reasonable to argue that chronic emotional and mental illness complicates daily existence, and can mask acute illnesses or prevent people from accessing services and taking care of themselves.

TABLE 15: Reported Health Problems

Health issue	2011 n	*2011%
Medical Condition	72	23.5
Physical Disability	58	18.9
Addiction	114	37.1
Mental illness	63	20.5
Total Response	307	100
NR	38	
Total	345	
Addiction and Mental Illness combined	46	15.0

**percent does not include non-responses*

According to Hulchanski (2004), homelessness in itself is an “agent of disease". Homeless people are more exposed to and more likely to develop health problems than the general population, as living conditions predispose them to be particularly at risk of developing ill health. For example, they are at greater risk of being infected with communicable diseases (Alperstein & Arnstein, 1988; Miller & Lin, 1988; MacKnee & Mervin, 2002).

Furthermore, homeless people are subject to stress because of the factors that made them homeless and because of the experience of being homeless. Poor diet, stress, cold and damp, along with inadequate sleeping arrangements, sanitation and hygiene, increase the risk of health problems and decrease life expectancy. For example, prolonged exposure to cold puts strain on the heart, and high stress is associated with an increased incidence of cardiovascular disease and cancers.

It is not clear whether the diseases and disorders identified by homeless people in the FVRD preceded the loss of a place to live or whether they were precipitated by life on the streets. However, it is probably reasonable to assert that homeless persons in the FVRD suffer from a wide variety of chronic and acute illnesses that are aggravated by life on the streets.

3.2 Usage of Services

Of the 345 respondents, 255 (73.9%) reported that they have accessed various services over the past 12 months. Table 16 indicates the extent to which various services in the community are used by homeless people. Food banks and meal programs/soup kitchens are frequented most, followed by outreach services, emergency rooms, drop-in services, addiction services, etc.

TABLE 16: Usage of Services Last 12 Months

Service	2011 n	2011%
Ambulance	38	3.7
Emergency Room	93	9.0
Hospital (non-emergency)	62	6.0
Dental Clinic or dentist	29	2.8
Mental Health Services	49	4.7
Addiction Services	68	6.6
Employment/Job Help Services	64	6.2
Parole or Services for ex-offenders	12	1.2
Drop-in Services	80	7.6
Food Banks	114	11.0
Meal Programs/soup kitchens	125	12.1
Health Clinic	72	6.9
Newcomer Services	3	0.3
Transitional Housing	29	2.8
Housing help/eviction prevention	30	2.9
Outreach	103	9.9
Legal	29	2.8
Budgeting/trusteeship	3	0.3
Other	28	2.7
None	5	0.5
Total Response	1036	100

3.3. Last Good Meal

Respondents were asked when they had last had a good meal. The biggest proportion (34.6%) reported that they had eaten a good meal the day of the survey, followed by 20.9% who indicated they had had a good meal the previous day, and 13.1% who said they had eaten a good meal “this week”.

A significant proportion (26.2%) of respondents reported that they had had a good meal a week ago or longer, while 5.2% said they could not remember when they had last had a good meal (Table 17, p.35).

TABLE 17: Last Good Meal

Time of Meal	2011 n	*2011%
Today	66	34.6
Yesterday	40	20.9
This week	25	13.1
1 week ago	17	8.9
2 weeks ago	11	5.8
3 – 4 weeks ago	5	2.6
More than a month ago	17	8.9
Don't remember	10	5.2
Total Response	191	100
NR	154	
Total	345	

**percent does not include non-responses*

4. SUMMARY OF FINDINGS

The following summarizes the main findings of this survey:

- In comparison with 2008, the number of homeless people interviewed in the FVRD has decreased from 465 to 345.
- The numbers of homeless people interviewed have decreased substantially in Abbotsford and Mission, but the numbers in Chilliwack, Agassiz–Harrison, and Hope have increased.
- Homelessness is a result of inadequate income (poverty), unaffordable rental rates, relational breakdown, and the roles played by mental health issues and/or addiction to substance use, as well as a concomitant lack of adequate care and support at the community level.
- Lack of affordable housing is directly related to low wages, erosion of the social safety net, insufficient social housing inventory, and increased rental accommodation cost.
- Almost two thirds of homeless persons experience long-term homelessness (one year or longer).
- The number of persons counted in emergency shelters in 2011 is slightly lower (41) than in 2008 (48). The total emergency shelter capacity in the FVRD at the time of the survey was 64 beds.
- The number of women counted in transition houses is 34. This is higher than the 21 women in transition houses during the 2008 survey. The total transition house capacity in the FVRD at the time of the 2011 survey was 65.
- There remains a need for transition (second-stage) housing and long-term, if not permanent, housing with supports for those persons who live with mental illness and/or addiction to substance use.
- The number of youth shelter beds has gone down from 8 in 2008 to 5 in 2011.
- The proportion of women within the homeless population has increased from 32.1% in 2008 to 45.0% in 2011.
- The largest proportion of homeless respondents in 2011 (37.2%) falls within the age bracket 35–54 years, with a substantial proportion (25.6%) within the age category 25–34 years.
- The respondents who self-identified as Aboriginal/Métis make up 28.2% of the homeless persons surveyed.
- Almost three quarters of the respondents (74.8%) indicated that they live alone.
- Welfare as a source of income was reported by 42.8% of respondents, whilst 12.4% indicated that their source of income is employment, mostly part-time, temporary employment.
- Just under half of the respondents (46.4%) reported a health related problem; of these, 53.0% reported having multiple conditions.
- 37.1% reported an addiction problem and 20.5% reported a mental health problem, with 15.0% reporting “dual diagnosis or concurrent disorder”—i.e., both addiction and mental health issues.
- Almost three quarters (73.9%) of respondents reported that they have used community based services in various combinations over the past 12 months.
- 68.6% of respondents reported that they had had a good meal during the week of the survey.

5. CONCLUDING CONSIDERATIONS

5.1 Housing Continuum

The typologies of responsiveness to homelessness vary widely, ranging in degree from homelessness prevention to emergency shelter to independent housing. Each typology requires different funding and management resources, and serves different client needs. The goal of communities, governments, and service providers should be to provide the right type of service to clients, fitting their long- and short-term needs.

5.1.1 Prevention

The first approach to addressing homelessness is prevention. Keeping people housed is the primary way of avoiding homelessness. Many communities have set up programs such as rent banks, landlord mediation, community worker/tenant aid, or basic needs services/referrals, to limit the number of people who become homeless. To this end, a two-year rent assistance pilot project is being implemented in the FVRD by Mennonite Central Committee, British Columbia (MCC BC). The findings of this pilot project, which will come to an end in March 2012, will determine how to proceed with rent assistance as one way of preventing homelessness. It needs to be noted that prevention of homelessness also relates to making affordable and social housing available, expanding rent supplements that are currently provided by BC Housing, and addressing the housing affordability issue on the side of wages.

5.1.2 Emergency shelters and safe houses

Emergency shelters provide short-term accommodation to individuals who have lost their homes and who would otherwise “live rough” in parks, parking garages, doorways, etc. Some emergency shelters are permanent and some only operate in adverse weather conditions. Emergency shelters are often a point of entry into the housing continuum.

Emergency shelters will often limit their service to certain populations (e.g., men, women, or youth only.) Emergency shelters have historically underserved certain populations, including single women, women with children, two-parent families, couples, youths, and pet owners. Emergency shelters do not seem to be the most effective and efficient way to deal with chronic homeless persons who live with mental health issues or substance use addiction, or both. This subpopulation needs long-term or permanent supportive housing or housing with supports. There is a view among some service providers in the FVRD that the current emergency shelter provisioning is not equipped and resourced to deal successfully with this subpopulation. Leading housing and care practices for homeless persons living with mental and substance use addiction are multifaceted interventions with ongoing support that require integrated and accountable universal services from government housing and health care. This level of service is, to some extent, provided and could be improved through a partnership arrangement between government and the social economy sector organizations.

5.1.3 Supportive housing

Supportive housing represents the broadest area of the housing continuum and ranges from short-term transitional housing for crisis stabilization to permanent supportive independent living. This type of housing can be targeted to different groups, and the ratios of individuals needing little or more

support can vary. Supportive housing assists clients who would otherwise have great difficulty in maintaining housing, due to addiction, mental illness, or limited functional capacity. It provides clients with a wide variety of services, including addiction recovery programs, counseling, mediation, financial planning, medication management, vocation and life-skills training, and meals. Supportive housing can be delivered through residential care models, congregate housing, group homes, block apartments, and satellite apartments. The key to successful supportive housing is matching the needs of the client with the appropriate levels of service.

5.1.4 Independent housing

Independent housing is at the far end of the housing continuum and represents individuals who have achieved successful housing in self-contained units either with or without government subsidies. Although clients may still have access to a variety of support, the support is not directly linked to their housing.

5.2 Housing-first and No-barrier/Low-barrier Housing

The literature is clear that effective treatment for homeless people with concurrent disorders requires comprehensive, highly integrated, client-centred services, as well as stable housing. Housing is essential both during and following treatment. There is growing evidence that supported housing is essential, regardless of treatment. Safe and secure housing, with an integrated service team, is a key factor for residents/program participants to address their substance use issues by becoming abstinent, reducing their substance use, or reducing the negative impacts of their use. It is imperative to understand that in the context of providing housing to chronically homeless people, housing becomes the platform from which services are delivered in order to facilitate social inclusion. In this regard, the notion or concept of “housing first” seems to represent a significant value shift in how housing is provided to people with concurrent disorders.

No-barrier/low-barrier housing (also referred to as minimal-barrier housing) is provided with

> flexible service based on need regardless of eligibility for income assistance, lifestyle, condition (e.g. intoxication) or number of times receiving the service, in a building that is accessible to everyone, regardless of physical condition, while acknowledging that acuteness of health needs, behavior or level of intoxication, may limit the ability of a provider to give service. (Social Planning and Research Council of BC, 2003, p. 29)

Two recent Canadian studies (Kraus et al., 2005 and Patterson et al., 2008) have identified the need to provide homeless persons who have substance use issues with a “housing-first” model (also referred to as low-barrier housing).

“Housing first” is defined as the direct provision of permanent, independent housing to people who are homeless. Central to this idea is that clients will receive whatever individual services and assistance they need and want to maintain their housing choice. The housing is viewed primarily as a place to live, not to receive treatment (Kraus et al., 2005). Housing-first models are predicated on the assumption that all individuals, regardless of substance misuse, are entitled to a safe place to live. They are also predicated on the assumption that addiction recovery is more likely to be successful when secure housing is met. Housing-first models encourage clients to seek addiction treatment, but do not make it mandatory before housing is provided.

By utilizing the approach of “no-barrier” or “minimal-barrier” housing, a conscious effort is made to ensure that nothing will get in the way of successfully keeping a roof over someone’s head. That

means that although the client may have an addiction issue that is not approved of, housing will not be refused and all support necessary will be provided to reduce the harm that may come from using drugs or alcohol. The reasoning is that support and care will remain in place, which is necessary for the relationship to remain intact, which in turn will contribute to the building of trust, in the belief that through continuing support and care, the person will come to a decision point in favour of choices toward a healthier lifestyle. The reasoning is furthermore that keeping people housed and providing ongoing support based on empathic therapeutic relationships will prevent people from going back to the street again or ending up in housing settings where they will be evicted and wind up on the street.

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

Housing is the foundation that recovery programs (if chosen by the clients) can build upon. Patterson et al. (2008) found that providing housing with supports, without requiring clients to actively engage in treatment services, is very effective, and that British Columbia would benefit from more housing-first and low-barrier housing.

In April 2008, a telling report was published, calculating the annual public sector costs of housing and supporting adults with serious addiction and/or mental illness (SAMI) in British Columbia at $644 million in health, corrections, and social services (Patterson et al., 2008). On average, homeless persons with SAMI cost taxpayers $54,833 per year, while supported housing costs an average of $36,848 annually—a savings of $17,985. Overall, the study estimates that after removing what the Province is paying for health care, jail, and shelters, and by spreading the capital costs out over several years, taxpayers could ultimately stand to save nearly $33 million annually by providing supported housing for all homeless persons in British Columbia with serious addiction and/or mental illness.

5.3 Recommendations

1. That community efforts, building on the work undertaken and progress achieved in FVRD communities over the past five years, be focused on establishing a more coherent and more comprehensive intervention to implement housing and care, based on the housing-first and no-barrier/low-barrier approach.

The aim of this should be to provide housing with supports, inclusive of assertive community treatment (ACT) teams, to homeless persons in FVRD communities who live with mental illness and/or addiction to substance use.

2. That the Province continue to work with FVRD communities to address ongoing homelessness challenges.

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APPENDIX – HOMELESSNESS COUNT QUESTIONNAIRE

Interviewer Profile

Name
Municipality
Name of shelter

2011 Fraser Valley Regional Homelessness Count

Mennonite Central Committee British Columbia

Fraser Valley Regional District

Shelter Survey

SCREENING

1. **Will you be sleeping in a shelter tonight?**
   - ○ yes
   - ○ no **[END]**
2. **Have you already completed a shelter survey tonight?**
   - ○ yes **[END]**
   - ○ no
3. **Do you have a place you pay rent for?**
   - ○ yes **[END]**
   - ○ no

START SURVEY

1. **How long have you been without a place of your own?**

   _____ _____ _____ _____
   # Days # Weeks #Months #Years

   ○ no answer

2. **How many nights, including tonight, have you stayed at this shelter in the past 12 months?**

   _____

   ○ no answer

3. **How long have you lived in this city?**

   _____ _____ _____ _____
   # Days # Weeks #Months #Years

   ○ no answer

4. **Where did you come from?** *(municipality)*

   _____

   ○ no answer

5. **What brought you to this city?**

   _____

   ○ no answer

6. **What do you think is keeping you from finding a place?** *check all that apply*
   - ○ income too low
   - ○ no income / not receiving income assistance
   - ○ rents too high
   - ○ family breakdown / abuse / conflict
   - ○ evicted
   - ○ health or disability issues
   - ○ mental health issues
   - ○ addiction
   - ○ criminal history
   - ○ poor housing conditions
   - ○ other (specify)_____
   - ○ no answer
7. **How old are you?**
   - ○ 25 and over Age: _____ [go to 8]
   - ○ under 25 Age: _____
   - ○ no answer

   If under 25, have you been affected by a change or withdrawal of youth services?
   - ○ yes What age did this happen? _____
   - ○ no
   - ○ don't know
8. **What services have you used in the past 12 months?** *check all that apply*
   - ○ ambulance
   - ○ emergency room
   - ○ hospital (non emergency)
   - ○ dental clinic or dentist
   - ○ mental health services
   - ○ addiction services
   - ○ employment/job help
   - ○ parole or services for ex-offenders
   - ○ drop-in
   - ○ food banks
   - ○ meal programs/soup kitchens
   - ○ health clinic
   - ○ newcomer services
   - ○ transitional housing
   - ○ housing help/ eviction prevention
   - ○ outreach
   - ○ legal
   - ○ budgeting/trusteeship
   - ○ other (specify) _____
   - ○ none
   - ○ no answer

Page One—continued, please turn over...

Interviewer Profile

Name
Municipality
Name of shelte

2011 Fraser Valley Regional Homelessness Count

Mennonite Central Committee British Columbia

Fraser Valley Regional District

Shelter Survey

9. **Are there any services that you have refused in the past 12 months?**
   - O yes Why? _____
   - O no
   - O no answer

10. **Gender OBSERVATION ONLY - DO NOT ASK**
   - O male
   - O female
   - O transgendered
   - O unknown

11. **Is there anybody with you today?**
   - O no [go to 12]
   - O yes Who?:
     - O with partner/spouse
     - O with child(ren) age(s)
     - O with friends
     - O with pet
     - O with relatives
     - O other (specify) _____
     - O no answer

12. **What ethnic or cultural group do you identify yourself with?** (*PROMPT: French, English, Salish, Metis, Chinese, African, Mexican, etc.*)

_____

O no answer

13. **Do you consider yourself to be an Aboriginal person?**
   - O yes [go to 16]
   - O no
   - O no answer

14. **Are you a newcomer to Canada?** *(PROMPT: immigrant or refugee)*
   - O yes
   - O no [go to 16]
   - O no answer

15. **Do you need services in a language other than English?**
   - O yes _____(language)
   - O no
   - O no answer

16. **Where do you get your money from?**
check all that apply
   - O welfare/income assistance
   - O disability benefit
   - O employment insurance
   - O old age security/guaranteed income supplement
   - O employment full-time
   - O employment part-time
   - O panhandling
   - O binning/bottle collecting
   - O money from family/friends
   - O other (specify)
   - O no income
   - O no answer

17. **Do you have the following health problems?**

	yes	no	
medical condition	O	O	O
physical disability	O	O	O
addiction	O	O	O
mental illness	O	O	O

O no answer

18. **When was the last time you had a good meal?**
(PROMPT: #days, #weeks, #months, #years)

_____

O no answer

19. **What one thing would help end your homelessness?**

_____

O no answer

P1072

Interviewer Profile

Name
Municipality

2011 Fraser Valley Regional Homelessness Count

Mennonite Central Committee British Columbia

Fraser Valley Regional District

UNSHELTERED SURVEY

OBSERVATION

1. **If person is asleep or incapable of completing survey but you believe the person is homeless, indicate:**

_____ age _____ gender _____ location

SCREENING

2. **Have you completed a survey today with someone wearing this yellow button?**
   - O yes [END]
   - O no
3. **Do you have a place you pay rent for?**
   - O yes [END]
   - O no
4. **Did you sleep in a shelter last night?**
   - O yes [END]
   - O no
5. **Were you released from an emergency department, hospital, detox centre or jail after midnight last night?**
   - O yes [END]
   - O no

START SURVEY

1. **Where did you stay last night?** *check only one*
   - O shelter [END]
   - O safe house [END]
   - O transition house [END]
   - O own place [END]
   - O friend or family's place
   - O sidewalk/street
   - O alley/laneway/loading dock
   - O park/woods/trail/riverbank area
   - O car/van/camper
   - O parking garage
   - O dumpster/bin
   - O abandoned building/squat building
   - O roof/entryway/staircase/fire escape
   - O bus depot
   - O transit shelter
   - O coffee/shop/internet cafe
   - O ATM foyer
   - O church steps or yard
   - O other (specify) _____
2. **How long have you been without a place of your own?**

   _____ #Days _____ #Weeks _____ #Months _____ #Years
   - O no answer
3. **What do you think is keeping you from finding a place?** *check all that apply*
   - O income too low
   - O no income / not receiving income assistance
   - O rents too high
   - O family breakdown / abuse / conflict
   - O evicted
   - O health or disability issues
   - O mental health issues
   - O addiction
   - O criminal history
   - O poor housing conditions
   - O other (specify) _____
   - O no answer
4. **What is the main reason you did not stay in a shelter last night?** *check only one*
   - O able to stay with a friend
   - O turned away - shelter was full
   - O turned away - not appropriate
   - O turned away - no reason
   - O didn't know about shelters
   - O can't get to shelter
   - O no shelter in the area
   - O dislike (why) _____
   - O other (specify) _____
   - O no answer
5. **How long have you lived in this city?**

   _____ # Days _____ # Weeks _____ #Months _____ #Years
   - O no answer
6. **Where did you come from?** (municipality)

   _____
   - O no answer
7. **What brought you to this city?**

   _____
   - O no answer

Page One—continued, please turn over...

DO NOT COPY

8. How old are you?

- ○ 25 or over — Age: _____ [go to 9]
- ○ under 25 — Age: _____
- ○ no answer

If under 25, have you been affected by a change or withdrawal of services?

- ○ yes — What age did this happen? _____
- ○ no
- ○ don't know

9. Gender OBSERVATION ONLY - DO NOT ASK

- ○ male
- ○ female
- ○ transgendered
- ○ unknown

10. Is there anybody with you today?

- ○ no [go to 11]
- ○ yes — Who?:
  - ○ with partner/spouse
  - ○ with child(ren) — age(s) _____
  - ○ with friends
  - ○ with pet
  - ○ with relatives
  - ○ other (specify) _____
- ○ no answer

11. What ethnic or cultural group do you identify yourself with? *(PROMPT: French, English, Salish, Metis, Chinese, African, Mexican, etc.)*

_____

- ○ no answer

12. Do you consider yourself to be an Aboriginal person?

- ○ yes [go to 15]
- ○ no
- ○ no answer

13. Are you a newcomer to Canada? *(PROMPT: immigrant or refugee)*

- ○ yes
- ○ no [go to 15]
- ○ no answer

14. Do you need services in a language other than English?

- ○ yes _____ (language)
- ○ no
- ○ no answer

15. Where do you get your money from? *check all that apply*

- ○ welfare/income assistance
- ○ disability benefit
- ○ employment insurance
- ○ old age security/guaranteed income supplement
- ○ employment full-time
- ○ employment part-time
- ○ panhandling
- ○ binning/bottle collecting
- ○ money from family/friends
- ○ other (specify) _____
- ○ no income
- ○ no answer

continued

16. Do you have the following health problems?

	yes	no	
medical condition	○	○	○
physical disability	○	○	○
addiction	○	○	○
mental illness	○	○	○

- ○ no answer

17. What services have you used in the past 12 months? *check all that apply*

- ○ ambulance
- ○ emergency room
- ○ hospital (non emergency)
- ○ dental clinic or dentist
- ○ mental health services
- ○ addiction services
- ○ employment/job help
- ○ parole or services for ex-offenders
- ○ drop-in
- ○ food banks
- ○ meal programs/soup kitchens
- ○ health clinic
- ○ newcomer services
- ○ transitional housing
- ○ housing help/ eviction prevention
- ○ outreach
- ○ legal
- ○ budgeting/trusteeship
- ○ other (specify) _____
- ○ none
- ○ no answer

18. Are there any services that you have refused in the past 12 months?

- ○ yes — Why? _____
- ○ no
- ○ no answer

19. When was the last time you had a good meal? *(PROMPT: #days, #weeks, #months, #years)*

_____

- ○ no answer

20. What one thing would help end your homelessness?

_____

- ○ no answer

21. Surveyor: Note Interview Location *(intersection or landmark)*

_____

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HOMELESS IN THE FRASER VALLEY

Report on the 2011 Fraser Valley Regional District Homelessness Survey

September 2011

Fraser Valley Regional District