Exploring Housing Solutions in Abbotsford:

Survey of Individuals with Housing Needs

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INTRODUCTION

The issue of homelessness has been widely identified as a national crisis in Canada, affecting communities—both urban and rural—across the country (Canadian Alliance to End Homelessness [CAEH], 2012; Gaetz, Donaldson, Richter & Gulliver, 2013; Layton, 2008). While it is nearly impossible to precisely determine the extent of the problem, most recently it is estimated that at least 200,000 Canadians experience homelessness each year (Gaetz et al., 2013; Mental Health Commission of Canada [MHCC], 2014). Further, a growing number of Canadians are considered to be at risk of homelessness due to inability to afford the cost of rent or mortgage, unstable or unreliable income, health and safety risks, or other living concerns that contribute to housing insecurity (Gaetz et al., 2013; Layton, 2008). As such, various levels of government have identified the need to respond to homelessness, as it represents a serious economic and public policy concern at the senior levels, as well as one of urban health and community planning and development at the regional and municipal level (Gaetz et al., 2013; MHCC, 2014).

However, beyond that, homelessness also represents a serious human rights and social justice concern. While individual circumstances—such as family conflict, physical and mental health concerns, and substance addiction—play a significant contributing role, homelessness is also largely the result of interplay between these individual circumstances and larger systemic and societal barriers, including the lack of adequate affordable and social housing, unemployment, poverty, inequality, and discrimination (Canadian Homelessness Research Network [CHRN], 2012; Gaetz et al., 2013; Keller et al., 2014; Layton, 2008; Pauly, Reist, Belle-Isle, & Schactman, 2013). In this regard, the challenges to developing strategies to address

the issue of homelessness are myriad; particularly as they are situated within the varying political and cultural contexts of the communities in which they exist (Keller et al., 2014).

Local Context

As municipalities across Canada attempt to develop plans to meaningfully respond to homelessness, in Abbotsford in particular it has been identified as one of the central issues affecting the community—alongside cost of living, employment opportunities, affordable housing, poverty, addiction, and other related concerns (Abbotsford Community Foundation, 2013). Various homelessness surveys have been conducted over the past number of years that have provided empirical data on homelessness in the region (see van Wyk & van Wyk, 2005; 2001; van Wyk, van Wyk, & Bullock, 2008), and most recently it was shown that at least 151 homeless individuals are currently living in Abbotsford (Fraser Valley Regional District [FVRD], 2014). In this regard, various local reports have identified the growing need for affordable and supportive housing as a key part of meaningfully addressing the issue in Abbotsford (City of Abbotsford, 2011a; van Wyk, van Wyk, McBride, Jonker, & Franklin, 2009; van Wyk & van Wyk, 2011). In response to this growing need for housing options, in February 2014 Abbotsford Community Services (ACS) submitted a rezoning application to construct a 20-bed low-barrier supportive housing facility for homeless men—a proposal that was widely viewed by service providers, advocates, and a large proportion of the community as being an important step to addressing the issue. However, the proposal was subsequently denied by Abbotsford City Council due to zoning restrictions, and as such the growing need to develop housing solutions to address the issue of homelessness in Abbotsford continues.

While Abbotsford has long been confronted with homelessness, the issue has particularly intensified recently following a number of other high-profile incidents that have raised concerns

around the treatment of homeless persons in the community. Most notably, in June 2013 the City of Abbotsford was responsible for spreading chicken manure on a longstanding homeless camp in an effort to deter homeless individuals from living there. This incident subsequently received national media attention, and—alongside other incidents—resulted in a civil claim and human rights complaint from advocates and members of the homeless community (most recently, see B.C./Yukon Association of Drug War Survivors v. Abbotsford (City), BCSC, 2014; Pivot Legal Society, 2013a). In addition, in May 2013 a longstanding anti-harm reduction zoning bylaw that restricted homeless and at-risk drug users from accessing harm reduction services was similarly challenged, and has since been amended to remove these restrictions (City of Abbotsford, 2014a; Pivot Legal Society, 2013b).

As a result of these recent developments within the local discourse around homelessness, the issue has indeed been largely reconfigured as one of human rights and social justice, and the growing need to address it has intensified. As such, in March 2014 Abbotsford City Council announced the formation of a *Homelessness Task Force* (City of Abbotsford, 2014b). The Task Force was specifically directed "to work closely with all levels of the community to design and initiate a comprehensive, community-wide homelessness response plan" (City of Abbotsford, 2014b).

HOUSING SOLUTIONS

Current efforts to respond to homelessness across Canada and the US have largely represented a shift in focus from crisis interventions—such as emergency housing and emergency health care services—, to developing and improving access to permanent stable housing for homeless and at-risk individuals (CAEH, 2012; Henwood, Cabassa, Craig, & Padgett, 2013; MHCC, 2014; Parsell & Marston, 2012; Stefancic & Tsemberis, 2007). In

alignment with this broader shift, the *Draft Action Plan* produced by the Abbotsford Homelessness Task Force similarly seeks to focus on permanent, preventative housing solutions (City of Abbotsford, 2014b). The central component of this broader prevention framework—one that has dominated the academic literature on housing interventions for homelessness—is known as *Housing First*.

Housing interventions have traditionally existed along a 'continuum', whereby individuals move along various stages of housing—from emergency shelter, to transitional housing, supportive housing, and eventually permanent independent living (Jost, Levitt, & Porcu, 2010; Kraus, Serge, & Goldberg, 2005; Tsemberis, Gulcur, & Nakae, 2004). This traditional housing continuum largely represents a 'treatment-first' approach; requiring that individuals graduate between the various stages of housing by engaging in treatment and demonstrating sobriety and stability, to eventually achieve 'housing readiness' (Jost et al, 2010; Kraus et al, 2005; MHCC, 2014; Stefancic & Tsemberis, 2007; Stergiopoulos et al, 2014). Housing First, however, is a newly emerging evidence-based approach that is becoming widely established across Canada and the US as a powerful alternative to the traditional housing continuum. Housing First seeks to provide immediate access to permanent stable housing, alongside wrap-around support and services to homeless and at-risk individuals—such as housing placement support, mental health and addictions treatment, counseling, and social support services—; essentially bypassing the traditional stages of the continuum (Jost et al, 2010; Kraus et al, 2005; MHCC 2014; Stefancic & Tsemberis, 2007; Stergiopoulos et al, 2014; Watson, Wagner, & Rivers, 2013). Housing First is unique, therefore, in that it provides housing to individuals regardless of mental illness or current patterns of substance use (MHCC, 2014; Pauly, Reist, Belle-Isle, & Schactman, 2013; Stefancic & Tsemberis, 2007; Stergiopoulos et al 2014; Watson

et al., 2013). In this regard, it is rooted in the principle that housing is an essential human right and an individual's primary need. From this perspective, it is maintained that once stable housing is provided, other concerns such as substance addiction, complex health problems, and mental illness can be more effectively addressed (Bean, Shafer, & Glennon, 2013; MHCC, 2014; Stergiopoulos et al, 2014; Watson et al, 2013).

Numerous studies have examined the effectiveness of Housing First programming in Canada and the US, and it has been overwhelmingly supported within the broader academic literature, demonstrating exceptionally positive outcomes in terms of client housing retention, access and utilization of services, client quality of life, and cost outcomes (Bean et al., 2013; Collins, Malone, & Clifasefi, 2013; Greenberg, Korb, Cronon, & Anderson, 2013; MHCC, 2014; Palepu et al., 2013; Polvere, Macnaughton, & Piat, 2013; Stefancic & Tsemberis, 2007; Stefancic et al., 2013; Stergiopoulos et al., 2014; Tsai, Mares, & Rosenheck, 2010; Tsemberis, Gulcur, & Nakae, 2004). Most significantly, these positive outcomes have been demonstrated to remain stable even for individuals with severe mental illness and co-occurring addictions—who make up the majority of chronically homeless individuals in Abbotsford (Van Wyk & Van Wyk, 2011)—, thereby directly challenging the traditional treatment-first model and its interpretation of what is means to be 'housing-ready' (Collins et al 2013; Kraus et al 2005; MHCC 2014; Palepu et al 2013; Stefancic & Tsemberis, 2007).

While Housing First has indeed been overwhelmingly supported within the broader literature, there exists significant variance in the implementation and structure of Housing First programming across communities (Greenberg et al 2013; Keller et al., 2014; Kraus et al 2005). In this regard, Housing First can be largely understood as a broader system of approach, within which there may exist customization and adaptation of specific programming at the local level

(Keller et al., 2014; MHCC, 2014). However, there are a number of fundamental components of Housing First that are central to achieving positive outcomes. In a broad sense, successful Housing First programming is guided by a client-centered approach, wherein a range of housing options and support services is provided to suit the individual needs of clients, providing consumer choice in housing and service participation, and recognizing that clients have varying degrees of need (Kraus et al., 2005; MHCC, 2014; Tsemberis et al., 2004; Watson et al., 2013).

Within this range of housing options and support, the importance of low-barrier admission and harm reduction options has been particularly highlighted (Collins et al., 2013; Kraus et al, 2005; MHCC, 2014; Pauly et al., 2013; Tsemberis et al., 2004; Watson et al., 2013). Low-barrier policies provide access to housing for individuals struggling with addiction and mental health-related concerns, without requiring participation in treatment (Collins et al., 2013; Kraus et al., 2005; Watson et al., 2013). In addition, harm reduction aims to reduce the adverse consequences associated with drug use—and may include the provision of clean syringes and other harm reduction supplies—, recognizing that clients may be at various stages of the recovery process (Kraus et al., 2005; Tsemberis et al., 2004; Watson et al., 2013). While low-barrier and harm reduction approaches are often labeled as controversial, they are supported by the argument that the circumstances of homelessness do not allow for an environment that is conducive to treatment and recovery (Stefancic & Tsemberis 2007; MHCC, 2014). Rather, housing is identified as a critical first-step in stabilizing substance use and facilitating treatment participation (Kraus et al., 2005; MHCC, 2014).

The need for implementing a Housing First approach has long been identified in Abbotsford (van Wyk, van Wyk, & Bullock, 2008; Van Wyk et al., 2009; van Wyk & van Wyk, 2011), and was highlighted as a key policy for responding to homelessness in the 2011

Affordable Housing Strategy (City of Abbotsford, 2011). However, in the absence of low-barrier and harm reduction housing options, alongside the general shortage of affordable housing to address homelessness and housing insecurity, Abbotsford has struggled to meaningfully implement this approach. However, most recently Abbotsford's Homelessness Task Force has outlined its intention to "Initiate a comprehensive community-wide 'Housing First' approach as a strategy for ending and preventing circumstances of chronic homelessness in Abbotsford" (City of Abbotsford, 2014b).

STUDY OBJECTIVES

This study is situated within the ongoing effort to develop affordable and supportive housing options in Abbotsford, particularly within the framework of Housing First. In this regard, this study is not focused on crisis interventions to homelessness, but rather on housing solutions. More specifically—provided the need to understand the dynamics of implementing Housing First at the local level (Keller et al., 2014)—, this study is intended to align with a client-centered approach to housing, and begin to identify what the range of housing options and wrap-around support in Abbotsford should look like. In this regard, the purpose of this study is not to enumerate or provide data on homelessness trends in the region—as various other regional homelessness surveys have done (van Wyk and van Wyk, 2011; 2005; van Wyk et al., 2008). Rather, it is to gain an understanding of what a housing solution looks like from the perspective of individuals most heavily impacted by inadequate housing and homelessness-related issues in the community.

This study specifically focuses on three different groups of individuals affected by housing insecurity; namely, those who are homeless, in unstable housing, or in supportive housing. This study is therefore also intended to gain an understanding of the challenges and

barriers individuals in these three groups face, and thereby help to more meaningfully contextualize the particular housing needs and preferences they identify. In providing the participants an opportunity to identify the services and housing features most important to them, and where progress can begin to be made in breaking down some of the barriers they face in finding and maintaining permanent stable housing, the intended outcome of this project is that the information be used by service provision agencies—including housing service providers—to help ensure that clients receive services that more meaningfully align with their needs.

METHODS

Structured interviews in the form of a survey were administered to individuals who identified their current housing situation as homeless, in unstable housing, or in supportive housing. Participants were recruited by an outreach campaign facilitated alongside a number of community agencies and service providers, of which many participants were clients or residents. The majority of surveys were conducted at weekly community dinners held by 5 and 2 Ministries at Jubilee Park in Abbotsford for homeless and at-risk individuals, whom they are connected with through their outreach and ministry. Eligible individuals taking part in the community dinners were informed by members of 5 and 2 Ministries of the survey, and invited by members of the research team to participate. Additionally, a number of surveys were administered to residents in supportive housing at the George Schmidt Centre, a second-stage housing facility for adult men operated by the Kinghaven and Peardonville House Society. Finally, a significant number of surveys were administered to clients of the Women's Resource Society of the Fraser Valley (WRSFV). These surveys were conducted at the Christine Lamb Residence, a second-stage affordable housing complex that provides a safe supportive place to live for women and children, as well as the Warm Zone, a drop-in facility for street engaged women.

Survey Process

Surveys were three pages in length, and contained a combination of multiple choice, fixed choice, and open-ended questions. Key questions that were asked related to concerns participants had about their current housing situation—including safety and security, affordability, cleanliness, discrimination and stigma—, the particular services they had used in the past 12 months, and the most significant barriers they face in finding permanent stable housing. Additionally, participants were asked to identify what type of housing they would most prefer, the particular housing features that are most important or desirable to them, and what services they would find most helpful in finding and maintaining permanent stable housing.

Surveys were conducted over a four-month period at the four locations—Jubilee Park, George Schmidt Centre, the Christine Lamb Residence, and the Warm Zone. Each survey was approximately 10-20 minutes in length, and prior to administering each survey participants were fully informed of the details of the project—including its purpose, procedure, and plans for dissemination of the findings—, and asked if they had any questions or concerns about the study. In addition to the multiple choice and fixed responses, room was provided for each question to record additional responses and thoughts provided by the participant. In this regard, this study utilized a somewhat mixed-methods design, as responses were recorded as fully as possible in order capture the various nuances and anecdotes provided by many of the participants in their responses. In this regard, based on the experiences and anecdotes shared, much of the research findings could be more meaningfully contextualized. Finally, participants received a $5.00 Tim Horton's card, and clients of the WRSFV received a $10.00 gift card for Save-On-Foods—as donated by the WRSFV—for taking the time to help with the project.

Profile of Participants

In total, 81 individuals participated in the survey: 37 homeless, 27 in unstable housing, and 17 in supportive housing. For the purposes of this study, homelessness was defined as having no fixed or secure residence where one can expect to maintain shelter or accommodation whenever they chose; unstable housing was defined as being uncertain if one can maintain their current housing situation because of the unaffordable cost of rent or mortgage, unstable or unreliable income, health and safety risk, or other living concerns; and supportive housing was defined as being a resident of a facility in which affordable, secure housing and residency is provided alongside services to individuals with housing needs. In terms of gender distribution, 52% of all participants were male and 46% were female (see Table 1). While there were no significant differences between the three groups in terms of gender distribution, when initially conducting surveys among homeless and unstable housing individuals at the Jubilee Park location there was significant overrepresentation of male respondents. As such, the support of the WRSFV was key, as the surveys conducted at the Christine Lamb Residence and the Warm Zone provided for greater female representation in the study.

The median age of all participants was 47. However, the proportion of respondents in each age category varied significantly across all three groups. The age distribution between the three groups within the 19-29 age category is particularly notable. Among the homeless group, 21.6% of respondents were between the ages of 19 and 29, compared to only 3.6% and 11.8% in the unstable housing and supportive housing groups respectively. While this finding is limited in terms of statistical significance provided the small sample sizes of the unstable housing and supportive housing groups, it is nonetheless striking that 8 (21.6%) of 37 homeless respondents were young adults between the ages 19 and 29. This observation aligns with the most recent

regional homelessness survey, which similarly highlights that youth homelessness, and in this case homelessness among young adults, is a continuing concern (FVRD, 2014).

Table 1

Profile of Participants

	Homeless (n = 37)		Unstable Housing (n = 27)		Supportive Housing (n = 17)	
	N	%	*N*	%	*N*	%
Gender						
Male	20	(54.1)	12	(44.4)	10	(58.8)
Female	17	(45.9)	13	(48.1)	7	(41.2)
Not Identified	0	(0.0)	2	(7.4)	0	(0.0)
Age						
19–29	8	(21.6)	1	(3.6)	2	(11.8)
30–39	8	(21.6)	5	(17.9)	5	(29.4)
40–49	8	(21.6)	7	(25.0)	6	(35.3)
50–59	8	(21.6)	12	(42.9)	1	(5.9)
60–69	4	(10.8)	2	(7.1)	3	(17.7)
Not Identified	1	(2.7)				
Living Location					(Previous Locations)	
On the Street/Outside	22	(59.5)	0	(0.0)	3	(17.6)
Rent/Own Place	0	(0.0)	19	(70.4)	5	(29.4)
Emergency Shelter	3	(8.1)	0	(0.0)	2	(11.8)
Transition House	5	(13.5)	1	(3.7)	2	(11.8)
Squatting/Abandoned Place	1	(2.7)	0	(0.0)	0	(0.0)
With Friends	0	(0.0)	5	(18.5)	3	(17.7)
With Family	0	(0.0)	2	(7.4)	4	(23.5)
Couch Surfing	6	(16.2)	0	(0.0)	0	(0.0)
In the Hospital	0	(0.0)	0	(0.0)	1	(5.9)

Note. Participants in the supportive housing group were asked to identify where they were living immediately prior to their residence in a supportive housing facility.

Participants in the homeless and unstable housing groups were also asked to identify the location where they were currently living, and participants in supportive housing were asked to identify where they were living prior to their residence at a supportive housing facility. The

majority (69.5%) of homeless respondents indicated that they were living outside or on the street; while the majority (70.4%) of those living in unstable housing indicated that they rented their own place. Among the supportive housing group, seven (41.2%) of the participants were residents of the Christine Lamb Residence operated by the WRSFV, and ten (58.8%) were residents of the George Schmidt Centre. When asked where they stayed prior to these residencies, responses varied from having owned or rented their own place, living with family and friends, living on the street, at emergency shelter, transition house, in their car, and in the hospital. Some respondents identified two previous locations that they had stayed prior to their residence in supportive housing, as they felt that these locations similarly represented their previous housing situation. For instance, one respondent identified both living on the street and in an emergency shelter in the time immediately prior to having obtained supportive housing.

In relation to the service use of participants (see Table 2), on average between the three groups community meals were frequented most often—likely attributed to the fact that a large majority of the surveys were completed at the Jubilee Park location during the weekly community dinners held by 5 and 2 Ministries. The second most frequented service was the Food Bank, as 64% of all respondents indicated that they had used the Food Bank in the past 12 months. However, there is significant variance in usage of services between the three different groups. Drop-in services were frequented by homeless and unstable housing participants at much higher rates than those in supportive housing, and, unsurprisingly, homeless participants frequented the emergency shelter most often in the past 12 months. On the other hand, supportive housing participants indicated significantly higher usage of addiction services, at 64.7%, compared to 18.9% and 22.2% in the homeless and unstable housing groups respectively; as well as the dental clinic, at 58.8%, compared to 8.1% and 22.2 %.

Table 2

Service Use in the Past 12 Months

	Homeless (n = 37)		Unstable Housing (n = 27)		Supportive Housing (n = 17)	
	N	%	*N*	%	*N*	%
Services						
Community Meal	24	(64.9)	25	(92.6)	4	(23.5)
Food Bank	20	(54.1)	18	(66.6)	14	(82.4)
Health Clinic	13	(35.1)	18	(66.6)	15	(88.2)
Drop-in Services	23	(62.2)	15	(55.6)	5	(29.4)
Emergency Shelter	21	(56.7)	7	(25.9)	4	(23.5)
Employment Services	12	(32.4)	10	(37.0)	8	(47.1)
Mental Health Services	10	(27.0)	11	(40.7)	8	(47.1)
Emergency Room	10	(27.0)	11	(40.7)	4	(23.5)
Addiction Services	7	(18.9)	6	(22.2)	11	(64.7)
Dental Clinic	3	(8.1)	6	(22.2)	10	(58.8)
Ambulance	8	(21.6)	8	(29.6)	1	(5.9)
No Services	2	(5.4)	0	(0.0)	0	(0.0)
No Response	2	(5.4)	0	(0.0)	0	(0.0)

Ethical Considerations

In accordance with the principles maintained in the Human Research Ethics Policy at the University of the Fraser Valley and the Tri-Council Policy Statement on research ethics involving human subjects, this project required significant ethical consideration. First, participants largely represent a vulnerable population who may struggle with various disadvantages, including mental illness, disability, and substance addiction. Further, the survey contained questions relating to the participants housing situation, safety and security, and concerns and barriers, to which responses may relate to sensitive or challenging issues. As such, maintaining the participants' dignity throughout the process of administering the survey was a central concern for the research team. In addition, participants were required to be fully capable of understanding the nature of the survey and be able to provide informed consent. Finally, many

participants may have been receiving services from the agencies at the various research locations, and therefore ensuring that their involvement in this research project would not affect their ability to obtain services was also a key consideration.

In light of these considerations, the research team maintained the following principles throughout the surveying process: (1) surveys were administered only to individuals older than 18 years of age; (2) prior to each survey, participants were fully informed about the nature of the project and asked to provide verbal consent; (3) individuals who displayed apparent signs of mental health impairment or intoxication that would impede their ability to understand and complete the survey would be excluded from participating; (4) participants were reminded that their participation was fully voluntary, and that they would be able to skip any question they were uncomfortable with, or withdraw from the survey at anytime; and (5) the research team did not ask for identifiable information, and responses were kept fully anonymous.

Provided these considerations and principles, and following a standardized ethical review process, the ethics procedure of this research project was approved by the Human Research Ethics Board at the University of the Fraser Valley.

FINDINGS

Participant Concerns

While this study is primarily focused on identifying the housing needs and preferences of participants, it is also important to gain an understanding of the challenges and concerns that are associated with homelessness and housing insecurity, in order to contextualize those needs. Table 3 presents the various concerns identified by participants in the homeless and unstable housing groups. For those participants in supportive housing, this portion of the survey was left open-ended, rather than fixed-response, largely due to the fact that the experiences of individuals

in supportive housing represented a stark contrast in relation to many of the concerns identified by those in the homeless and unstable housing group. This was particularly true in relation to safety and security, cleanliness, the lack of proper facilities, and stigma and discrimination, as positive experiences around these concerns strongly correlated with the quality of housing services they received. In this regard, the concerns that were identified by participants in supportive housing were in large part more nuanced than those of the other two groups, and therefore also less helpful to quantify by way of a table.

Table 3

Respondent Concerns & Challenges—Homeless & Unstable Housing Groups

	Homeless (n = 37)		Unstable Housing (n = 27)	
	N	(%)	*N*	(%)
Safety & Security				
Absolutely Safe	9	(24.3)	7	(25.9)
Somewhat Safe	11	(29.7)	7	(25.9)
Somewhat Unsafe	5	(13.5)	8	(29.6)
Absolutely Unsafe	11	(29.7)	5	(18.5)
Affordability	8	(21.6)	16	(59.3)
Discrimination/Stigma	15	(40.5)	7	(25.9)
Inconsistent/Non-Permanent	13	(35.1)	9	(33.3)
Lack of Proper Facilities	13	(35.1)	8	(29.6)
Cleanliness/Health & Safety	10	(27.0)	8	(29.6)
No Response	4	(10.8)	2	(7.4)
Other	10	(27.0)	6	(22.2)

Safety & Security: Participants were first asked to identify how felt about the safety and security of the place where they were currently staying. Nearly one-third (29.7%) of homeless participants, and 18.5% of those in unstable housing indicated that they felt absolutely unsafe in their current housing situation. However, when examining the responses in relation to safety and security of those participants who lived on the street/outside, the proportion of those participants

who felt absolutely unsafe rises dramatically to 45.5%. Primary concerns around safety and security for both the homeless and unstable housing groups related to theft and vandalism. Further, among the unstable housing group, a reoccurring theme that arose related to the general lack of safety and security of low-income/affordable housing. One participant in unstable housing indicated that there had recently been a stabbing in the hallway in their apartment, and similarly another commented that, "the ambulance is not allowed to attend to my diabetic brother without a police escort". In contrast, all of the supportive housing participants indicated that they felt *absolutely safe* in their current housing situation—again, representing a stark contrast in comparison with the experiences of those in the homeless or unstable housing groups.

Affordability was the most commonly identified concern for participants in unstable housing, at 59.3%. Participants repeatedly highlighted the need to live with others in order share the cost of rent; as one participant described, "You can't afford to live on your own while on income assistance". Also, a number of participants reported difficulty affording rent upon separation from their partner. In this regard, the need to share the cost of rent with a roommate or partner represents its own challenges in relation to living with others. Some participants indicated that they were "trying to get clean" while their roommate uses drugs—specifically highlighting the difficulty this represents in maintaining their own sobriety. Further, participants expressed concerns about their roommate's level of honesty and trustworthiness, and ability to cover their share of the rent. Herein the need to live with others is a key component of the challenges associated with the lack of affordable housing for those in the unstable housing group. Indeed, for many individuals who are at-risk of homelessness a common theme that was raised repeatedly throughout the study was that, on the one hand, rent is unaffordable while on income

assistance, but on the other hand, living with others may represent a barrier to recovery and contribute to further insecurity.

Among homeless participants, discrimination and lack of respect for dignity was the most commonly identified concern, at 41%. The primary challenges in relation to stigma and discrimination identified by homeless participants related to verbal abuse, as it was reported that people from "outside the camps" would often make walk-by comments, and "throw stuff" at homeless individuals. One participant also indicated that he felt serious anxiety about using public transit due to concerns related to stigma. Further, participants expressed concerns regarding the treatment of homeless and vulnerable individuals at services and welfare; according to a homeless participant, "The people at welfare get treated like crap". A number of participants also expressed concerns regarding difficult landlords; specifically, having their rent suddenly increase without warning, or being wrongfully evicted. Finally, a significant number of participants expressed concerns related to recent occurrences that have dominated the media around the treatment of the homeless population by the City of Abbotsford—as was earlier highlighted.

Additional concerns identified related to cleanliness, including the lack of proper facilities. Homeless participants reported excessive amounts of garbage and rats; while participants in unstable housing expressed concerns related to bed bugs, rotting sinks, asbestos, mold, and water damage. A common theme that arose around cleanliness and the lack of proper facilities again related to the nature and quality of low-income/affordable housing. As one respondent in unstable housing reported, "low-income housing is generally not safe or clean", arguing that "landlords don't keep up with the places". Participants also expressed concerns related to the unreliable or non-permanent nature of their current housing situation, particularly

in eventually having to leave their friends or family members' place, the transition house, shelter, or—for those individuals in supportive housing—the residence they are staying at. In relation to the insecurity of not knowing where to go next, one respondent commented, "I don't want to leave here, but I have no choice".

While the responses of participants in supportive housing were for the most part overwhelming positive in relation to their current residence, a number of challenges and concerns were identified. The most commonly identified concern was the lack of transportation or transit, particularly in relation to the need to access services and attend medical appointments. This was a key concern particularly for residents of the George Schmidt Centre location, which is not in close proximity to many of the services in Abbotsford or local transit routes. In this regard, one respondent in supportive housing commented, "I would like to access more services but have no ride. I would like to go to Labour Unlimited but can't get there". Additional concerns identified by respondents in supportive housing similarly related to the non-permanent nature of the residence.

Additional Challenges & Barriers to Housing

Homeless and at-risk individuals are also often faced with a number of barriers and challenges to obtaining permanent stable housing; related to both personal circumstances, as well as broader systemic or structural disadvantages (CHRN, 2012; Gaetz et al., 2013). In this regard, participants were asked to identify what they found to be the most significant barriers to findings and maintaining permanent stable housing in order to further contextualize the needs and preferences identified by participants in subsequent sections of the report, as well as help identify where progress can be made to begin breaking down some of these barriers. The various challenges and barriers identified by participants are outlined in Table 4.

Table 4

Participant Barriers to Housing

	Homeless (*n* = 37)		Unstable Housing (*n* = 27)		Supportive Housing (*n* = 17)	
	N	(%)	N	(%)	*N*	(%)
Lack of Affordability	25	(67.6)	24	(88.9)	12	(70.6)
Chronic Pain	20	(54.1)	14	(51.9)	9	(52.9)
Low Wages	20	(54.1)	15	(55.6)	7	(41.2)
Unemployment	18	(48.7)	8	(29.6)	9	(52.9)
Mental Health	14	(37.8)	13	(48.2)	6	(35.3)
Lack of Identification	17	(45.9)	13	(48.2)	1	(5.9)
Lack of Transportation	13	(35.1)	13	(48.2)	5	(29.4)
Unreliable Income	10	(27.0)	13	(48.2)	4	(23.5)
Addiction	16	(43.2)	6	(22.2)	3	(17.7)
No Telephone	14	(37.8)	4	(14.8)	6	(35.3)
Criminal Record	13	(35.1)	6	(22.2)	1	(5.9)
Disease	7	(18.9)	11	(40.7)	2	(11.8)
Lack of Employment Opportunities	11	(29.7)	6	(22.2)	2	(11.8)
Lack of Fixed Address/Mailbox	11	(29.7)	5	(18.5)	2	(11.8)
Discrimination/Stigma	7	(18.9)	9	(33.3)	1	(5.9)
Lack of Access to Physician	8	(21.6)	6	(22.2)	2	(11.8)
Lack of Education	4	(10.8)	4	(14.8)	4	(23.5)
No Response	1	(2.7)	0	(0.0)	0	(0.0)

The most commonly identified barrier across all three groups was the lack of affordable housing—67.6% of homeless individuals identified the lack of affordability, 88.9% of individuals in unstable housing, and 70.6% of those in supportive housing. Other significant barriers identified included chronic pain, low wages, unemployment, mental health concerns, addiction, criminal record, disease, and discrimination and stigma. In relation to mental health, participants most commonly reported struggling with depression, anxiety, posttraumatic stress disorder, and bipolar disorder. Among the various diseases identified, participants most commonly identified cancer, arthritis, lung disease, liver disease, and injection drug-related

diseases such as hepatitis C. In addition, a number of participants also seemed to highlight a theme related to a general lack of 'connectedness' that is largely inherent to being homeless and living on the streets. In this regard, 43% of homeless individuals surveyed identified the lack of personal identification as a significant barrier. Also, the lack of a telephone, Internet access, transportation, and fixed address or mailbox were all similarly identified as a significant barrier

The various barriers outlined in Table 4 do not represent isolated challenges, but were rather identified by participants as being largely interrelated. For instance, in relation to challenges pertaining to mental health, a number of participants felt that their struggle with anxiety and depression was largely the result of other individually identified barriers, such as chronic pain, addiction, disease, stigma and discrimination, and unemployment. Many of the barriers were also identified as directly resulting from the struggle of living on the streets or in unstable housing, including substance use and addiction, and drug-related diseases. Further, in relation to unemployment, one homeless participant remarked, "How can you look for a job when you're homeless? I went to work at the Work Center, and came home to half of my stuff stolen". In this regard, on the one hand, unemployment is identified as a barrier to housing, but on the other hand, not having secure housing to store one's belongings is a barrier to employment. Also, participants repeatedly expressed the challenges associated with finding work while struggling with chronic pain, mental illness, or addiction; as one participant described, "It's hard to find work with a disability", and another remarked, "Poor health leads to a lack of employment. No one will hire me". Further, the lack of identification, telephone, Internet, and mailbox—representing a broader lack of 'connectedness'—was also regarded as a barrier to employment.

Finally, discrimination and stigma again arose as a significant barrier, particularly within the homeless and unstable housing groups. Participants generally expressed that challenges around stigma and discrimination were associated with mental illness, criminal record, disability, substance addiction, and ethnicity—particularly for Aboriginal participants. It was indicated that this significantly affected their ability to access income assistance, find a place to rent, and obtain health care and service provision. In this way, stigma and discrimination is again identified as largely underlying many of the challenges and barriers that homeless and at-risk individuals face.

Housing Needs & Preferences

Among the central components of successful Housing First programming is the principle of highly individualized, consumer-driven and client-centered housing and service provision (Greenberg, Korb, Cronon, & Anderson, 2013; MHCC, 2014; Pauly et al., 2013; Stefancic & Tsemberis, 2007; Stefancic et al., 2013; Tsemberis et al., 2004). In this regard, this section is focused on outlining the needs and preferences of participants *from their perspective*; specifically in relation to preferred housing type, most important or desirable housing features, and service needs. Further, a number of important gaps in relation to existing housing services are also highlighted, as identified by those participants already in supportive housing.

Type of Housing: Homeless and unstable housing participants were asked to identify what type of housing they would most prefer—between private/own home, or single-site supportive housing (see Table 5). The majority of participants in these groups indicated that they would prefer private/own home—at 89.2% and 81.5% in the homeless and unstable housing groups respectively—, while 37.8% of homeless and 33.3% of those in unstable housing indicated that they would live in supportive housing. A number of participants selected both

options, as supportive housing was viewed as a means to get stable and independent—as one participant described, "to first address life concerns"—, and then eventually move into something more private/independent. Also, roughly the same proportion of participants in the homeless and unstable housing groups identified supportive housing as a preferred housing type, suggesting that many individuals who are at-risk of homelessness share a similar degree of need for wrap-around supports and services as those that are homeless.

Table 5

Participant Housing Needs & Preferences

	Homeless (n = 37)		Unstable Housing (n = 27)		Supportive Housing (n = 17)	
	N	(%)	*N*	(%)	*N*	(%)
Preferred Housing Type						
Private/Own Home	33	(89.2)	22	(81.5)	--	--
Supportive Housing	14	(37.8)	9	(33.3)	--	--
No Response	1	(2.7)	0	(0.0)	--	--
Important/Desirable Housing Features						
Showers	36	(97.3)	25	(92.6)	16	(94.1)
Laundry	33	(89.2)	24	(88.9)	15	(88.2)
Kitchen/Cooking Facilities	31	(83.8)	25	(92.6)	16	(94.1)
Permanent Address/Mailbox	28	(75.7)	24	(88.9)	13	(76.5)
Personal Storage	27	(73.0)	20	(74.1)	10	(58.8)
Telephone	26	(70.3)	21	(77.8)	12	(70.6)
Transit/Transportation Services	26	(70.3)	20	(74.1)	15	(88.2)
Co-ed	22	(59.5)	12	(44.4)	9	(52.9)
Computer/Internet Access	22	(59.5)	19	(70.4)	13	(76.5)
Pets Allowed	18	(48.6)	19	(70.4)	9	(52.9)
Tolerance of Drug Use	18	(48.6)	7	(25.9)	2	(11.8)
Security/Controlled Entrances	16	(43.2)	19	(70.4)	13	(76.5)
Overnight Guests/Visitors	16	(43.2)	11	(40.7)	12	(70.6)
On-Site Caretaker	10	(27.0)	9	(33.3)	9	(52.9)
Religious Room/Prayer Room	7	(18.9)	5	(18.5)	6	(35.3)
Provided Meals	7	(18.9)	7	(25.9)	6	(35.3)
24-Hour Front Desk	5	(13.5)	7	(25.9)	7	(41.2)

Housing Features: In relation to housing needs and preferences in terms of housing features, almost all participants selected the basics—showers, kitchen/cooking facilities, and laundry—as most important. While the proportion of positive responses in relation to each remaining feature was generally similar across all three groups of participants, responses in relation to one feature in particular varied significantly; namely, tolerance of drug use. Among homeless participants, 49% identified tolerance of drug use as an important housing feature, compared to 25.9% of participants in the unstable housing group, and just 11.8% of participants in supportive housing. Indeed, the supportive housing group showed much lower approval rates and even ambivalence toward 'tolerance', as these participants were concerned that it would threaten their own sobriety and recovery process. However, this response from the supportive housing group in relation to tolerance of drug-use is likely related to their residence at a housing facility with existing no-tolerance drug policies, and—for those residents of the George Schmidt Centre—criteria for participation in a personal recovery plan. On the other hand, the significant number of positive responses from the homeless group in relation to 'tolerance' aligns with the earlier finding that 43.2% of homeless individuals view their addiction as a significant barrier to housing (see Table 4).

Other notable housing features identified include co-ed housing, pets allowed, overnight guests and visitors, and having an on-site caretaker. Co-ed housing was identified as a particularly important need for some; as one participant in supportive housing described, "It is very difficult for couples to stay together and receive support". Additionally, responses in relation to these other features highlighted a more nuanced perspective in terms of the housing needs of individuals, wherein housing is identified as more than just a safe and secure place to live that contains basic amenities, but also important to restoring a sense of normalcy and dignity

as an integral part of improving an individuals overall quality of life. In this regard, one participant commented in relation to overnight guests and visitors, "I would like to be able to just have friends over for dinner". Also, the significant proportion of positive responses in relation to having pets allowed is highlighted—48.6% of homeless, 70.4% of those in unstable housing, and 52.9% of those in supportive housing. This may further align with the finding that private housing was overwhelmingly identified as the preferred housing type, providing a greater degree of independence.

Service Needs: In addition to housing, the provision of wrap-around support and services is an integral component of successful homelessness interventions (CAEH, 2012; Greenberg et al., 2013; Keller, et al., 2014; MHCC, 2014). However, as part of a larger client-centered approach, allowing client choice and self-determination regarding service participation has been identified as one of the key determinants for positive service outcomes (Kraus et al., 2005; MHCC, 2014; Watson et al., 2013). Watson et al. (2013) indicates that "allowing consumers to have choice of service participation was a powerful tool for facilitating positive change" (p. 175); including allowing clients to be responsible for their own decisions, facilitating normal community functioning, social integration, and increased independence and personal control, which are essential for meaningful recovery and treatment (Kraus et al., 2005; Stefancic & Tsemberis, 2007; Watson et al., 2013). Therefore, while the provision of housing to individuals should not be contingent on service participation within a Housing First model, ensuring that the supports and services are in place and readily available to individuals is key (Jost, Levitt, & Porcu, 2010; Palepu, et al., 2013). In this regard, participants were asked to identify what services they found to be most important to finding and maintaining permanent stable housing.

Table 6

Participant Service Needs

	Homeless (*n* = 37)		Unstable Housing (*n* = 27)		Supportive Housing (*n* = 17)	
	N	(%)	N	(%)	*N*	(%)
Employment Services	16	(43.2)	10	(37.0)	11	(64.7)
Counseling	14	(37.8)	15	(55.6)	8	(47.1)
Financial Services	17	(46.0)	11	(40.7)	7	(41.2)
Mental Health Services	13	(35.1)	12	(44.4)	7	(41.2)
Medical Services/Physician	10	(27.0)	6	(22.2)	11	(64.7)
Identification Assistance	15	(40.5)	7	(25.9)	1	(5.9)
Addictions Services	11	(29.7)	5	(18.5)	6	(35.3)
Learning Center	2	(5.4)	5	(18.5)	4	(23.5)
Harm Reduction/Needle Exchange	8	(21.6)	3	(11.1)	0	(0.0)
Transit/Transportation	1	(2.7)	0	(0.0)	8	(47.1)
Detox Services	5	(13.5)	3	(11.1)	0	(0.0)
Housing Listings	4	(10.8)	1	(3.7)	3	(17.7)

On average between the three groups, employment services and counseling were the most commonly identified services. In relation to employment, many participants indicated that were unable to work in a full-time capacity due to disabilities, mental health concerns, and addictions—the same challenges earlier identified as barriers to employment. In this regard, many participants highlighted the need for support in finding part-time employment that would be flexible enough to accommodate the various circumstances that may be associated with being impaired, such as regularly attending medical appointments, time for recovery, and potentially a need to work at a slower pace than their unimpaired colleagues. These circumstances were understood by a number of participants as also representing a significant challenge to potential employers.

The need for medical services was largely regarded by participants as self-evident—given the various challenges that were earlier identified in terms chronic pain, disease, mental

illness, and addiction. While the majority of participants indicated that they already maintained reasonable access to medical services via the various medical clinics and local hospital, a number of participants did express a need for finding a personal/family physician to receive more consistent and personable health-care service, rather than in an acute emergency medical service environment. In addition, counseling was a commonly identified service need—as one participant describes, "Counseling was critical in the road to recovery. Someone to get me through the maze". Other notable services included mental health and addiction services, as well as other services related to drug-use, such as harm reduction/needle exchange and detox services. Among responses related to harm reduction services, the proportion of responses across all three groups resembled those in relation tolerance of drug-use, as again the homeless group much more commonly expressed a need for addiction-related services. Specifically, many participants within the homeless and unstable housing groups largely regarded these as an acute medical service—as one participant described, "It saves lives".

Financial services were also identified as particularly important, as participants described the need to address concerns related to credit, debt, and taxes; to get reliable information regarding income assistance; and to do basic banking, such as setting up a bank account and obtaining a debit card. In this regard, the focus was not solely on acute services—such as medical, mental health, and addictions services—, but also on those related to everyday, routine activities and life skills. Indeed, one participant specifically identified the importance of "Skills to independence; sewing, art, money management, and budgeting". In this regard, another key concern that was identified in existing housing services related to the perceived lack of services and resources provided to non-crisis individuals. One participant in supportive housing reported, in relation to services provided at their residence, "there is a lack of services for people like me.

No addiction. No mental illness. I came from domestic violence … but resources are all going to people in crisis". Another participant similarly expressed dissatisfaction, commenting, "This place is such an opportunity … but there is no type of life skills offered. Any courses that are offered are not conducive to my work schedule. I'm missing out because I'm employed". Herein, the importance of individualized service provision is highlighted, and particularly the need to distinguish between clients in crisis with high needs, and those with moderate needs.

DISCUSSION

Overall, this study provides support for the central principles and components of Housing First. Specifically, the findings demonstrate a need for a client-centered approach in Abbotsford, including a range of housing options and support suited to the varying needs of clients. Further, the need for low-barrier and harm reduction housing options is key, as participants identified various challenges—such as addictions, mental illness, unemployment, disability, and discrimination—as representing significant barriers to finding and maintaining permanent stable housing. On the other hand, the need for drug-free supportive housing options is also highlighted, recognizing that clients may be at various stages of recovery. Similarly, the need for providing both supportive housing and independent living options is identified. In this regard, there are two key housing provision models commonly used within the framework of Housing First which are both supported in the broader literature; namely, single-site and scatter-site housing models (Collins et al., 2013; Kraus et al., 2005; Pauly et al., 2013; Stefancic & Tsemberis, 2007). Single-site models may be typically utilized for more challenging and chronically homeless clients (Greenberg et al, 2013; MHCC, 2014), whereas scatter-site housing models, which provide independent apartments in buildings rented from private landlords, may be preferable to less challenging clients who are more willing and capable to integrate within the

community (Pauly et al., 2013; Stefancic & Tsemberis, 2007). One model may be better suited for a particular client than the other, as some individuals may prefer the more independent nature of scatter-site housing, while others prefer the sense of community and peer support offered in single-site models (Kraus et al., 2005).

In this regard, this study also particularly highlights the need to distinguish between more challenging, chronically homeless and at-risk individuals with high needs, and those with moderate needs. Herein, two key types of support are commonly identified components of Housing First programming; namely, Intensive Case Management (ICM) and Assertive Community Treatment (ACT) (Kraus et al., 2005; MHCC, 2014; Palepu et al., 2013). ICM is a support service model for Housing First whereby each client is assigned one staff person who is their primary contact and responsible for addressing immediate and basic client needs, and connecting clients with existing services in the community (Kraus et al., 2005). ACT is a service delivery model involving an interdisciplinary team—from psychiatry, nursing, social, and other expertise such as substance use treatment—to provide services to clients 24 hours a day, 7 days a week (Palepu et al., 2013; Phillips et al., 2001). In this regard, ACT is provided as problems arise and support is needed, rather than from an office location (Phillips et al., 2001). In relation to these two service provision models, ICM may be provided to moderate-need clients, while ACT is provided to clients with more challenging needs (MHCC, 2014).

These recommendations, however, largely represent operational or organizational areas of improvement. However, many of the challenges and barriers that homeless and at-risk individuals face as identified by participants was attributed to stigma and discrimination, and the ongoing marginalization of vulnerable individuals affected by homelessness and housing insecurity. In this regard, a more fundamental conceptual shift around the treatment of vulnerable

members of the community struggling with mental illness, addiction, disability, unemployment, and poverty, is needed in order to meaningfully carry out client-centered housing programming. In this regard, while chronic addiction and behavioral challenges have traditionally been dealt with through criminalization, Housing First indeed represents a shift in focus to treatment (Greenberg et al., 2013). However, support must be gained at the community level through education and awareness (Kraus et al, 2005; City of Abbotsford, 2014).

CONCLUSION

In alignment with the broader shift away from emergency and crisis interventions for responding to homelessness and housing insecurity, the focus in addressing homelessness in Abbotsford should similarly be on permanent sustainable solutions. In this regard, developing and improving access to housing—particularly within the framework of Housing First—has been overwhelmingly identified within the broader literature as essential part of a meaningful response. However, the various challenges and barriers that homeless and at-risk individuals face, such as mental illness, substance addiction, disability, unemployment, and poverty—which are all largely interrelated—contribute to the exceedingly complex nature of the issue. In this regard, responses cannot be singular but must rather be part of a more holistic approach, identifying the various structural and personal challenges that largely underlie the issue. This calls for ongoing community-academic partnerships, including cooperation and interaction with consumers or potential consumers and clients of housing services, to further identify their needs, and to begin to break down the barriers to obtaining permanent stable housing—as indeed everyone should be entitled to a safe and secure place to live.

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