Housing and Harm Reduction:

A Policy Framework for Greater Victoria

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University of Victoria | Centre for Addictions Research of BC

This policy framework was requested by the Greater Victoria Coalition to End Homelessness to guide its work in implementing a *housing first* strategy and the necessary supports. The Coalition required a relevant and realistic regional harm reduction action plan to complement the Coalition's housing and prevention plans that takes into account existing strategies, responds to real needs in the community and is based on the evidence for best practices.The recommendations and views expressed in this report are those of the authors and do not necessarily reflect the position of the Coalition.

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Background

Homelessness is a sad fact in most cities in North America. In 2007, it was estimated that there were about 1,200 homeless people living in Greater Victoria (Victoria Cool Aid Society, 2007). Approximately 41% of those surveyed identified problems with alcohol and drug use as contributing factors to their current housing situation. Between 2008 and 2010, the High Risk Populations Study from the BC Alcohol and Other Drug Monitoring Project found that approximately 50% of adults who participated in the study and inject drugs were homeless as defined by living outside, in shelters or having no fixed address, and approximately 30% of youth interviewed identified as homeless (CARBC, 2010a). While there is continuing injection drug use, increased rates of crack use have been found among those who use injection drugs (VIHA, 2010). Approximately 23% of those who use injection drugs in the 2009 I-track survey were also homeless at the time of the survey. Although there are differences in sampling, this percentage is increased from previous I-track studies. Further, concerns related to housing and substance use were identified by VIHA in 2000 in a study of injection drug use in Victoria (Stajduhar, Poffenroth & Wong, 2000).

While substance use and increased rates of problematic substance use have been documented among those who are homeless, the increasing number of homeless people is a result of societal changes and years of social policy shifts that have limited the growth and, in some cases, reduced housing supply and available income for vulnerable men, women and youth (Shapcott, 2009). The traditional linear approach to services, where people "progress through a series of congregate living arrangements with varying levels of on-site support before graduating to independent living arrangements" (Gulcur, Stefancic & Shinn, 2003, p. 172), is characterized by frequent moves and barriers to service, and is not meeting the needs of those requiring supports (Mayor's Task Force, 2007a).

A key recommendation of the City of Victoria Mayor's Task Force to End Homelessness was that ending homelessness will require a fundamentally different approach in the way homeless people are served and assisted. In particular, the Mayor's Task Force Expert Panel commended a series of leading practices that included the following (Mayor's Task Force, 2007b, p. 14-15).

- **Client-centred approach.** Services to homeless residents with mental illness and addictions are most effectively delivered in a context of services adapted to client needs—rather than organized around efficiencies or expertise in service delivery—and requires a client-centered approach, low barrier programs and a policy of harm reduction.
- **Low barrier programs.** Programs that do not require clients to be abstinent or in treatment for mental illness have been shown to be more likely to attract clients, motivate them to begin making changes, retain them in treatment, and minimize attrition and drop-out rates.
- **Harm reduction.** The reduction of risks and harmful effects associated with substance use and addictive behaviours not only assists the affected person, but has a positive impact on urban neighbourhoods where street-level substance use problems are concentrated. Examples of harm reduction programming include needle exchange services, substitution therapy, safe consumption sites, and law enforcement practices that attach a priority to enforcement of laws against trafficking while adopting a more a cautious approach toward drug use.
- **'Housing First'.** An approach to housing where homeless residents are provided immediate access to a place of their own without requiring treatment or sobriety as a precondition for housing. Residents are supported with treatment options for their recovery and integration into the community.
- **Emphasis on choice.** Client-centred strategies that cater to various subpopulations, each with its own unique needs and challenges, demonstrate higher success rates for recovery and community integration. A "one-size-fits-all" approach has proven to be unsuccessful.

Formed as a response to the work of the Mayor's Task Force, the Greater Victoria Coalition to End Homelessness was established in 2008 as a non-profit community-based organization that engages community organizations, governments, business and individuals to work in partnership with each other and the broader community to lead and drive the commitment to end homelessness. The Coalition has endorsed a *housing first* strategy which is a harm reduction approach to housing, and is committed to implementing it with the necessary supports. Both the Mayor's Task Force and, subsequently, the Greater Victoria Coalition to End Homelessness recognized harm reduction as an essential component of a response to end homelessness that seeks to house and provide appropriate supports for individuals experiencing homelessness.

In order to move forward with its work, the Coalition requested that the Centre for Addictions Research of BC (CARBC, University of Victoria) lead a process to develop a regional housing and harm reduction policy framework that takes into account existing strategies, responds to real needs in the community, and is based on the evidence for best practice.

The central premise of this framework is that access to appropriate housing is a fundamental need and a human right, and therefore, a range of low barrier housing options should be available to meet the diverse needs of the individuals and families needing homes in Greater Victoria. It is recognized that respecting and acting on this right will require critical attention to certain assumptions and changes to the structures and systems currently in place. In this document, we outline key concepts and then provide *eight priority areas for action* to guide the work of the Coalition.

Key Concepts

Substance Use and Homelessness

There is no society on earth that does not in some way celebrate, depend on, profit from, enjoy and also suffer from the use of psychoactive substances. Psychoactive substances include those chemical substances that alter consciousness, mood, perception and behaviour. Caffeine in coffee, tea and other products is an example of psychoactive substances that are widely regulated and consumed. The last century saw an upsurge in the cultivation, manufacture and trade of psychoactive substances, some quite ancient and others new. Some have been developed from pharmaceutical products made initially for treating pain, sleep or mental health problems (e.g., heroin, barbiturates and benzodiazepines). Others have been manufactured for recreational purposes (e.g., ecstasy). Still others, notably cannabis, are made from plants or seeds that have been cultivated and traded to new and much larger markets.

In general, people take psychoactive drugs for a variety of reasons:

- **To feel good.** Most psychoactive substances produce feelings of pleasure. Sometimes, particularly with stimulants, this is accompanied by feelings of power, self-confidence and increased energy. In contrast, depressants tend to provide feelings of relaxation and satisfaction.
- **To feel better.** Many people who suffer from social anxiety or stress may use drugs to "take the edge off" and feel more comfortable. Some people who have experienced trauma (particularly when young) or who suffer from depression may use drugs to lessen intense feelings of distress.
- **To do better.** The increasing pressure to improve performance leads many people to use chemicals to "get going" or "keep going" or "make it to the next level."
- **Curiosity or social interaction.** As social creatures, we are strongly influenced by the behaviour of those around us, and substance use can be seen as a way to build connections with others. Additionally, some people naturally have a higher need for novelty and a higher tolerance for risk which can promote substance use.

Psychoactive drugs target the brain's system that regulates movement, emotion, cognition, motivation and feelings of pleasure. Our brains are wired to associate life-sustaining activities with pleasure or reward. When people use drugs to achieve what they perceive as positive effects, they are manipulating this reward system in the brain.

Psychoactive substance use involves risk. But when used with care, many psychoactive substances can be beneficial. That is, the positive impact may outweigh the risks involved. Substance use can be regarded as ranging along a continuum from mainly low-risk and sometimes beneficial use to clearly harmful use (Health Officers Council of British Columbia, 2005). The reasons a person uses a drug powerfully influences the pattern of use and the risk of harmful consequences. If the motive is fleeting (e.g., curiosity), then only occasional or experimental use may follow. If the motive is strong and enduring (e.g., a chronic mental health problem), then more long-lasting and intense substance use may follow. Experience of adverse life events, such as physical, sexual or emotional abuse, may impact a person's physical or mental health as well as contribute directly to risky substance use patterns.

Substance use patterns are important in understanding the complex relationship between substance use, mental health and homelessness. Homelessness has been associated with poor mental health and problematic substance use. However, the pathways between homelessness, mental illness and substance use are not linear with one always preceding the other. Factors related to income, employment, affordable housing, mental health policies and broad social determinants are key in the development and increasing rates of homelessness among certain people and groups (Canadian Institute of Health Information, 2007; Shapcott, 2009).

Homelessness can compromise a person's mental health and contribute to initiation or worsening of problematic substance use (Frankish, Hwang & Quantz, 2005). Heavy use of alcohol or other drugs may precede homelessness, and substance use may also worsen or be a response to coping with the difficulties of homelessness and adapting to the homeless condition (Johnson & Fendrich, 2007). Other risk factors that influence homelessness, mental health and substance use patterns include family breakdown, sexual or physical abuse, school exclusion, and low educational attainment (Neale, 2008). In light of these complex relationships, it does not make sense to assume the pathways out must always be the same – that stopping substance use must always precede getting a home. Creating such a barrier may in fact contribute not only to continued homelessness but also increased substance use and mental illness.

Housing is essential to good health and recovery from mental illness. Housing can play a role in managing addictions and problematic substance use. Some studies have found that substance use is decreased when stable housing is provided (Larimer, Malone, Garner et al., 2009; Podymow, Turnbull & Coyle, 2006). Stable housing is also important in preventing and reducing harms associated with HIV and Hepatitis C (Canadian AIDS Society, 2009; Corneil, Kuyper & Shoveller., 2006). Mental health is more than the absence of mental illness and is impacted by housing status. The Public Health Agency of Canada describes positive mental health as "the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity" (Public Health Agency of Canada, 2006). Social support (e.g., number of social relationships, frequency of contact, diversity of support received) is critical to positive mental health. Housing is a site through which relationships and social support as well as privacy is enacted. A lack of social support is associated with homelessness and a risk factor for mental illness or poor mental health among homeless people. Homelessness in turn disrupts social networks and leads to social exclusion (Canadian Institute of Health Information, 2007).

Harm Reduction

Harm reduction begins with the recognition that substance use has been part of human society for thousands of years. That is, humans—from ancient times to modern times—have been using psychoactive substances to aid them in their daily lives. Today, we have access to and use a wide range of substances as part of everyday life. For instance, many of us use caffeine to perk us up in the mornings, alcohol to wind down after work,

medications to help us sleep or relieve pain, and so on. There are harms and risks associated with all types of substance use.

Most of us can and do manage our substance use and associated risks without experiencing problems. For example, not driving when consuming alcohol or other drugs, or drinking within safe limits. But some of us—for a variety of individual, social and environmental reasons—have trouble managing our use of alcohol and other drugs and continue using them despite negative consequences. One theory is that substance use can be a strategy for coping with difficult life situations such as homelessness, trauma and abuse (Maté, 2008).

Usually, people who struggle with other health issues are given choices about the types of treatment they receive, if indeed they choose treatment, and are offered a wide range of services and supports. People who struggle with substance use deserve the same respect for choices, services and supports.

Harm reduction is *both* a philosophy and a set of strategies that applies to all substance use, not merely problematic substance use. As a philosophy, harm reduction seeks to minimize or eliminate adverse health, social and economic consequences of substance use for all individuals and communities. It respects the complexity of factors that bear on drug-related harm and the rights and responsibilities of the individual as an agent in making choices and managing change. It also recognizes a continuum of appropriate responses with a range of beneficial outcomes (Marlatt & Witkiewitz, 2009). As a set of strategies, harm reduction involves a pragmatic, multidisciplinary, non-judgmental approach that meets people where they are at right now. Some of the key outcomes include:

- imparting skills in self-care (and care for others),
- lowering personal risk,
- encouraging access to treatment,
- supporting reintegration,
- limiting the spread of disease,
- improving environments,
- cutting down on public expenses, and
- saving lives.

The focus of harm reduction is on prevention of the harms associated with drug use rather than eliminating use. An additional feature of harm reduction is that safer use, managed use and abstinence all have benefits not only for individuals but for families and communities as well. For example, refraining from driving after drinking, observing safe drinking guidelines, provision of safer crack kits, supervised injection and using new injection equipment to reduce the spread of blood-borne diseases promote the health and well-being of the whole community. Harm reduction can apply to other risk behaviours such as use of condoms, bicycle helmets and seat belts to reduce risk associated with certain behaviours.

Harm reduction is part of a public health framework to prevent, reduce and mitigate the harms of drug use for individuals and communities. Harm reduction encompasses much more than services such as needle exchange and supervised injection sites. Harm reduction programs vary, based on individual and group needs. The particular harm reduction strategies are specific to population needs and circumstances, and support choices about abstinence, safer use, or managed use. For example, some individuals may wish to be in environments free of drugs and alcohol while others would be better served by housing programs that provide small amounts of safe alcohol or tolerate drug and alcohol use as long as it does not disrupt others.

Harm reduction as a philosophy embraces key principles that are clearly aligned with the Coalition's core values and principles. The guiding principles of harm reduction as developed by the International Harm Reduction Association are identified in Table 1 and aligned with the Coalition's Values and Principles as outlined in the Coalition's Strategic Plan.

Table1: Alignment of Values and Principles

Harm Reduction Principles (IHRA, 2010)	Coalition's Strategic Plan Values and Principles
Targeting Risks and Harms	We are inclusive. We provide housing to all people facing homelessness and it is not contingent on abstinence or treatment.
Evidence based and Cost effective	We are effective: Base actions on evidence and best practices available. Innovation: Draw on evidence as to what works.
Incremental: Meeting people where they are at	People centered Accessible where people live and work Adaptable to individual needs
Dignity and Compassion	Respectful
Universality and interdependence of human rights	*Housing First* emphasizes rights to housing and client choice.
Challenging policies and practices that maximize harm	*Housing First* and Ending Homelessness
Transparency, Accountability and Participation	We are accountable to the community.
Wide range of stakeholders should be involved, including those who use drugs.	We engage partners, including target populations affected by homelessness. Community Engagement

The GVCEH, in both its strategic plan and business plan, has urged the need for implementation of harm reduction strategies as set out in the Mayor's Task Force. It is important to note that in 2005, the City of Victoria, in collaboration with the downtown service providers, recommended harm reduction as a key feature of their action plan on addressing issues associated with problematic substance use (City of Victoria, 2005). Housing was one of the four pillars of this plan, along with prevention, treatment and law enforcement. In both the City of Victoria Mayor's Task Force report and this earlier report on harm reduction, wet shelters and housing, as well as harm reduction services, were embraced as important harm reduction strategies. In 2009, City of Victoria Council endorsed harm reduction as a key principle and one of seven priority areas for action.

The British Columbia provincial government is a leader in Canada and has clear and consistent policies that support harm reduction at the municipal level (BC Ministry of Health, n.d.). The recently released BC Ministry of Health Services ten-year plan to address mental health and substance use in British Columbia clearly identifies the harms of substance use as one of four priorities for all British Columbians, and specifically calls for harm reduction as an appropriate approach (BC Ministry of Health Services, 2010). While harm reduction is relevant for all citizens to reduce harms associated with all types of substance use, the plan specially indicates the need to "where appropriate, expand the reach and range of harm reduction services that prevent and reduce the health, social and fiscal impacts of illegal drug use" for people vulnerable to mental health and substance use problems (p. 22). VIHA's strategic directions for reducing and preventing HIV and Hepatitis C strongly support the need for a harm reduction approach and services for general and at-risk populations (VIHA, 2006). Further, housing advocacy is integral to VIHA's strategic directions related to reducing and mitigating harms associated with HIV/Hepatitis C.

In spite of consistent support and endorsement of harm reduction as an appropriate response to addressing problematic substance use and homelessness, the community consultation[1] conducted for this report identified that there is still considerable misunderstanding of harm reduction, lack

[1] As part of this project, a half-day community consultation was held in the City of Victoria. This consultation was intended to obtain input from a range of stakeholders on the development of a housing and harm reduction strategy. A series of presentations on housing and harm reduction models, followed by small group discussions, was conducted in February 2010. Stakeholders who attended included health care managers and providers, business leaders, researchers, municipal and provincial policy makers, people affected by drug use, and non-profit health and housing service providers.

of implementation of recommended harm reduction strategies and inconsistent policies related to harm reduction. Further, comprehensive needle exchange, a major component of a community-wide harm reduction plan and integral to VIHA's strategic directions for prevention of HIV/Hepatitis C (VIHA, 2006), has been challenged with the closure of Victoria's only fixed site needle exchange in 2008. While the VIHA needle exchange advisory committee endorsed needle exchange as important to health and well-being, numerous obstacles to finding a location have prevented the establishment of a new site. During this time, there have been concerted efforts to increase needle distribution and recovery through enhanced mobile services and more secondary distribution that, while important, do not replace fixed site needle exchange services (MacNeil & Pauly, 2010). Mobile services have also faced restrictions in their ability to distribute in areas of highest need. Following the closure, the Ministry of Health initiated the development of a pharmacy distribution program as part of comprehensive needle exchange. In fall 2010, a local pharmacy, after considerable police pressure, ended its needle exchange service. Clearly, there are considerable challenges that need to be addressed. Although not as much the focus of public attention, obstacles related to distribution of safer crack kits have been encountered. The ongoing controversies related to needle exchange services indicate fears, stigma, lack of support, and understanding of harm reduction need to be addressed as part of a comprehensive public health and homelessness strategy that ensures access to appropriate and essential services to reduce health and safety concerns.

Housing First

When looking at how homelessness was being addressed in Greater Victoria, the Mayor's Task Force concluded that ending homelessness in the region would require a fundamentally different approach to the way homeless people were being served. They pointed to *housing first*.

Housing first is a harm reduction approach to breaking the cycle of mental illness, substance use and homelessness. It starts with helping homeless people where they are at the moment. *Housing first* prioritizes placing people in secure housing options that are appropriate to the individual or family circumstances and not contingent on sobriety or willingness to accept treatment. It seeks to foster a sense of home, self-determination and social inclusion. Once housed, client-centred supports can vary from a little support to assist an individual or family in stabilizing in their new housing, to ongoing assertive support to ensure that individuals or families remain housed. In other words, *housing first* separates treatment from housing, considering the former voluntary and the latter a fundamental need and human right (Padgett, Gulcur & Tsemberis, 2006, p. 75). *Housing first* emphasizes client choice and is based on the assumption that housing is central to recovery from homelessness.

Housing first was developed in direct contrast to other approaches that require treatment first and a series of housing transitions before obtaining permanent housing. There are a number of housing models that can be aligned with *housing first* principles. Housing may be provided in a single site model where most or all of the units are designed to provide housing for previously homeless people and services are provided onsite; a scattered site model where people access private market suites with rental subsidies and additional supports are coordinated by case managers or interdisciplinary teams such as assertive community treatment teams; or a hybrid model where single sites have a mix of supported and affordable housing. The most well-known *housing first* program, Pathways to Housing in New York, uses a scattered site model. In this model, clients are placed in living units available on the market (usually not more than 10% of the units in any single building) and have normal occupancy agreements. Supportive services aimed at helping clients maintain housing stability are provided independently from property management (though often a collaborative relationship exists). Other housing programs use a cluster or congregate model that concentrate housing units for clients in a single building or that involve communal living arrangements and on-site or proximal staff. The evidence for effectiveness of scattered site versus congregate models is limited and inconclusive. However, when given the choice, the majority of homeless people express a preference for independent housing, and those living in independent apartments report greater satisfaction. However, they can also

experience greater feelings of isolation if not supported in building meaningful social networks (Caton, Wilkins & Anderson, 2007).

Supportive housing models, even those sometimes designated as *housing first*, vary across a number of important dimensions (Caton et al., 2007). These dimensions are outlined below.

Housing First Versus Housing Readiness

Housing first is generally understood as an approach that places people directly into affordable housing without requiring that tenants be 'housing ready.' This is in contrast to the continuum of care model in which clients are expected to transition through a number of stages and types of housing to achieve 'housing readiness.' Housing readiness is often interpreted as being drug and alcohol free and agreeing to abstain from use of substances. *Housing first* stands in contrast to programs that require the client to demonstrate a high level of motivation to participate in treatment, several months of sobriety, basic living skills, and so forth. *Housing first* programs have achieved exemplary rates of housing stability for populations with high rates of severe mental illness and, in one study, severe alcoholism (Larimer et al., 2009; Stefanic & Tsemberis, 2007; Padgett et al., 2006; Greenwood, Schaefer-McDaniel, & Winkel, 2005; Tsemberis, Gulcur & Nakae, 2004; Gulcur et al., 2003; Kertesz, Crouch & Milby, 2009). Research has demonstrated that many individuals with severe mental illness and substance use problems can live independently in the community. Harm reduction is a key principle of *Housing first* as individuals are not expected to undergo treatment or be drug and alcohol free in order to obtain permanent housing.

Harbour House: Red Deer, Alberta

Harbour House was established as a *housing first* demonstration project of the Safe Harbour Society whose "mission is to welcome, shelter and support people with addictions, mental health, or housing needs." Harbour House is one of the Society's supported housing initiatives. Eight individuals who had been chronically homeless were identified and invited to move into Harbour House. The house offers 24-hour support staff, with specialized services. Residents are 'screened in' for services rather than 'screened out' and participation in programs is always voluntary. Staff develop relationships with the residents by emphasizing trust and respect, and by facilitating a home environment where residents participate in all household-related decisions. The house works within a harm reduction approach and emphasis is placed on improving health in whatever way possible. When the pilot project was first envisioned, organizers predicted that they would perhaps start seeing health improvements in the residents after three months of stay. They were amazed at seeing that even after just a few days, they could already see significant changes in the residents' alcohol and substance consumption and eating habits.

(K. Arnold, Program Coordinator, Safe Harbour Society, personal communication, 2008)

Low Barrier Versus High Barrier Housing

Low barrier or low demand approach to housing does not place any requirements on a tenant that are outside the normal conditions of tenancy: paying the rent, not destroying property, refraining from behaviour that would harm or greatly inconvenience others. Utilization of services and supports is encouraged but not mandatory. In the past, housing programs in a continuum of care model usually required participation in treatment as well as compliance with rules governing behaviour (e.g., curfews, visitation and abstinence). Housing programs vary as to the requirements that must be met as a condition of retaining housing. Low barrier housing requirements may range from no conditions except those of normal tenancy, to agreements to meet with a case manager once or twice monthly, or to participation in programs such as money management. Evidence suggests that engagement and retention increase when clients are able to actively participate in their own treatment decisions (Padgett et al., 2006). *Housing first* and harm reduction approaches have not been demonstrated to increase substance use despite the increased freedom. In fact, consumption of alcohol has been shown to decrease when people with chronic alcohol problems are provided with housing and permitted to drink indoors in a secure setting (Podymow et al., 2006; Larimer et

al., 2009). There is initial evidence that such models are cost effective in that health, policing and social services costs have been shown to decrease for individuals who are high users of these services. Neither is a *housing first* approach associated with any increase in psychiatric symptoms (Tsemberis et al., 2004).

Permanency of Housing

Numerous research studies have demonstrated the effectiveness of permanent supported housing in increasing housing stability and decreasing shelter use, incarceration, hospital stays, and visits to emergency departments (Caton et al., 2007). Permanent housing does not have time limits or requirements that tenants move to other settings. In contrast, the traditional linear model is often made up of various transitional components with strict time limits or needs profiles, and clients are expected to move through the process and from place to place before graduating to permanent housing. Transitional housing (usually with tenures of 3 months to 3 years) has traditionally been part of a continuum of care model that emphasizes 'housing readiness' and treatment first. Most evaluations of transitional housing have found that the ability to achieve housing readiness is based on the availability of a supply of affordable housing and income supports that are adequate to gain entry to market housing rather than sobriety or achievement of abstinence (DeVerteuil, 2005; Zlotnick, Robertson & Lahif, 1999; Dordick, 2002). In practice, some transitional housing programs have begun building in greater flexibility, allowing clients to stay until more permanent housing options are found, or even allowing tenants to 'transition in place,' meaning they can remain in the same housing unit with increasing responsibility for paying rent and other terms. Transitional housing has limited effectiveness if the threshold to permanent housing is too high (Kertesz, Mullins, Schumacher et al., 2007). In a recently completed Victoria study, transitional shelter was found to provide an alternative to low barrier shelters for those who choose treatment, and prevented a return to the streets following detoxification and treatment in the absence of affordable housing (Pauly, Wallace & Ranfft, 2010). Victoria has one of the lowest vacancy rates and highest rental costs in Canada. These and other findings point to the fundamental need for affordable housing as a basic building block for addressing homelessness.

Intensity of Services

Intensity of services refers to the breadth and depth of services available to program participants. It can be measured in staff/client ratios or the intensity of case management, including assertive community treatment. Assertive community treatment as a form of case management is characterized by teams being responsible for care and lower case loads than individual provider-driven case management models. Research has not been able to demonstrate clear findings related to the impact of duration or intensity of services (Patterson, Somers & McIntosh, 2008). Nonetheless, retention appears to be greatest when housing is combined with support services regardless of the particular model of housing (Caton et al., 2007).

The Current System

Systems are hard to change. Proponents of the linear continuum of care approach have worried that giving homeless people apartments before they were 'housing ready' was essentially setting them up for failure. The research, however, does not support this conclusion. High barrier or high demand and highly structured housing programs, and the rules often associated with them, can actually limit the ability of people to develop the social connections so critical to positive mental health. Clinicians often recommend supervising highly structured housing even when clients express a desire for independent living (Schutt, Weinstein & Penk, 2005).

The current system in Victoria was described by the Mayor's Task Force Expert Panel as a continuum of services that is reflective of a continuum of care approach that involves numerous disruptions, moves and gaps for clients. The lack of stability and coordination along the continuum made it next to impossible for clients to make it through the entire treatment plan.

> "The underlying assumptions of the present system are that clients can step through a linear progression of services arranged in a continuum. An unfortunate side-effect of progress is frequent

> moves from one location to another. For a drug-addicted person, there are a series of what could be called 'creative tests.' The first is to see if you can put enough distance between yourself and the use of substances or at least think about the possibility of not using substances to get withdrawal management services. Then after withdrawal management, you have a period of 'post-withdrawal management' stabilization in some moderately or highly structured setting, and then you graduate to a less heavily supported setting for a more extended period of time. And then, hopefully, graduate out of this system of care into market-rent housing and never go back to the streets. That's a very optimistic progression." (Mayor's Task Force, 2007b, p. 10).

The challenge is how to move from the continuum of care model described by the Expert Panel to a *housing first* model embraced by the Coalition. Both housing and support are vital elements that make it possible for clients to begin to address their substance use problems, reduce the negative impacts of use, reduce use itself, and perhaps become abstinent. Housing provides a base for clients to establish supportive social networks and become connected to the greater community. The *housing first* model views housing as a place to live, not to receive treatment, but central to this is the idea that clients will receive the services and supports they need to maintain their housing choice.

The following housing and harm reduction policy framework has been developed with the current and proposed housing and services in mind and with a clear focus on moving toward a *housing first* model that is consistent with the principles outlined above (*housing first* low barrier, permanency, and appropriate intensity of services for client needs). As a result, it provides a guide for transitioning programs to make them consistent with the values and principles that underpin harm reduction and *housing first*.

According to the Coalition's housing procurement plan, 1,233 new units need to be created between 2009 and 2014 to house the identified 1,200 people who are homeless. Of this total, new purpose-built housing would comprise 743 units. The rest would be a combination of conversions/renovations and purchase of existing housing (125 units) and leases and rent supplements (365 units). It is assumed that the new purpose-built housing would be some form of social housing, either subsidized or supportive, that would be consistent with congregate or hybrid models of housing. The 125 units of conversions or renovations of existing housing could take a variety of forms including motel conversions, single room occupancy units and so on. The 365 leases and rent supplements would most closely resemble a scattered site model of housing.

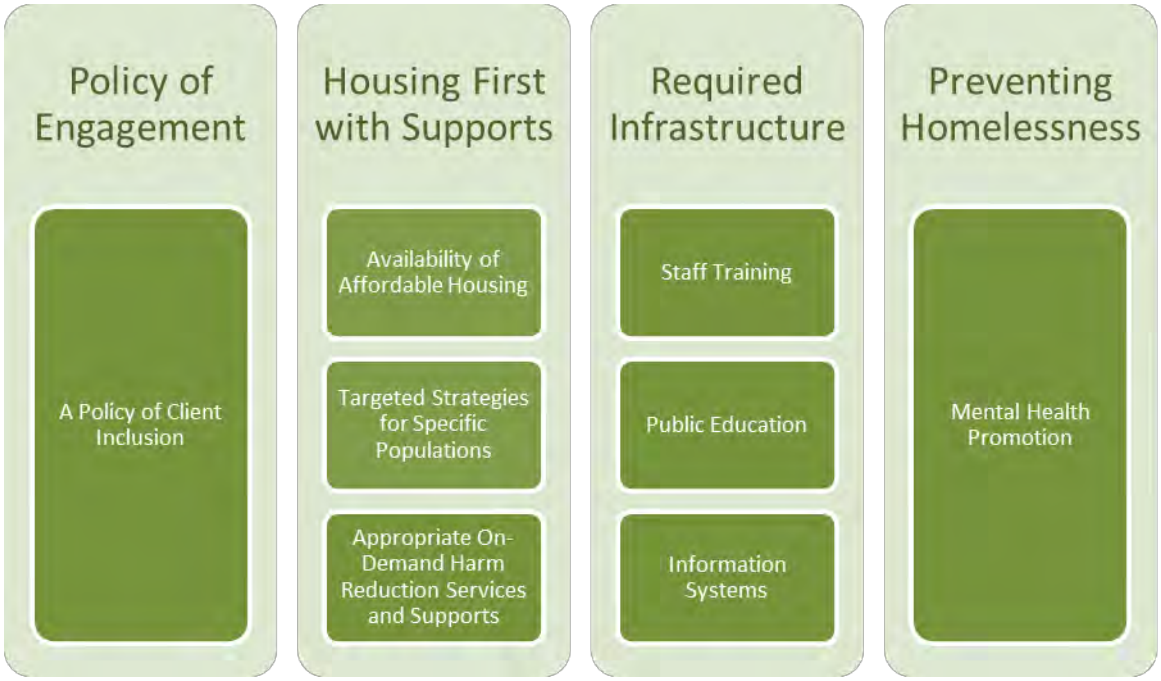
Specific housing models will naturally foster the development of different approaches to the integration of harm reduction. For example, services such as needle exchange and supervised injection could be provided onsite in congregate housing. Those in scattered site market housing would require access to such services in the community, potentially as stand-alone or part of primary health care services. Policies that tolerate drinking onsite are relevant to congregate settings but not necessarily needed in market housing as long as the rules of being a good tenant are met.

Critical to making a *housing first* system work is the application of harm reduction philosophy and strategies. Principles of *housing first* and harm reduction can be applied to all housing programs that are aimed at groups who are homeless or at risk of homelessness. Differences will exist appropriate to client choice and needs. Simply re-describing the system, however, will not suffice. A fundamentally different approach is needed if we are to break the cycle of homelessness.

The Policy Framework

The primary purpose of this document is to propose a relevant and realistic policy framework for applying harm reduction principles within the Coalition's strategy to end homelessness that embraces *housing first*. In addition to drawing on the evidence reviewed by the Mayor's Task Force and in other provincial and regional documents, and reflecting on the Coalition's own strategic planning documents, the authors conducted a review of recent research literature, an environmental scan to identify successful models in other jurisdictions, and a local community dialogue event to consult with key partners and stakeholders.

The proposed framework involves focus in four main areas. The first area – essential to any harm reduction approach – involves establishing clear policies of engagement and inclusion to guide the process of change needed to transform the system. The other three areas reflect the goals of the Coalition's strategic and business plans. The priority actions identified reflect the broad values and principles of harm reduction and *housing first*. Sometimes they also offer specific guidance on particular harm reduction strategies, but these should be seen as illustrative rather than prescriptive. The following diagram outlines the priority actions related to the application of harm reduction in each area.



Priority Action 1: A Policy of Client Inclusion

Substance use, especially illicit drug use, is often highly stigmatized and misunderstood. A key principle of harm reduction involves the participation of the people affected in every aspect of the development and implementation of policies and programs that affect them. This principle emerged in the discourse on disabilities, was applied to the HIV/AIDS experience (UNAIDS, 1999), and has now become central in the broader discussion of substance use (Jürgens, 2005) and homelessness (Paasche, 2009; Owen, 2009). Involving people with direct experience

- helps break the stigma attached to homelessness, mental illness and substance use by modelling social inclusion,
- improves the efficiency of services by reducing barriers created by the misperceptions and prejudices often shared by (even well-meaning) service providers and decision-makers, and
- improves outcomes for clients by ensuring more relevant services and through the positive impact of social engagement and self-efficacy.

Making It Happen

The literature provides several tips and suggestions for effectively involving people affected by homelessness, mental illness and substance use.

1. Avoid tokenism – involve multiple representatives
2. Engage with the groups and organizations that represent people who use drugs, have mental illnesses or are homeless
3. Involve people who have current experience as well as people with past experience
4. Hold meetings at times that are convenient and in places that are comfortable for participants
5. Guarantee and protect confidentiality, and use input respectfully
6. Provide effective facilitation and training for participants
7. Provide resources to maximize participation (e.g., travel support, child care, cash honorariums)

Measuring Success

The following indicators can be used to measure success in meeting this priority:

- A written policy requiring the participation of people affected by homelessness, mental illness or substance use is developed and implemented by the Coalition and is regularly audited.
- Representatives from the community who have experienced substance use and homelessness are consulted on issues related to the development of housing programs and engaged in development of responses and solutions. Information about attendance, participation and sense of social inclusion is collected for all participants in policy and program structures (e.g., through meeting minutes and periodic surveys) and used to improve levels of engagement.
- Representatives from the community of people who use drugs and experiencing homelessness are invited to be members of the Coalition's experiential group.
- The Coalition encourages all of its member agencies to adopt policies and practices that ensure people who use drugs and experiencing homelessness are represented in policy and program development that affect them at both operations and governance levels.

Priority Action 2: Availability of Affordable Housing

Housing is integral to reducing harms of drug use and can have a positive impact on drug use patterns, with decreases in use and safer use (Larimer et al., 2009; Podymow et al., 2006; Corneil et al., 2006). Enhanced housing with supports is identified as a key priority for people with severe and complex mental illness and substance use (BC Ministry of Health Services, 2010). Lack of housing is associated with a wide range of harms. For example, homelessness is associated with poor physical and mental health (Beijer & Andréasson, 2009; Evans, Wells & Moch, 2003) and increased mortality (Morrison, 2009). Risks of substance use are increased when there is a lack of stable housing. HIV risk is increased for those who are homeless (Corneil et al., 2006; Culhane, Gollub & Kuhn, 2001; Robertson, Clark & Long, 2004; Shannon, Ishida & Lai, 2006), as are other consequences of drug use. Lack of adequate housing was identified as a key harm for adults and youth who use injection drugs in a recent BC Alcohol and Other Drug Monitoring Study that follows high-risk populations in Victoria (CARBC, 2010b).

The success of any strategy to address homelessness is dependent on the availability of affordable housing. In fact, availability of appropriate affordable housing is probably the single most important factor in predicting outcomes (Patterson et al., 2008). When the cost of housing consumes an inordinate amount of an individual's or family's income, harm is likely to follow. A complex web of decreased mental and physical health, poor nutrition, increased stress, poor performance and fractured relationships begins to emerge. To ensure the success of the *housing first* model recommended by the Mayor's Task Force, access to permanent low-cost housing options is critical. However, according to data from the Canada Mortgage and Housing Corporation (Greater Victoria Coalition to End Homelessness, 2010a, p. 8), compared to national rates, Greater Victoria has:

- Higher average rental apartment prices
- Higher growth rates of average rental apartment prices
- Lower rental apartment vacancy rates
- Lower rental apartment availability rates

This has led the Coalition to conclude that "Greater Victoria has the most unfriendly rental market in the country" (Greater Victoria Coalition to End Homelessness, 2010a, p. 8).

Making It Happen

The Coalition has already begun implementing a multi-faceted strategy to address the current challenge. The following comments seek to identify implications and suggest possibilities related to the values and principles of harm reduction.

1. Rental subsidies bridge the housing affordability gap. This suggests that when people have access to adequate housing and still have sufficient resources to address their other needs, they are able to function in the community. The Housing Procurement Plan for Greater Victoria (City Spaces, 2009) suggests more leased units and rent supplements are needed to expand the pool of affordable housing. To ensure housing costs are not contributing to homelessness and other harms, policy initiatives to continue to expand the availability of rental units and rent supplements, as well as other initiatives such as voluntary rent controls, will be needed.

2. Establishing working partnerships with the property managers and owners is critical for maximizing access to low-cost housing options. Indications are that work on this is already underway. An important component of the Streets to Homes program involves recruiting and enrolling building managers and owners in order to find new market units suitable to a **variety of needs**. It is recognized that key to the success of this initiative will be building good working relationships to increase awareness of the issues and address them in ways that reduce the potential harm for clients, other tenants, the building managers and owners, and the community. However, in a very tight and unaffordable housing market such as Victoria, landlords have the advantage related to choice of tenants, which highlights the need to focus on

specific advantages to landlords of renting to Streets to Homes tenants such as long-term leases and availability of supports. Further, it reinforces the need for affordable housing that is available on a rental income of $375.00 per month for those on social assistance and working at minimum wage.

3. Attention to the broad social and economic determinants of health is critical to long-term success. Individuals and families need access to economic and social resources. When they have these, they maximize their health and the community is healthier. No strategy to end homelessness is likely to be successful without attention to factors such as income, employment, food security, education and social connectedness. The comprehensive nature of the Coalition provides opportunity for ensuring that housing is linked to the other social determinants of health, including income, employment, food security, social inclusion and education that are key supports to break the cycle of homelessness.

Measuring Success

The following indicators can be used to measure success in meeting this priority:

- Increased supply of available and affordable housing units as laid out in the Housing Procurement Plan, with adjustments made for growth in homeless population.
- Placement into housing or receipt of rental supplements is based on the normal requirements of tenancy rather than on sobriety or abstinence.
- Clients with a strong desire for permanent independent housing are settled in *housing first* supported units within one month of application.
- Formal working partnerships have been established between *housing first* service providers and a growing number and diversity of property owners or managers.
- No client is required to pay more than 30% of their income for housing.[2]

[2] Similar affordability stipulations are found in Calgary's *housing first* program, whereas Ottawa's program addresses affordability by ensuring that no participant pays more than the shelter portion of their monthly support cheque.

Priority Action 3: Targeted Strategies for Specific Populations

While a key feature is to ensure accessibility, availability and acceptable supply of affordable housing, the housing strategy must be responsive to the needs of specific populations experiencing homelessness. At times and for some people, systemic barriers may prevent them from having meaningful access to services and supports that exist in the community and from being able to fully participate in society. For example, people who use drugs may be discriminated against when attempting to access housing or supports because of real or perceived substance use. Operating from *an equity lens* framework can assist the Coalition in removing some barriers and developing more inclusive policies and practices. An equity lens focuses on highlighting policies and practices that contribute to poor health and harms associated with homelessness, and accounts for considerations of age, gender, ethnicity, geography, and other intersecting factors such as substance use and mental illness that shape access to housing and resources (Pauly et al., 2010). An equity lens brings into focus the fact that differences in our social location impact access to resources such as housing and supports (e.g., Graham, 2004).

Aboriginal people are over-represented within the homeless population. Twenty-six percent of those served by Housing Outreach supports in Greater Victoria in 2009/10 were Aboriginal (Greater Victoria Coalition to End Homelessness, 2010a). Women make up about 40% of the homeless in Greater Victoria and may be particularly vulnerable to harms. Women may exchange sex (or practise unsafe sex) for housing, food and safety. Being pregnant and parenting small children may deter them from accessing services if they are actively using substances, for fear of losing custody of their children. Youth have increased vulnerability to harms of life on the streets and often feel unsafe in shelters or housing for adults as a result of the abuse that may have contributed to life on the street. Other sub-groups include youth transitioning out of foster care, individuals leaving correctional facilities or transitioning from a health care setting, and individuals with developmental disabilities, as identified in the Coalition's *A Plan to Prevent Homelessness* (Greater Victoria Coalition to End Homelessness, 2010b). Little is known about the housing and support needs of immigrants/refugees, veterans, those with brain injuries and other sub-groups impacted by social policy changes that have contributed to homelessness.

Individuals leaving corrections, youth, women, Aboriginal populations, veterans and others have unique housing and harm reduction needs as a result of their position in society and the degree to which resources are available to them based on their history, gender, ethnicity and current situation. For example, youth may have difficulties renting because of their age, lack of employment opportunities and other factors. While a supply of adequate, appropriate, accessible and affordable housing is foundational to ending homelessness, specific considerations are needed relative to the needs of different sub-groups in the homeless population.

Care must be used as we address particular populations so that we do not repeat the mistakes of the Indian Act that robbed Aboriginal peoples of their independence and self-determination and contributed to poverty and inadequate housing. Effective harm reduction strategies will only emerge with the full engagement of the people we seek to serve as noted in Priority Action 1.

Making It Happen

In order to set appropriate priorities related to housing and harm reduction, engage meaningfully with particular populations of interest and develop effective strategies, the Coalition will need to develop partnerships and systems to collect, analyze and act on data about homelessness and those at-risk of becoming homeless.

There are some promising beginnings. The Coalition has begun to develop an Aboriginal Housing Strategy in collaboration with Aboriginal leaders. A recently purchased Traveller's Inn will provide housing specifically for Aboriginal people. This is an important opportunity to consider integration of culturally appropriate harm reduction strategies. The Coalition's Prevention Working Group has included a focus on specific vulnerable sub-groups in the development of the prevention plan to develop specific strategies that respond to the needs of target groups such as youth in transition, families, and adults leaving correctional facilities, health care

settings, and with developmental disabilities (Greater Victoria Coalition to End Homelessness, 2010b). Specific attention to integration of housing and harm reduction as part of the strategies within these plans should be encouraged.

The proposed Her Way Home project is specifically focused on the needs of women experiencing substance use and, with appropriate support, has potential to respond to a major gap in meeting the needs of women. This project would be a made-in-Victoria model that builds on the successful Sheway project in Vancouver for pregnant and parenting women. The establishment and ongoing operation of the Sobering and Assessment Centre in response to shelter needs of those experiencing alcohol intoxication and chronic inebriation points to the need to better understand the housing and harm reduction needs of those who use this facility. These and other projects are posed to provide important services, current information and learning about culturally appropriate housing and harm reduction strategies for specific sub-populations. The Canadian Centre on Substance Abuse (CCSA) has prepared a series on harm reduction in special populations, including Aboriginal people, youth, and those leaving the criminal justice system that could serve as a starting point for culturally appropriate harm reduction strategies.

Keeping in mind the diversity of the homeless and at-risk populations and the various unique challenges and needs, policies and programs need to be regularly reviewed to determine whether they meet specific needs.

Measuring Success

The following indicators can be used to measure success in meeting this priority:

- Ongoing and current profile and needs of the homeless and at-risk populations in Greater Victoria is available and utilized in program planning.
- Targeted strategies and priorities are developed with representatives of the affected populations when particular needs are identified, and all strategies and outcomes are regularly reviewed to determine how well the unique needs of specific populations are being served.
- Specific housing projects are supported, developed and endorsed to address the needs of identified sub-groups such as women, youth and Aboriginal people.
- Partnerships with organizations providing housing to specific sub-populations are developed, such as with Her Way Home.

Priority Action 4: Appropriate On-Demand Harm Reduction Services and Supports

Even though the most important factor in meeting the housing needs of homeless people is providing access to adequate affordable housing, the provision of housing alone is not always sufficient to break the cycle of homelessness. For some, supports that respond to individual needs are necessary to assist them with remaining housed and participating positively in their communities. These supports may facilitate skill development or assist with access to employment, social networks, health and social services, or other resources. For people who use drugs, supports must include access to safer use equipment, information and related services, as well as to safe disposal of used equipment, and treatment services when they are ready and asking for them. For the purposes of this action plan, the focus is on enhancing harm reduction within a *housing first* approach.

The concept of 'on-demand' means not forcing clients to accept services they do not want and that are not essential to their continued housing. On the other hand, it involves a commitment to provide the range of services and supports that meet client needs in ways and at times that are accessible and acceptable to them and that address public health and health promotion needs.

The Mayor's Task Force was critical of the "underlying assumptions of the present system." Transforming the system to provide better harm reduction, treatment and support services related to substance use will require a careful, critical audit of all existing services, both at the macro and micro level, to determine which of them can be restructured to align with the values and principles of harm reduction and *housing first*, and which are incompatible and should therefore be phased out. The resources recovered can then be used to increase capacity or develop needed services. The importance of restructuring existing programs is necessary as homelessness is growing, particularly among certain sub-groups. Concerns related to open injection drug use, homelessness and chronic alcohol use have repeatedly been identified as areas for action in the Mayor's Task Force and 2005 City of Victoria Harm Reduction Strategy.

Making It Happen

It is never easy to re-direct resources or reduce or close programs. However, unless the community is prepared to stop doing what is not working, there will be little success in evolving a system that is truly effective. Addressing this priority, of necessity, requires attention to Priority Action 1. Participation of those affected will help ensure planning focuses on relevant services and supports. The services and supports will be a combination of on-site and off-site services provided by case managers and other program staff, as well as services and supports provided through a broad network of community partners and agencies. Effort is needed to ensure that this network provides services and supports that are available, accessible and acceptable to the client population, and that no matter where clients access services, they are supported in linking to the services they need ("every door is the right door"). It is imperative to recognize that harm reduction services will vary based on population needs and housing type.

1. Harm reduction philosophy should guide the design of the entire system, and various harm reduction services can be provided in different contexts throughout the system in response to client need. The four dimensions related to *housing first* discussed above and the values and principles that underpin the recommended Priority Action items can offer some guidance. For example:

    a. If housing is a fundamental need and a human right, then programs with higher thresholds of housing readiness can only be acceptable if they are embedded within a system characterized by *housing first*. That way, when an individual or

Seaton House

Seaton House, a shelter for homeless men in downtown Toronto, started an Annex Harm Reduction Program in September 2002 (CMAJ, 2003). Alcohol is stored overnight for the men, and returned to them the next morning. Men are also offered beer or wine under supervised conditions. Seaton House has allocated 36 beds for men who require these services. The managed alcohol program avoids situations where men quickly drink their alcohol before seeking shelter, or sleep outside so as not to have to give up their alcohol. It also prevents harms related to use of unsafe and damaging sources of alcohol such as rubbing alcohol.

family cannot meet or maintain the requirements of the high threshold program, they are not thereby denied housing altogether. This may mean that some currently high threshold programs need to be reduced or phased out in order to provide a better balance of low and high threshold housing, and provide more options to individuals and families.

b. Consumer choice is fundamental to harm reduction and *housing first*. This means that clients should be able to give informed consent to participate or refuse to participate in any harm reduction, treatment or support service without their choice impacting on their housing status. Programs for which there is insufficient demand or where consumer choice is not an option or full participation is required should be reduced or phased out.

c. In light of the numerous challenges related to continuity in the current system and in light of the importance of social connectedness to positive mental health, the bias of the system should be toward permanent as opposed to transitional housing alternatives. This is not to say that there is no place for transitional programs, but resources need to be directed toward models that create stability and prioritize the development of social networks within the larger community.

d. In light of the lack of clear evidence related to scattered site versus congregate living and intensity of service, harm reduction principles suggest that on these issues the system should be responsive to client preference. Care must be taken to ensure clients are given a meaningful menu of options and that congregate arrangements support self-efficacy and social inclusion rather than undermine these as has sometimes happened in the past. In particular, low barrier congregate living programs are needed to address the needs of people who continue to use drugs and alcohol. This has been repeatedly identified (e.g., in the community consultation conducted for this report, the City of Victoria Mayor's Task Force and several other local reports). Policies and practices for integrating safer use and managed use into low barrier housing programs have been developed in other jurisdictions and can be adapted. These may include:

    - Policies for private use in private spaces (e.g., 1811 Eastlake, Seattle)
    - Supplying alcohol in a managed use program (e.g., Seaton House, Toronto, see insert)
    - Providing safe injection/inhalation equipment on-site (e.g., Tommy Sexton Centre, St. John's)
    - Integration of harm reduction, housing and health care services, including nursing supervision of drug injections (e.g., Dr. Peter Centre, Vancouver, see insert)

By developing common protocols and practices related to the reduction of harms from substance use, the Coalition can help ensure a more cohesive and consistent delivery of service to homeless clients across the partner agencies. The case managers within the Streets to Homes program and the Assertive Community Treatment (ACT) teams could help provide leadership in facilitating development of these common protocols and practices.

2. Beyond the specific housing programs, all health and social services within the broader network of supports need to be infused by a harm reduction philosophy. This would mean that the values and principles of harm reduction would characterize the services and supports (Manitoba Harm Reduction Network, n.d.). It might also mean that services traditionally associated with stand-alone harm reduction programs become normalized and offered wherever people access services, including

    - Safer use information widely distributed by health and social services
    - Safer injection/inhalation equipment widely available on outreach, from dedicated sites and primary care providers (health clinics, physician offices, pharmacies)
    - Nursing supervision of injections in primary care settings and selected housing

Dr. Peter Centre

Dr. Peter Centre in Vancouver, British Columbia, is a unique and comprehensive program that serves people with HIV/AIDS and experiencing addiction, mental illness, poverty and discrimination. The program consists of two key components, the day health program and 24-hour nursing care residence. The day health program provides nutrient dense meals, comprehensive nursing services, including management of HAART, laundry, showers, computers, telephones, gym, art and music therapy, counselling services, recreational and complementary therapies. The 24-suite residence provides a home for people to avoid hospitalization, transition from hospital back into the community, and stay to be supported for their long-term needs. Nursing care is provided to residents 24 hours a day, 7 days a week. The two floors, each with communal living-dining room, overlook Vancouver's historic Mole Hill's restored roofs and turrets, West End high-rises and the North Shore mountains. Meals are provided on site and access to the day health program assists with community integration. Opportunities for recreation, art, music and complementary therapies are open to residents to enrich residence life. Volunteers enhance care by assisting with outings, personal shopping, laundry, hair styling, pet care, bedside vigils and more. Six overarching concepts guide clinical practice in order to achieve the mission at Dr. Peter Centre West End: Maslows hierarchy of needs, self care, therapeutic community, restorative practices, trans-theoretical model of change, and harm reduction. Approximately 70% of the participants at Dr. Peter Centre West End have either a history of using substances or are currently struggling with addiction. Many of these individuals have experienced poverty, violence, abuse, are polysubstance users, and are living with mental health problems. To reflect this reality, and to meet their very complex health needs, Dr. Peter Centre West End's interdisciplinary clinical team provides harm reduction services including: safe injection service/needle exchange, distribution of condoms and lubricant, sexual health education, and safe money storage for participants who feel triggered by cash in their pocket. The Dr. Peter Centre community of care is built on acceptance and support, helping people find strength in the face of an illness which to date does not have a cure. They offer respect, dignity and a sense of belonging to people who are most in need. (Available online from http://www.drpeter.org/home/.)

3. Diversity of service models is to be encouraged. One size does not fit all, and client choice is associated with better outcomes. Nonetheless, attention to evidence-informed practices is associated with more efficient services and better outcomes. Therefore, the Coalition and its members could improve service quality by developing and implementing an ongoing knowledge exchange strategy to develop capacity among service providers across different partner agencies and the people they provide services to, in the application of evidence to practice and to increase awareness of other services in the network. Attention should be given to the growing body of current local research and evidence. Specifically,

    a. Local research has demonstrated that the lack of a fixed site needle exchange has led to increased difficulties with disposal of needles, increased re-use of injection equipment, decreased access to clean equipment, and decreased access to other health and social services such as nursing and counselling (MacNeil & Pauly, 2010; Isvins, Chow & Marsh et al., 2010; VIHA, 2010). In a study of injection drug use, Stajduhar et al. (2000) concluded that there is a need for mobile services to complement but not replace fixed site services. While mobile services were established following these recommendations, fixed site services were closed in 2008.

    b. Fischer & Allard (2007) undertook a feasibility study of supervised drug consumption options in the City of Victoria and recommended a decentralized and integrated approach to supervised injection. At a minimum, they recommended, on the basis of a literature review and key stakeholder interviews, one facility in the downtown core, as well as one or two additional facilities based on need in other areas, be implemented. The programs should be closely aligned with a range of core health, housing and social services required by target population, and could be operated by existing consortium of community-based health care providers in Victoria.

    c. Further, Fischer & Allard (2007) recommended services also be offered to those who use non-injection drugs such as smoking crack or stimulant use. The 2009 I-track study found that 86% of those who use injection drugs had smoked crack in the previous six months. This suggests the need for increased attention to availability of safer crack use environments, equipment and education.

d. Stajduhar et al. (2000) recommended considering the feasibility of a heroin prescription trial. While heroin trials have been conducted in Vancouver, the feasibility of these has not been explored in Victoria.

4. One program element that has been identified as critical to the success of *housing first* implementations is a requirement that clients participate in money management. The Coalition and its members are advised to implement such a requirement within their *housing first* programs. Money management can help reduce harms associated with substance use.

5. All services and supports should operate from a motivational enhancement rather than directive perspective whenever possible. Motivational enhancement therapy uses motivational strategies to mobilize a client's own resources instead of guiding and training the client step by step though recovery (Miller, Zweben & DiClemente, 1995). Specific training in motivational enhancement techniques may be helpful (see Priority Action 5).

6. Ensuring that all services and supports are offered in a client-centred way that supports self-efficacy requires careful planning and diligent monitoring. A tool developed by the Manitoba Harm Reduction Network could be adapted to create a means of assessing and monitoring services within the homelessness strategy and across the entire service network (Manitoba Harm Reduction Network, n.d.).

7. The Coalition is advised to develop mechanisms to regularly review the network of services and to draw attention to gaps and facilitate action as appropriate (see Priority Action 7). Currently, there are gaps in needle exchange services and supervised injection that are useful in improving the health and safety of people who use injection drugs and in protecting the entire community from the transmission of blood-borne diseases such as HIV and Hepatitis C. Such services are integral to the provision of housing and supports. Such programs seek to mitigate many of the harms of drug use such as HIV, overdose, Hepatitis C and so on. However, it is also the case that such resources increase access to housing, treatment and other referrals that mitigate the harms of homelessness. For example, Insite in Vancouver has been identified as a key source of referral for treatment (Tyndall, Kerr & Zhang et al., 2006). Needle exchange services often serve those who are the most vulnerable, with high rates of homelessness among those who access such services. Needle exchange services often serve as an important point of access to housing, income, nursing, treatment and counselling services (MacNeil & Pauly, 2010).

Tommy Sexton Centre

The Tommy Sexton Centre, a project of the AIDS Committee of Newfoundland and Labrador, provides integrated HIV/AIDS services and emergency shelter. The short-term, four-bed emergency shelter accepts both men and women, regardless of whether they are living with HIV/AIDS or not. It is staffed 24 hours a day.

Although the Centre does not allow the use of illegal substances on site, residents are not refused entry into the Centre when they are under the influence. Shelter residents can obtain new needles and all other injection equipment 24 hours a day from shelter staff. Sharps containers are kept in the staff office, and residents are encouraged to use them. If a resident wishes, staff will help develop plans and set goals to address drug use. Since the shelter operates from a harm reduction approach, residents seem to be more willing to discuss their substance use openly, without running the risk of losing their bed in the shelter.

Perhaps the Tommy Sexton Centre's emergency shelter example works well as it is set in a small town and handles a small number of residents. It also benefits from being situated in the same building as the needle exchange program and other services related to HIV/AIDS. The Centre is also a certain distance away from the downtown core where most of the street-involved substance use activity takes place. However, its harm reduction activities are useful to illustrate a proof of concept that could be considered by other housing initiatives. (Belle-Isle & Cavalieri, 2008)

Measuring Success

The following indicators can be used to measure success in meeting this priority:

- There is a balance of low barrier and high barrier housing available that is affordable. Low barrier housing does not require abstinence and tolerates safe and managed use.
- Eighty-five percent of clients placed in permanent supported housing are still stably housed after one year, and at least 75% of these are still stably housed after five years (Caton et al., 2007).
- Clients of the housing programs report increased self-efficacy one year after entering the program compared to when they entered.
- Clients of the housing programs report increased wellness, decreased health and social harms related to substance use, and decreased police encounters and use of emergency services compared to when they were homeless.
- Appropriate harm reduction services are available and accessible to clients on service sites, in selected congregate housing and in the community.
- Findings of local research related to the impact of the closure of the needle exchange and feasibility of supervised injection services are acted upon, and clients report improved access to local resources that reduce harms of drug use for those who smoke crack and use injection drugs and increased access to services that can be the first step to ending homelessness for those with problematic substance use (MacNeil & Pauly, 2010; Ivsins et al., 2010; Fischer & Allard, 2007).
- Homeless people who use alcohol or other drugs nonetheless report improved access to a range of housing options similar to other homeless people, without being obliged to abstain from substance use.
- People who use alcohol or other drugs report increased access to a range of harm reduction services and supports delivered in a way that does not create added stigma.

Priority Action 5: Staff Training

The literature demonstrates that program innovation is often resisted rather than embraced by current service providers (Tsemberis, Moran & Shinn et al., 2003). This situation can be addressed partially through the collaborative development of clear policies and protocols. It also requires careful attention to training. From a harm reduction perspective, this training is needed at two levels. Staff and volunteers involved in working with homeless clients who use alcohol or other drugs need training focused on practical, everyday operations related to safety practices, procedures for handling injection equipment and other harm reduction supplies, and how to deal with critical incidents. But it is equally important that staff receive effective training in the broad principles and techniques that underpin a harm reduction and *housing first* perspective: the importance of self-efficacy, motivational enhancement techniques and harm reduction philosophy.

Making It Happen

Clearly a comprehensive training strategy will need to be developed in the context of the Coalition's larger strategy. However, the Coalition need not begin from scratch.

1. The Justice Institute of BC has already developed several training modules related to harm reduction and motivational interviewing. The Centre for Addictions Research of BC recently developed an online resource to support the roll-out of a new motivational approach within Youth Justice. The BC Substance Use Network is supporting expansion of a basic training curriculum for substance use workers throughout the province. These and other resources within the province can be adapted and utilized within the recommended training strategy.

2. York University offers a certificate program in harm reduction that is available either online or may be provided onsite. This course provides a grounding in harm reduction theory and practice, harm reduction policy, research and ethics.

3. Harm reduction training protocols developed at the community level are also available (Hodgins, 2005) and can be adapted for use within the Greater Victoria strategy.

Measuring Success

The following indicators can be used to measure success in meeting this priority:

- The Coalition develops and endorses a harm reduction policy and facilitates a process for developing harm reduction practices and training among service providers.
- Coalition partners develop policies related to substance use and harm reduction as part of housing programs and implement training programs across agencies.
- Staff are aware of policies and practices and are involved in their development and revisions.

Priority Action 6: Public Education

Program innovation, particularly when promoting increased inclusion of socially excluded populations, is often met with opposition within public discourse. Too often the response has been a polarized debate that has rarely led to better understanding or broad community support. What is needed is a well-planned approach to community education that presents the evidence, appeals to community values and addresses the concerns of all major stakeholders. From a harm reduction perspective, the starting point is not about the adoption of particular strategies like needle exchange or supervised injection. The starting point needs to be about social inclusion and the reduction of harm for all citizens. Also, many specific harm reduction strategies will only be accepted by the public when they understand and accept the role of the social and economic determinants of health.

Making It Happen

While the Coalition and its members should continue to implement harm reduction principles within their policies and programs, they should also engage in coordinated public education about the social and economic determinants of health and the importance of social inclusion to community well-being.

These themes should be included within the planned communications plan (Project 12) and community engagement strategy (Project 13). In addition to the strategies identified in the Coalition's business plan, carefully planned public lectures and forums utilizing resources within the community (e.g., homeless persons, post-secondary institutions, provincial ministries, Coalition partners) could contribute to growing public understanding. When these concepts are an essential part of public discourse, the debate around individual strategies will be more grounded and more resolvable.

Measuring Success

The following indicators can be used to measure success in meeting this priority:

- Coalition documents and information on *housing first,* including principles of harm reduction, are widely available.
- Factual information on harm reduction as part of housing solutions is regularly used to inform the public.
- Specific public presentations are provided to business associations and owners.
- The public is aware of the role of harm reduction in addressing homelessness.

Priority Action 7: Information Systems

As outlined above, it is important to monitor progress on the degree to which *housing first* and harm reduction principles have been incorporated into housing and support programs. Clearly, there is a need to ensure accurate monitoring and reporting to ensure that harms associated with homelessness and problematic substance use are addressed.

Making It Happen

In the 2007 homelessness needs survey, there was indication that substance use was a major health and social concern for 40% of the people surveyed at that time. Information is needed on the degree to which problematic substance use impacts the population and sub-population of people who are homeless in Victoria. Also, there is a need to monitor the number of people associated with substance use who are evicted or have difficulty finding housing. In other words, housing programs can be monitored to determine the degree to which people with problematic substance use are among those housed.

Incorporation of indicators related to substance use could be included in the next Coalition report card. For example, the BC Alcohol and Other Drug Monitoring Project assesses the degree to which homelessness is a harm associated with substance use among high-risk and vulnerable populations who use injection drugs.

Monitoring the number of individuals who use withdrawal management services, particularly those who are repeat users, entering into treatment and leaving treatment only to return again, would be useful. A review of the number of people who use the sobering and assessment centre for housing could provide some indication of the need for low threshold housing programs with a higher tolerance for drug and alcohol use on site. Such a review could also help quantify the need for managed alcohol programs.

Finally, information about current policies and programs in various housing programs related to substance use is not available. Thus, the degree to which low barrier programs are available is not clear. However, indications from the community consultation suggest that there is a lack of low barrier programs and inconsistent policies related to harm reduction.

Measuring Success

The following indicators can be used to measure success in meeting this priority:

- Information systems are developed and in place to monitor reasons for evictions from housing programs, including supportive housing and Streets to Homes, to assess whether or not individuals with substance use problems are over-represented.
- Evictions due to drug use are decreased.
- The Coalition leads a working group with partner agencies to review evictions monthly and come up with key elements that would be useful to know in preventing such evictions. From this exchange, a common data collection sheet on evictions would be developed and reported monthy and annually in the Coalition report card.
- Harms related to housing among high-risk population are reduced as evidenced by BC Alcohol and Other Drug Monitoring Project for Victoria.
- Repeat users of withdrawal management services are reduced.

Priority Action 8: Mental Health Promotion

The determinants of homelessness and the determinants of mental health are inter-related in complex ways. Touching on harm reduction principles of dignity, compassion and participation, promoting positive mental health involves empowering people to achieve well-being through self-esteem, healthy relationships and social support, effective coping skills, adequate housing and employment. When people generally have these things, they tend to be resilient and able to cope with momentary disruptions and challenges.

Promoting positive mental health is an effective way to prevent homelessness. In particular, the stigma associated with drug use and homelessness can have very negative impacts on the mental health and well-being of individuals and prevent them from accessing resources. Stigma may be real or perceived but in either case it negatively impacts the health of those involved, and reducing stigma associated with drug use is essential to mental health promotion and facilitating access to supportive resources. Furthermore, as outlined previously, providing adequate housing is important to promoting positive mental health and reducing substance use problems. As a result, the Coalition and its members are encouraged to take a holistic approach to the issues.

Making It Happen

Preventing homelessness ultimately involves creating resilient citizens and healthy communities. The following comments are meant to assist the Coalition and its members in applying a harm reduction perspective to the work of mental health promotion and homelessness prevention.

1. A harm reduction perspective would encourage a pragmatic approach that focuses on any opportunities to have an impact in reducing harm. The risk and protective factors related to mental health and homelessness occur at multiple levels – individual, social relationships, school/work, community, etc. The potential for harm created by factors at one level can be exacerbated or mitigated by factors at other levels. Harm reduction looks for and makes use of opportunities at any level to reduce the potential for harm rather than focusing only on one particular set of risks. This is particularly relevant to reducing stigma associated with drug use. Encouragement and support for activities that destigmatize drug use and drug users are needed as part of mental health promotion and education regarding homelessness and substance use. Those who have experienced such discrimination are integral to responses as per Priority Action 1 and, if inclusion is done well, it can be therapeutic for those involved.

2. The way we respond to homelessness could itself impact the risk of future homelessness. The evidence on positive mental health and preventing a whole range of health and social problems points to the importance of social connectedness. It would therefore seem critical that policies in addressing homelessness, particularly among youth and parents with children, should carefully consider how to maximize stability and maintain positive relationships wherever possible. We need to ensure that, in trying to do good, we also try to do no harm.

3. As mentioned earlier, attention to the broad social and economic determinants of health is important. This is particularly true as we consider prevention. Even though the Coalition was formed to address homelessness, the members are involved in a whole range of health and social activities. The more effectively all of these activities can be coordinated through the goal to end homelessness, the more Greater Victoria will be a community of healthy communities.

Measuring Success

The following indicators can be used to measure success in meeting this priority:

- Regular client surveys reveal improved mental health indicators such as well-being, self-esteem, healthy relationships and social support, effective coping skills, adequate housing and employment.
- Those who use drugs report decreased stigma when accessing housing, health and social services.

- Client surveys provide feedback regarding agency practices and services and how these address their needs.
- A review of agency protocols indicates successes to be built upon and areas that need improvement to better respond to client needs and promote mental health.

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