PART TWO: CHANGE THE SYSTEM

Section Three
No Access, No Support: Service Gaps and Barriers

Through the course of our research for Project Inclusion, we connected with a number of people like the soft-spoken woman we met one rainy morning in front of an emergency shelter where she was staying. She was doing her best to make herself comfortable near the shelter’s front door, despite the fact that she was in extreme physical pain. We later learned that she was also living with advanced cancer.

She took some time to consider before deciding she would like to share her story, although she wasn’t sure she would have too much to say. We are deeply indebted to her for making the choice to speak with us. She is alone for the first time and living on basic income assistance after having spent her life living with a parent until they passed away a few years ago. Unable to find housing, she was now homeless in the same community she had lived in all her life.

We don’t know where this woman is today, but we do know that the shelter is now gone, as it was only operating on a temporary basis. We also know that we have a responsibility not just to share the heart-wrenching details of her story, but to pose the question: how, in contemporary British Columbia, could this situation even happen?

Some of the answer lies in issues we were not going to take on here, such as housing stock and income assistance rates, because they have been documented ad nauseam.265 These are critical issues that must be addressed to ensure that people who rely on income assistance, low-income workers, and other low-income people are not sentenced to homelessness or forced to decide between housing and other necessities of life such as food and transportation.

Stigma is embedded in the fabric of health and social services in a way that is undermining public health, perpetuating criminalization, and, in some cases, leading to violations of human rights.

We also need to look deeper, because the answer lies not only in infrastructure and funding levels, but in the ideologies and beliefs that underlie the development and delivery of many essential services. To be more specific, stigma is embedded in the fabric of health and social services in a way that is undermining public health, perpetuating criminalization, and, in some cases, leading to violations of human rights.

Many participants in this project identified services and specific service providers as critical sources of support. They talked about the importance of having access to services that were user-friendly and easy to navigate, as well as services that were able to provide what they needed in a timely manner.

of safety, support, and community. We know that we could not have undertaken this project without the openness and dedication of overtaxed frontline service providers who were willing to add to their already overflowing plates by sharing their knowledge and facilitating research visits to their communities.

Despite the many highly skilled service providers working tirelessly to support people in their communities, project participants across the province consistently identified ways in which not only emergency and health services geared toward the public at large, but also organizations and programs ostensibly operating specifically to serve people experiencing deep poverty, homelessness, and substance use, were not meeting their needs.

The service barriers and gaps that project participants identified span the gamut, from waitlists due to chronic underfunding, to logistical barriers that make services inaccessible, to attitudinal issues among staff, to underlying stigma embedded in program design. Considering this range of barriers and gaps, participants emphatically shared that they need services that support people’s sense of dignity and autonomy, that are trauma-informed, that are culturally appropriate, and that engage peers in program design and delivery. Services that lack those features have negative impacts on health, safety, dignity, and well-being in the short term, and in the long term, they drive people away from engaging with health services, shelter and housing options, and income support programs.

**STIGMA CUTS PEOPLE OFF FROM BASIC NECESSITIES, PUBLIC RESOURCES**

People who took part in this project experienced many of the barriers we discuss when accessing even basic necessities like washrooms and clean drinking water. Many people also experience barriers in accessing services that are generally available to the public as a whole.

People spoke, for example, about barriers to spending time in public libraries as this couple, who participated together, explained. “Sometimes they’ll call security (459a),” he said. His partner added, “Yeah, it depends on if…that’s one of the days where all the kids are in…like a field trip there. Then they’ll ask you to leave or call security, and get security to get you to leave (459b).”

When evaluating the role that stigma and discrimination play in limiting access to services generally available to the public, we feel compelled to share that as we write this, we are well into our fifth hour in a study room at the Vancouver Public Library that is explicitly limited to two-hour bookings in a given day. Security has walked by several times over the last three hours and has said nothing.

**“No Address, No Food”**

Discrimination also shows up in services meant to cater exclusively to people living in poverty. One participant explained that in her community, the local food bank does not serve homeless people. “I don’t have ID, which makes it hard for me to go to the food bank or anything. I can’t get food or anything (397),” she said, explaining that her community food bank requires people to produce documentation that shows they have a fixed address in order to access its services. “You have to have a residence, too.”

This woman was one of many participants who explained the “no address, no food” rule. “You can’t get food from the food bank if you’re homeless (262a),” another participant said. “If you don’t have an address, if you’re homeless…they will not so much as give you a can of pop, a bottle of water, nothing...You have to have an address, they will check with welfare...if you only get 266 Government of British Columbia, Rate Table: Income Assistance (BC Employment & Assistance Policy & Procedure Manual), online: https://www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual/bc-employment-and-assistance-rate-tables/income-assistance-rate-table.
Throughout the course of our research, the following key findings emerged from our exploration of service gaps and barriers which surfaced through discussion with Project Inclusion participants:

- across BC, there are too few safe drop-in services, shelter spaces, harm reduction services, treatment beds, and advocacy services to meet the most basic needs of people living in poverty;
- a range of factors, from stigma to resource constraints, result in services that are, by design, difficult for their intended population to access or that are inadequate to meet people’s complex needs;
- decades of de-funding and resulting privatization of services for people who live in deep poverty has created a patchwork system of service delivery, where the number and types of services available, rules for clients, and oversight standards vary arbitrarily from municipality to municipality;
- even well-intentioned service providers and health care professionals set up policies and engage in behaviours that are based in stigma and create service barriers; and
- the barriers we have identified, particularly where they result from attitudes of staff or policies rooted in stigma, have real-time negative impacts on people’s psychological and physical health, making it less likely that people will engage with the health care system in future.

We will explore each of the three broad service areas in detail, and conclude this chapter with a look at the role that engaging peers can play in improving service design, delivery, and advocacy.

**NEOLIBERALISM IN CONTEXT: HOW BC WAGED A NEW WAR ON THE POOR**

While the housing crisis in BC is not attributable to any one cause and not all homeless people rely on income assistance or disability assistance, it is clear that both the inadequacy and the inaccessibility of government income assistance are major drivers of homelessness.

There is widespread recognition among social scientists that many western nations, including Canada, have embraced an economic philosophy termed neoliberalism since the 1980s. Among other things, neoliberalism strives to achieve so-called “smaller government,” lower taxes on income and corporations, and privatization of government services. The continual rise in BC’s rates of homelessness since 2002, and the increasing role that private charities play in the lives of people living in poverty, track alongside the coordinated implementation of neoliberal policies in this province, including aggressive restrictions on the availability and adequacy of income assistance.

Despite already stringent eligibility requirements and poverty-level assistance rates, when the BC Liberal party came to power in 2001, they declared that they would put an end the “culture of entitlement” the previous government had purportedly fostered. The government of the day implemented a number of far-reaching changes to income assistance, with the goal of reducing the operating budget of the then-named Ministry of Employment and Income Assistance by approximately one-third, over a three-year period. The BC Liberal government began its economic restructuring program in 2001 with a 25% across-the-board tax cut. This cut resulted in diminished levels and availability of income assistance, increased pressure on single parents to find paid work, an erosion of labour standards, and greater reliance on the private sector to provide formerly public services.

In April 2002, the provincial government revamped income assistance in British Columbia. While the province’s income assistance rates and policies were already a target of criticism from anti-poverty activists and scholars, support rates were reduced and employable clients were limited to 24 cumulative months of assistance in any five-year period. The $100–$200 earnings exemption for those who earned additional income while on assistance was discontinued. Those changes to income assistance have had profound, longstanding impacts on the levels of poverty in Vancouver and across BC.

The sweeping cuts, which came into effect in April 2002, included the closure of 36 income-assistance offices across the province and the loss of 459 full-time-equivalent positions. The provincial government justified the cuts by virtue of the fact that they planned to significantly reduce the number of welfare

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267 The 2017 Metro Vancouver Homeless Count found that 22% of homeless people counted had part- or full-time employment and that others engaged in informal labour such as binning/bottle collecting to support themselves.

268 Key texts include: David Harvey, A Brief History of Neoliberalism (Oxford: Oxford University Press, 2005) and Jamie Peck, Constructions of Neoliberal Reason (Oxford, Oxford University Press, 2010).

269 Doug Ward, “BC Liberals’ 12 Years of Tax Shifts, Explained” The Tyee (May 6, 2013), online: https://thetyee.ca/News/2013/05/06/BC-Liberals-Tax-Shifts/.

270 This policy was changed in 2012 see: Legal Services Society Updates to your Welfare Rates (October 1, 2012), online: https://sci-bc-database.ca/wp-content/uploads/Your-Welfare-Rights-Update.pdf.

271 Earning exemptions were re-introduced in 2012 see: Government of British Columbia, Changes to Income and Disability Assistance take effect today (October 1, 2012), online: https://news.gov.bc.ca/stories/changes-to-income-and-disability-assistance-take-effect-today.
recipients. Other changes included an unwieldy new process for applying for disability benefits. Changes to income assistance were part of a broader project that unfolded during the early 2000s of dismantling social services including drastically reducing investment in low-income and social housing, privatization of formerly public services, and reducing regulations in areas such as labour standards.

In order to combat homelessness, income assistance rates must be raised to reflect the actual minimum cost of living, and the provincial government must invest in building an adequate supply of welfare-rate housing that meets the demand for it. What we learned from participants in this study is that BC needs to take immediate steps to address both the deliberate and the downstream access issues that make it difficult to secure and maintain even the meager income assistance benefits that are available.

A PROJECT OF EXCLUSION: INCOME ASSISTANCE IN BC

Access

The provincial government has described income assistance, known colloquially as welfare, as a “program of last resort.” Even if we accept that dissuading people from accessing income assistance is a legitimate policy goal, which we dispute, it is clear that the notion that welfare is and should be a last resort for people has been taken to such an extreme that it is causing objective harm to people in need, the communities in which they live, and society as a whole. A major study of people who are homeless in Vancouver reveals that the over half of respondents, 57%, never or only sometimes had access to Income Assistance within the previous two years.

People experiencing deep poverty are precisely the people income assistance exists to support. This statistic demonstrates the chasm that exists between the people who require social services and the real-life accessibility of those programs.

The provincial changes to income assistance in 2002 included new mandatory wait times for accessing assistance. This change had an immediate, negative impact for people who suddenly lost their housing or found themselves unable to pay their rent. One man who took part in this study was a professional contractor who found himself destitute in the midst of a struggle with anxiety, depression, and substance use.

He explained the reality of mandated wait times from the perspective of someone experiencing homelessness for the first time.

I was sleeping outside in a ditch at the time. And when you apply for welfare it takes over a month before they’ll even think about cutting you a cheque...So, I mean, I don’t know where I’m going to be in a month. I don’t have a clue. – 175

Once this cycle of poverty begins, a person may become entrenched in homelessness. The cycle makes it increasingly difficult to re-enter the labour or the housing market.

Someone is like, ‘Get a fucking job.’ Well, if that person...doesn’t have an alarm clock, doesn’t have food, doesn’t have something nice to wear, they are not going to get a job and then they are not going to be able to go to work. You need somewhere, somebody, to help you somewhere along the line. – 373

Along with the wait time, the closure of offices and the application process for both income assistance and disability benefits have become a major barrier for the people the system is intended to support.

One woman we heard from, who lives with a range of physical and intellectual disabilities, told us that her boyfriend helps her with the administrative aspects of accessing income assistance. “He knows how to read and write and he knows how to talk to the system (121),” she told us. For a person struggling with literacy, accessing income assistance would be impossible without help. That struggle also places the


275 For a current overview of wait times for accessing income assistance benefits, visit the Ministry’s website, online: https://www2.gov.bc.ca/gov/content/family-social-supports/income-assistance/apply-for-assistance
woman in a position of significant dependence in her relationship.

Many of the people we spoke with find web-based systems, like the main system through which people are expected to apply for income assistance and through which many rental vacancies are posted, to be highly inaccessible. "I need help sometimes finding housing (256)," one participant told us. "I'm kind of computer illiterate so I have a hard time with that [accessing rental listings online]. Telephoning is fine."

Even many of the participants in this study who felt comfortable using the internet did not have access to digital devices or places where they could go to use web-based services. "The only internet that's there is in [local service hub] we're not allowed access to it. Only the workers can... It's like in the back of the staff room, like our little office (313)," one person said. "And you ask them to do stuff like that and it's just like—like they're so busy."

We learned from service providers that in rural and remote communities, accessing services online is virtually impossible. People cannot access the internet from home and service hubs are located far from where people live.

Many people we spoke to also explained that they need help from an advocate to successfully navigate the income-assistance process. This means that community-based services mandated to serve a large potential client base and offer a broad range of services are increasingly overstretched as advocates spend much of their time helping clients access the government services to which they are entitled. This is especially the case for people like the woman we profiled at the beginning of this chapter who is homeless, living with cancer, and unable to access disability benefits.

She is the quintessential example of what happens when a system meant to provide a safety net for those in the greatest need is focused on keeping people off of benefit programs.

**Interviewer:** How do they treat you at the office?

**Interviewee:** Good. I know them all, so. I've been on it since I've been 18.

**Interviewer:** So you've been trying to get onto disability, you clearly have a diagnosis. What do you feel like the block has been?

**Interviewee:** Not enough services. The advocate. There's three different sections of it [the application form for disability assistance]. My doctor filled it out right away. I need the other two people to help me fill it out. I still haven't done that.

**Interviewer:** How long have you been trying?

**Interviewee:** Seven years now.

**Interviewer:** And nobody at the welfare office has offered to help you?

**Interviewee:** No. Of course not. – 397

The barriers people face in navigating the current system cannot be overstated. It is also important to recognize that people need to find ways to survive. While many people manage to get by engaged in lawful activities, such as collecting recyclables, the likelihood that someone will resort to illegal income generation is greatly increased when they have no access to basic income. One participant who was kicked off of income assistance explained his circumstances. "If you got warrants, they kick you off [income assistance] (459a)," he said. Getting kicked off of income assistance, he added, strips a person of their ability to attend to basic necessities like purchasing food and clothing for themselves. When asked if such a situation would make it more likely for him to steal food, he replied, "It does most definitely."

**Rules, Investigations, and Why Advocates are Sorely Needed**

Once a person has been successful at securing income-assistance benefits, experiences of precarity continue to feature prominently in their lives, particularly those living with intersecting barriers. Many people expressed frustration with the onerous requirements for maintaining their benefits, including implementing an employment plan,276,277 given all the challenges in their lives. One participant put it this way:

Last month, I had a hold on my cheque because I needed to sign an employment agreement. I tried to do so, but it was online. There's still no way for me to sign it. So now there's a hold on my cheque this month until it gets signed. – 332

Study participants also noted how easy it is for someone to reach out to income assistance and prompt an investigation questioning their eligibility due to income, assets, or family status. Several people who took part in this study had been kicked off of income assistance after someone contacted the Ministry with an allegation that prompted an investigation. Welfare “snitch lines” and anonymous fraud reporting are a major source of stress and concern in people’s lives. In BC, anyone can report suspected welfare fraud by filling out an online form that is easily accessible on the Ministry of Social Development

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276 Government of British Columbia, Employment Planning, online: https://www2.gov.bc.ca/gov/content/family-social-supports/income-assistance/on-assistance/employment-planning.

277 Government of British Columbia, On Assistance, online: https://www2.gov.bc.ca/gov/content/family-social-supports/income-assistance/on-assistance.
and Poverty Reduction’s website.\textsuperscript{278} The form allows people to tick a box stating that they would like to remain anonymous when making their allegation. The way in which fraud allegations, including those submitted anonymously, are investigated and the impact on people’s income, health, and safety is a complex issue that warrants further study.

In the current system, advocates play an important role; well-resourced advocacy services are needed in every community in BC. At the same time, when accessing government services, the need for advocacy support should be exceptional, not an everyday occurrence, because government services should be designed in such a way that they are accessible to those the services are in place to support.

The role of government employees administering these programs should be to connect people to services and benefits for which they are eligible. The stigma-driven ideology that underpins BC’s approach to income assistance has created a system that prevents the very people income assistance programs exist to serve from accessing desperately needed economic support.

Those with the fewest resources to fall back on have been diverted not into a booming labour market, but rather into homelessness for over a decade.\textsuperscript{279} Others have remained in abusive relationships, allowed employers to violate labour and human rights standards in order to keep their jobs, or turned to work in criminalized survival economies.

**SHELTERS**

Homelessness in Canada is not new, but it’s notable that homelessness has only emerged as a pervasive, growing so-called “social problem” in recent decades. In the late 1980s and early to mid-1990s, the federal government shifted its housing policy in favor of home ownership, and drastically cut spending in order to balance the budget. In practice, this shift meant cuts in federal funding transfers to the provinces, who then drastically cut their own program spending for housing and social services.\textsuperscript{280}

The result was a rise in homelessness and with it, the emergence of a loose system of faith groups, non-profit organizations, and local governments aimed at responding to the immediate needs of people who are homeless. That scattered web of supports responds to what needs it can in the form of emergency shelters, drop-in centres, counselling, social supports, and in some cases health supports, while being unable to provide adequate income and permanent housing, the actual keys to lifting a person out of poverty. This privatization process does not constitute a genuine replacement of the welfare state, but instead offers small-scale band-aid solutions. In BC, particularly from 2001 to the present, this process has led to the increasing formalization of the so-called “emergency” shelter system. This system provides beds or mats on a floor on a night-by-night basis. Some shelters only operate during specific times of year or when the temperature drops below a certain level.\textsuperscript{281}

Shelters are not an answer to the need for affordable housing in BC. However, as long as homelessness remains a reality in this province, it is critical that everyone in need has access to safe shelter that meets their needs on a more than overnight basis. Shelter providers must also do all that they can to promote health and dignity of their clients and offer as much privacy and autonomy as possible.

**Unavailable and Inaccessible**

In every municipality we visited, issues related to the availability of shelter spaces, living conditions inside of shelters, and reasons that people could not or would not access them, were a major topic of conversation.

One man who lives with anxiety, depression, and chronic back pain explained what living in the shelter is like for him.

I over-medicate myself at night so [I] can...not think about all the other people. And [I] do stay away from a lot of the people. Like I go outside a lot or I’ll hang out somewhere else away from inside, because once you’re inside, it’s 15 people to 20 people in a small little building, you’re cramped. You’re elbow-length away from your neighbour. So, it’s like a lot of little butting of heads here and there, and once in a while, of people. And it’s just part of having so many people in a small space, but I’m hoping this new shelter gets built because that will be helpful anyways...I already wanted to leave there many times and go stay in the bush if I could, but I can’t. So I’m just forcing myself through the process of being there like but it’s hard for me, so I smoke a lot more to medicate myself to just go sleep. – 269

He also explained that just maintaining access to his mat on the floor at the local shelter has taken over his life.

\textsuperscript{278} You can view the entire form here: BC Ministry of Social Development and Poverty Reduction, Fraud Allegation Reporting Form, online: https://www.reportfraud.gov.bc.ca/Allegation.aspx.


\textsuperscript{280} Stephen Goetz, “The Struggle to End Homelessness in Canada: How we Created the Crisis, and How We Can End it” (2010) 3 The Open Health Services and Policy Journal at 21.

\textsuperscript{281} BC Housing, “Emergency Shelter Program,” online: https://www.bchousing.org/housing-assistance/homelessness-services/emergency-shelter-program.
You get kicked out at eight o’clock and then you wait all day long and then you got to go back at four and then they will open up again... If it’s too full, that’s it, you are done, you got to go somewhere else...that’s why I show up early, I just go there at 3:30 and hang out ‘til it opens up and then I set my bed up and whatnot so I have my guaranteed spot every night. – 269

Another man explained the shelter situation in his community. “Especially through the winter months, they’re always full (175),” he said. “Basically, you got to pray that somebody goes and gets drunk and passes out in a bush and doesn’t show up so that you can get a bed.”

We heard stories of shelter turnaways in every region. For some regions, we have quantitative data that demonstrates the lack of shelter spaces is a pervasive problem. The Metro Vancouver homeless count is a 24-hour point-in-time measure of homelessness in the region. The 2017 count took place on March 7, and the report authors state that demand for shelter was so high on that single evening “that shelters, safe houses, EWR [Extreme Weather Response] shelters, transition houses, and detox facilities reported 334 instances of turning away individuals, primarily because they had reached full capacity.”

While the number of shelter beds in BC has increased since the last count in 2014, the latest count found that the increase was not enough to result in a lower number of persons turned away in 2017 compared to 2014.

The Problem with Shelter Operating Hours and Good Neighbour Agreements

Even where shelter beds are available on an overnight basis, they do not often address people’s need to have somewhere to spend time and attend to basic needs during the day.

As one participant explained, “We stayed [in the shelter] during the night, [they] kicked us out early in the morning, then we have to find shelter for the day (13).” She told us about having no shelter during the day, which results in exposure to the elements and pests, all while facing the threat of criminal sanction if she tries to shelter herself in public space. “We are not allowed to put up a tent or little tarp over us.”

This woman went on to explain that having to leave the shelter each day is made even more difficult because in her community, shelter residents have to take all their possessions with them and carry them around all day.

If I’m gone more than an hour they throw all our stuff in the bin... Like brand new clothes, whatever, they will throw it all way, no matter what. They will take the IDs out or whatever, and that’s the only thing they take out of the bag, and they throw everything away. All our personal...belongings, everything. – 13

She explained that having to carry all of their belongings, especially when using bags provided by the shelter, makes shelter residents who have no place to go more vulnerable to police...
harassment. “They know who all the homeless people are with the tote bags (13),” she said. “They know that the shelters are giving out tote bags and we are always getting our clothes thrown out, so we pack our stuff around, so now they just randomly search us all the time.”

In another community, a woman told us about the shelter where she stays when the temporary 24-hour shelter is not in operation. That shelter, like others we heard about in the course of our research, requires residents to leave after breakfast each day. While she shared that the staff are “lenient” with her because of her physical health condition and allow her to hang out in front of the shelter during the day, others are not extended the same courtesy. “Other people, they kick out (397),” she says.

We found this situation repeated itself in another municipality, where participants reported that shelter staff spent time looking for residents offsite during the day to ensure that they are not spending daytime hours too close to the shelter:

At [shelter], you are not allowed to be anywhere within a two-block radius. They do ground checks and they actually leave the property to do their grounds checks. They walk all the way around the [big box store], around the front of the business, and around an entire block. And then they go an entire block up, around the hardware store. So, they’re not even on their own premises. These are the [shelter] staff that does this. If you’re sitting, hanging out, and just chilling anywhere, they bar you. They kick you out. You can’t be across the street, down the road, anywhere. – 45 (focus group)

Many shelter operators are asked by municipal governments, surrounding residents’ associations, business improvement association, and other community groups to enter into what are known as “Good Neighbour Agreements” (GNAs). Municipal governments across Canada put GNAs into play as part of their response to public concern about services such as shelters. GNAs often include specific commitments by the service provider to take action on any issues or concerns identified by local residents.

Good Neighbour meetings, sometimes mandated as part of the agreements, are often unsafe for those who use the service in question to attend because service-users and their presence in the community is often conceptualized as a “problem.” In this way, the needs and realities of people who rely on shelters are not considered by the community in which they reside; this is yet another example of how essential services are not working to meet the needs of the people for whom they are designed.

Rules on Length of Shelter Stays: Reasonable in Theory, not in Practice

Not only are there limits on the hours shelters are open each day, some shelters also have restrictions on how many nights in a row people can stay or how many nights they can stay in a given month.

One man explained the rules around lengths of stay at the shelter in his community.

You have to have a plan in place...as far as I know it’s 30 days maximum...but there are extenuating [circumstances] where, like I know there’s one lady where she’s waiting on furniture. She has housing and she’s waiting on like a bed and stuff. So, her 30 days is up but she’s there an extra two days or something. There’s another fellow and he was there an extra eight days, and they gave him the boot last night, so he’s sleeping in a tent now. – 175

He went on to explain that while the rules around length of stay might make some sense in theory, given the affordable housing crisis in his community, they make little sense in practice.

They’re all run by [faith-based service provider], but each shelter has its own individual rules. And this one here you get, I think, five days. And then by the fifth day you have to have had an interview with one of the fellows out of the office. And you have to show them that you’re working towards something other than just staying there until your time’s up, which is, I mean, it’s good because it motivates you to try and find housing and whatnot, but unfortunately the housing situation here—you might just go beat your head against the wall because there’s nothing out there. – 175

In another community, people reported that the maximum length of time they could stay in the shelter was 15 days.

When asked whether this was because the shelter was at capacity, “I don’t know (170),” one participant replied. “That’s just the policy in town. Like, okay, your 15 days are up and it’s minus 40. What are you guys going to do?”

He explained that the application of the rule did not seem to be contingent on whether there was a waitlist for beds. After being out of the shelter for a couple of days, people were allowed to return. The ineffectual redundancy of this rule was not lost on participants.

Shelters were never intended to be permanent housing solutions, but they have become just that for a
A woman in her fifties explained the rules at her local shelter, the only one in her community. “No paraphernalia, right, and you can’t be high or drunk or anything coming in...then you have curfew. You have to be in by nine and you have to be gone by whatever time it is in the morning, I think it’s eight or nine (256),” she said. As has been discussed throughout this report, people’s experiences with homelessness can intersect with substance use. Because of the sobriety rules at this shelter, this woman has now been banned. “I OD’d [overdosed] in the shelter...I used outside of the shelter, right, and then I as soon I used I went directly in and then when it hit me because I don’t do IV right I do subcute,^286 so it takes about 20 minutes. So when it hit me, I was already in the shelter and I dropped, right (256),” she explained. “So, they said, ‘No, you can’t come back for 30 days or 90 days something like that.”

While it is clear that the rules at her local shelter are not meeting her needs, or the needs of many people experiencing homelessness in her community, she remains conciliatory. “It’s actually really good. Some of the people that run it aren’t, but regardless most of the times, it’s really good (256).” Some people were supportive of, or at least resigned to, the rules in place at their local shelter. However, in many cases, these rules are not aligned with the needs of local shelter users, and even work at cross purposes with the goal of keeping shelter users and the broader community safe.

Restrictions on Health Care Essentials

Shelters are the hubs for harm reduction supplies in some communities. In other communities, however, people reported not being able to keep harm reduction supplies at the shelter.

The shelter will take even clean rigs and stuff. And you know, like, they’re supposed to be into harm reduction and how can that be harm reduction when they’re taking our clean rigs?...Especially if it’s in its wrapper and stuff...I guess you have to be respectful and not use it in some places, but...I mean a lot of people won’t stay there because they’re alcoholics or drug addicts, right? – 181

Banning or confiscating harm reduction supplies from shelter users does little but put people at risk of further health-related harms. Shelter rules that prevent people from bringing harm reduction supplies inside have serious impacts on shelter users’ health and safety. As some participants explained, it also has public safety implications. Some people reported hiding harm reduction supplies or disposing of them improperly because they did not want to get caught bringing them into the shelter.

Discarding Belongings

In one community we visited, study participants expressed concern that shelter staff were regularly throwing away all of their personal belongings, not just harm reduction supplies. It was a major source of stress that was leading to deep distrust between shelter users and staff.

One participant told us that the regular practice of discarding shelter users’ belongings was especially hard on women. “There’s a lot of women that have a hard time finding clothes (326),” she said. She added that attempts to get belongings returned would result in losing access to the shelter. “If you try to get them back you get kicked out of [shelter].”

Shelters exist to provide a temporary housing solution for people with no other options. To discard what few belongings they possess does nothing to acknowledge their dignity, autonomy, and humanity.

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^286 A subcutaneous injection is administered as a bolus into the subcutis, the layer of skin directly below the dermis and epidermis, collectively referred to as the cutis.
Sobriety

We heard stories from people who had been banned from shelters as a result of intoxication. Many shelters have rules related to intoxication that span the gamut, from using on site to being identified by staff as being under the influence of a substance while on the premises. These rules, which can lead to a ban for a night, a ban for a specific period of time, or an indefinite ban, proved to be a major barrier to shelter access for many study participants.

When asked how often he sleeps outside, one man explained that as a result of vague shelter rules related to intoxication, he needs to sleep outside about twice a month. Sleeping outside, he told us, is especially difficult for his partner, “with her addiction. She’s on methadone and she’s got a problem with crack…being on the streets, it’s always there, and it’s really, really hard for her.” He said, “She starts smoking and when she does it and she takes her methadone and she flails so…But when she’s flailing a little bit she’s not hurting and bothering nobody, the [shelter] workers are like ‘No, you are out of here. Come back tomorrow.’”

Along with obvious health and safety concerns, denying a person shelter due to intoxication raises human rights issues, since BC’s Human Rights Code prohibits discrimination on the basis of physical or mental disability, with addiction being classified as a disability under s. 8 of the Code. It is important to note that having to sleep outside opens people (like the woman denied shelter access due to intoxication) up to health issues related to the cold and to criminalization because they have nowhere else to go.

They say that you can’t come in until you’re sober, so I had to sleep outside a lot…It’s hard. It’s getting cold at night…They come and they kind of bother me. They say, ‘You can’t be here.’ And I said, ‘Well, they won’t let me in the shelter, where else am I supposed to go?’”

Imagine getting kicked out of a shelter on a cold night and bedding down on the street, only to encounter a bylaw officer telling you that you can’t stay there. Even with nowhere else to go, people persist and survive.

“Choosing” to Forgo Shelters

Accessing shelter can be a matter of life and death, especially in extreme weather. Several participants explained the impact of not being able to sleep inside, even for a night or two. One woman told us about getting kicked out of her local shelter because she was intoxicated. To stay safe overnight because she was alone, she stayed close to the shelter and in a central area so she could scream if she needed help or press the shelter’s emergency button (312). Others also told us how being unable to access shelter for a night put their personal safety at risk.

Failure to access shelter can also open people up to harassment and criminal sanctions, such as police, private security, bylaw enforcement officers, and even members of the public patrol spaces where people could rest or sleep, prevent people from setting up encampments, and seize or destroy belongings.

Yet for some people who took part in this study, staying in a shelter is not an option. One man who is often hassled by police, bylaws officers, or private security for sleeping in public space explained his rationale for continuing to stay outside.

“I can’t sleep anywhere—anywhere. They say, ‘Well, we have the [main shelter] and [other shelter],’ but by the time I walk down there, will there be one of those 80 beds available? No. Am I actually going to allow you to treat me like a child and strip me of even more of my dignity and humanity? No. Am I going to walk away from that place with the stigma attached so everybody that sees me is now all of a sudden associating me with whatever it is they associate the shelters with? No, I’m not going to do that to myself. There’s no way.”

For some people who experience anxiety and other mental health challenges, the conditions in the shelter cause more distress than sleeping outside:

Interviewee:

There is just way too much shit in there…I want to choose who I’m around.

Interviewer:

Do you feel like that might be partly because you’re saying you had a lot of anxiety.

Interviewee:

Yeah, big time. – 416

Some shelters force couples to separate for the night; many study participants.

participants identified this policy as a major deterrent from staying in shelters. In order to fully understand the implications of the widespread lack of couple-friendly shelter spaces, it is important to recognize that these impacts go well beyond a situation where two people want to spend a night together. As the homelessness crisis continues to escalate, more and more long-term couples are experiencing sustained periods of homelessness. Many of the couples that took part in this study felt that having to separate every night had more negative impacts on their relationships than sleeping outdoors. One woman put it simply: “I’ve been with my spouse for 17 years. So when we were in the shelter I had to be away from him (181).”

No-pet policies also present major barriers to access to many people experiencing homelessness, including numerous Project Inclusion participants. Again, it is important to recognize that pets are family for some people who experience homelessness. They provide a source of connection, critical emotional support, and in the case of dogs, physical safety.

“We always say we’d rather be in the bush with our cat than downtown [in a shelter] (90),” one participant explained. “We couldn’t justify our cat sleeping out in the cold and we’re in there sleeping all warm and stuff. I love my cat.”

Our research shows that people’s experiences with shelters are at odds with the popular misconception that shelters are widely accessible, available, and welcoming to anyone in need. When considering how to improve BC’s shelter system, it is important to note the intersecting stressors that shape the lives of people experiencing homelessness. Those stressors are not inevitabilities or the result of individual shortcomings; they are driven by policy and stigma. Changing policy and how we treat people experiencing homelessness as a society, then, will contribute much to lightening their impact.

**HOSPITALS**

When we began this study, hospitals were not an area we were planning to explore, but issues related to people’s experiences in hospitals came up so clearly and consistently that they could not be ignored.

Homelessness entails a daily struggle for the essentials of life, and homelessness has a direct impact on health. Shelter conditions can result in exposure to infections and for those who spend their days outside, long periods of walking and standing and prolonged exposure of the feet to moisture and cold can lead to cellulitis venous stasis and fungal infection.\(^\text{288}\) As a result, people experiencing homelessness, whether they are staying in a shelter or sleeping outdoors, have unique and pressing health care needs.

Even under the Canadian system of universal health insurance, many people experiencing homelessness do not have access to a general practitioner or even a health card due to the barriers to maintaining possessions while living outdoors or in shelters. It is also difficult to make or keep appointments while living outdoors.

Health issues that are caused or compounded by homelessness, combined with lack of access to physicians, telephones, and safe places to rest comfortably make people experiencing homelessness particularly likely to use emergency health services\(^\text{289}\) and/or to require hospitalization.

Across the province, people felt that their local hospitals discriminated against people who use substances.

One respondent in a small community with very limited services described her experience seeking out harm reduction supplies from the hospital.

> We went because my ex-boyfriend, we sent him up there to get some harm reduction kits for us...And they told them they didn’t have any. And then another time he went back up there, they told him to sit down and wait and but they were on the phone calling the cops. So he took off.  – 108

Similar concerns arose in communities across BC when people who were homeless and people who use substances attempted to access care for health conditions that would lead anyone to seek treatment in a hospital.

In cases where there was no clear diagnosis, participants told us that hospital staff sometimes refused to believe that people identified as homeless or as substance users who were actually sick or injured.

At first, one woman was nervous to tell us she used illicit drugs. Once she opened up, however, it became clear that her local hospital’s response to her status as an illicit substance user was having a profound effect on her access to appropriate health care, despite her critical health issues.

This last time I was in the hospital with my leg, my doctor recommended I go to the hospital, so I went there...the staff in the emergency was so mean to me, like I couldn’t believe it, they were...


\(^{289}\) Our findings are in keeping with the results of the 2017 Metro Vancouver Homeless, which found that 50% of the respondents had used an emergency room in the past year; 40% had used the hospital for non-emergencies; 39% had used an ambulance; and, 39% had used a health clinic.
just so rude that they actually had me crying and I left and I went to their manager. I put in a complaint with their manager and I don’t know what happened with the two nurses that were being that way towards me. But I said, “I’m leaving,” and the manager says, “You can’t leave, it’s your health that’s the most important.” I said, “I don’t care, I’m leaving. I don’t want to deal with these two and I’m leaving.”…She accused me of being outside using drugs for an hour and a half. Some lady in the waiting room stuck up for me and said, “No she was only outside to have a cigarette and come back in.” And they still continued to be ignorant to me. – 397

This woman was one of three study participants who reported that they were dealing with cancer treatment while homeless.

In another woman’s case, the hospital was either unable or unwilling to provide a bed during treatment.

My last round of chemo I did living in a tent behind [business]. My husband thought I was going to die, the hospital wouldn’t keep me because I was an active addict, the hospital won’t keep me, and nowhere would help me. I’m still barred from all services of the [local shelter]…They barred me indefinitely two weeks before I was scheduled to start my last round of chemo…and they knew I was scheduled to start chemo, and they barred me indefinitely…I did a full round of chemo—of radiation—living in a fucking tent. – 153

In cases where there was no clear diagnosis, participants told us that hospital staff sometimes refused to believe that people identified as homeless or as substance users who were actually sick or injured.

If they know that you’ve used or whatever, they red-flag you. So, it pops up on the computer that you’re a drug addict or that you have addiction issues. So, basically—they’re done with you then…they started treating [you]…at first if you look okay and you’re not sick or looking rough, you know, like they’re okay, and they’re polite. They get you into a room fast. They come and see you every five minutes. And then as soon as they find out you’re an addict, they can leave you sitting for six hours sometimes…my boyfriend had appendicitis and they had him in the hospital here. And then they moved him up to [a larger hospital] and he went all the way without painkillers. And then they wanted to take X-rays in the morning and as they were taking X-rays, I guess his appendix burst because of all the pressure….You ask anybody who comes in here if they will go to the hospital, every single one of them will say no. – 181

Project Inclusion participants made it clear that BC hospitals are also poorly equipped to deal with the reality that people with addictions also have legitimate pain issues. Some are also failing to accommodate pain issues. – 181

One person described their experiences with pain medication and dope sickness while in hospital. “They don’t like to give me anything…they’ll pump me full of valium and saline and few times I’ve been in there, they’ll give me two milligrams or five milligrams of morphine every two hours, and which isn’t even enough to keep off the dope sickness (396),” they said. “Last time I was in there, I had to shoot up and they caught me shooting up and then they kicked me out…I was on intravenous Vancomycin for blood poisoning, yeah. And I had an abscess on my spine too, and they kicked me out.”

“There is strong evidence that these experiences are compounded for Indigenous patients. Several Indigenous participants in this project reported that they, a close friend, or family member had been ignored or sent away from the hospital despite being in serious medical distress. BC-based research indicates that Indigenous peoples face multiple barriers in their quest to receive…

“I did a full round of chemo—of radiation—living in a fucking tent.”

– 153
Several Indigenous participants in this project reported that they, a close friend, or family member had been ignored or sent away from the hospital despite being in serious medical distress.

health care. For example, a recent study published in Social Science & Medicine found that Indigenous people in the Downtown Eastside face stigma when accessing health care, including the denial of painkillers when in intense pain. Patients attribute this to the doctor's assumption that they are addicted to painkillers and seeking to obtain them. This perspective from patients is corroborated by some Indigenous health care workers, including a nurse who recently told CBC's The Current that she has heard of surgeons telling nurses during surgery that Indigenous patients have different pain receptors and that they do not require the same level of narcotics as a result.

When accessing emergency health services, Indigenous people are often presumed to be intoxicated and thus their medical needs are discounted. In 2015, Victoria's Times Colonist reported the story of an Indigenous woman who had a seizure and banged her head. Her boyfriend at the time called an ambulance. The woman recalled that her boyfriend was assisting her down the stairs. When they reached the bottom of the stairs, one of the paramedics who had arrived on scene said loudly, “oh great, another drunk native we have to pick up,” the woman recalled.

When compared to non-Indigenous Canadians, Indigenous people experience disparities in “health status, morbidity, and mortality rates, and health care access.” The racism that Indigenous people face in the health care system leads some people to avoid the system altogether, further endangering their long-term health. Racism in health care settings can also be deadly. There have been several high-profile incidents of Indigenous people in Canada dying after it was assumed incorrectly that they were under the influence of alcohol.

The contemporary experiences of Indigenous people, people experiencing homelessness, and people who use substances in hospitals across BC demonstrate the harmfulness and persistence of stigma and stigmatizing behaviours. As we've stated elsewhere in this report, this is not a simple case of “a few bad apples.” The stigma experienced by people who use substances and people who live in public space, alongside the racism that Indigenous people continue to experience at the hands of people who have a duty to provide them care, is an unacceptable outcome of generations of legislated racism and stigmatizing policy that we must all work to dismantle.

THE NEED FOR PEER-DRIVEN SERVICES

People who took part in this study had a lot of positive things to say about some of the service providers who made real differences in their lives. They also expressed that government and non-profit services often felt like unsafe, inaccessible institutions.

One participant explained how it feels to go into a government office and engage in self-advocacy. “Government offices are horrible, like I actually trip over my tongue (416),” she said. “I can't talk in them.”

Even where services have been designed specifically for people who use drugs, distrust, criminalization, and a history of experiences of stigma can make services inaccessible for people like this woman, who offered the following response when asked if she used the Local Overdose Prevention Site.

Interviewee:
No. No thanks.

Interviewer:
No, this is probably a dumb question, why not?

Interviewee:
Using drugs around people who don't use drugs, I'm sorry, but I just

290 Ashley Goodman, et al. “They treated me like crap and I know it was because I was Native”: The health care experiences of Aboriginal peoples living in Vancouver’s inner city” (2017) 178 Social Science and Medicine 88.

291 Ashley Goodman et al.

292 Ashley Goodman et al.

293 Piya Chattopadhyay “The Current” (March 2, 2018), CBC, 7.


295 Ashley Goodman et al.

296 Ashley Goodman et al.

can’t do it. Yeah, it’s just strange to me, very strange. – 416

In some communities, peer-run services—services operated by people with lived experience of poverty, homelessness, and substance use, such as peer-run needle exchanges or peer-run groups for people who use drugs—are not widely available or understood. When we explained the concept of such services to her, she expressed more openness to making use of them.

In other communities, people we heard from were already working as peer-service providers. However, barriers like shelter rules against carrying harm reduction supplies were making it hard for them to do their jobs.

I used to carry supplies, hand them out, because I was rig digging
digging through [peer outreach service] and I was homeless. They knew that I had supplies on me and they wouldn’t let me in [the shelter]...I was banned...So it was a catch 22, right. I’m just handing supplies out...I wasn’t implementing nothing. I am just here, if you need supplies I am here. I’d rather see you use safe supplies than bad supplies, like using the same rig or using the same shit over and over. That is not good, that is not healthy. – 165

In other cases, we heard that rules around employment are preventing people with lived experience from getting involved in service delivery.

“I wish I could become staff, but because I don’t want to stop [using] marijuana, they don’t want to give me a job (289b),” one participant told us. “They need to do a better job of hiring people who have experience living out.”

As we spoke to people around the province, a vision emerged for the types of services that people who have experienced poverty and social exclusion would like to see in their communities.

There was a notable interest in establishing safe, inclusive, community driven spaces for people to find community, solidarity in their shared experiences, and protection from the elements.

There’s a lot of street people that use drugs, and they don’t want to stay indoors, and I always say they should have a gigantic tent with heaters in there, and they could all come there and be safer...you be together and do their drugs together...that would help a lot. – 326

Participants also expressed a desire for an inclusive, one-stop facility in which people could use substances and dispose of harm reduction supplies safely, with supports close at hand.

If I ever won a lottery, I would like to have a place where people would go [to] like two different floors, one where they could use...safely, have a nurse there and all that, and a place where they could go without using...That way they could interact with each other but be more respectful and...in [a] safe and clean environment. And clean up after themselves, like if they use there’d be a room where they could go and there will be things for needles. – 71

Back in front of the shelter that opened this chapter, the woman who shared her experiences of homelessness with us described two

298 “Rig digging” is a term for locating and safely disposing of used syringes.
things she’d like to see change in the realm of service provision. “I think that there should be more advocates (397),” she said. “And they should be more lenient with the food [bank].”

In her words, we hear two simple themes that should guide services around the province: make sure that services and systems are accessible and navigable for those who need them most, and treat people in need with respect. Livable income assistance rates, more social housing, and health care options that work for people living with substance use and poverty, are also essential.

In order for all of this to happen, we need more financial resources, but we also need to undo the underlying stigma that informs everything from punitive income assistance policies to the negative experiences people have with service providers during a health crisis.

Recommendations

1. The Province of British Columbia must amend the Human Rights Code, RSBC 1996, c 210 to prohibit discrimination and harassment based on social condition.

2. The Ministry of Mental Health and Addictions and the Ministry of Health must improve the ability of BC hospitals to meet the needs of people living with the effects of substance use, mental illness, and/or homelessness by:
   a. auditing experiences in hospitals, beginning with an analysis of people’s experiences where they have been turned away from emergency rooms or discharged and where there have been negative health consequences;
   b. working with people with lived experience to audit provincial standards for effectively managing substance withdrawal in hospital settings;
   c. ensuring that all hospitals offer supervised consumption services to patients; and
   d. working with the Ministry of Municipal Affairs and Housing to create transitional housing options to ensure that sick and injured people are not released from the hospital to the streets or to emergency shelter.

3. The Ministry of Social Development and Poverty Reduction must make immediate changes to BC’s Income Assistance and Disability Assistance programs including:
   a. increasing income assistance rates to the Market Basket Measure299 and indexing them to inflation;
   b. reviewing the processes that are currently in place for reporting “welfare fraud” to provide greater accountability and ensure that people receiving income assistance are not denied survival income without due process;
   c. increasing access to in-person services for income assistance and disability applicants; and
   d. ensuring that people living with disabilities can access disability support by:
      i. simplifying the application process to reduce wait times and lessen reliance on advocates;
      ii. providing provincial guidelines for doctors/service providers on how and when to fill out disability forms; and
   iii. ensuring that hospital social workers are resourced and directed to work with patients in need to apply for disability benefits.

4. The Legal Services Society of BC must provide legal support for appeals where a person has been denied income assistance or disability assistance.

5. The Ministry of Housing and Municipal Affairs must immediately improve the number and accessibility of shelter options to ensure that everyone in BC always has access to a physical location where they can sleep, store belongings, and attend to personal care and hygiene in safety and without threat of displacement or sanctions. To do so they must:
   a. work in partnership with BC Housing to reinstate nightly turn-away counts at shelters and use data to ensure that there are adequate shelter beds to address the level of need in each municipality;
   b. with the exception of temporary Extreme Weather Response shelters, recognize that overnight-only shelters are untenable for residents and provide funding to expand shelter hours; and
   c. provide shelter residents an accessible and independent complaint process.

6. All government actors and health care providers must recognize the specific and indispensable expertise of people with lived experience. Increase peer-run and peer-delivered services and peer-support positions within government services by:
   a. developing a provincial advisory board of people with lived experience of homelessness for BC Housing;
   b. establishing provincial best practices for engaging people with lived experience of poverty, homelessness, and substance use in service delivery modelled on GIPA (Greater Involvement of People living with HIV/AIDS), MIPA (Meaningful Involvement of People Living with HIV), and NAUWU (Nothing About Us Without Us) principles;
   c. collaborating with peer-led organizations to audit all provincial services (hospital, health, income assistance, shelter, housing) to identify and fund opportunities for peer engagement in service provision and planning; and
   d. developing a model for peer-involvement in the design and execution of homeless counts.