Vancouver's Downtown Eastside:

A Community in Need of Balance

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I. Overview

There is likely no area in Canada that has been studied and experimented upon more widely than Vancouver's notorious Downtown Eastside. Long an area inhabited by low-income residents, it is now widely known as home to drug users and a myriad of drug dealers; as the community of last refuge for the mentally ill; as a ghetto filled with less than substandard housing; as a dangerous but accepting refuge for the homeless; as the nexus of crime for Greater Vancouver; as the danger-filled workplace for marginalized prostitutes; and as the destination of last resort for society's discards.

The Downtown Eastside, postal code V6A, has been cited for years by Statistics Canada as one of the country's poorest postal codes and likely remains Canada's poorest urban area. However, this neighbourhood includes much more than the few blocks of open-air drug market on East Hastings Street which commonly define the area to the world at large. Beyond the drug 'ghetto', V6A includes Chinatown, Strathcona, industrial land, co-op housing and high-priced condos, million-dollar houses, Science World, the Via Rail station, the bus depot, the rail yards, a number of churches, a vibrant business community, and numerous schools, daycares and community centres. Residents of the area include families, seniors, immigrants, long-time residents, middle to upper income earners and a disproportionate number of individuals and families on welfare. The community also includes a seemingly ever-increasing number of social service agencies, social housing units, shelters, and well-meaning service groups. The social service industry is alive and well in V6A.

For those who live and work in this community, it has become more --- the recipient community of numerous social experiments by governments, bureaucrats, academics, researchers, social agencies and well-meaning volunteers -- experiments designed to ameliorate the community's social problems. One has only to look at how the neighbourhood is portrayed in the news to know that most of these social experiments have failed.

So what went wrong? Years of attention and millions of dollars have been directed to 'solving' the Downtown Eastside, yet the problems still exist. Arguably, the situation is actually getting worse. Numerous scenarios compete for attention as THE solution: fill the area with social housing; build more social housing only in other neighbourhoods; legalize drugs; crack down on drugs; give people free drugs; reduce harm; promote only abstinence; crack down on crime; raise welfare rates; send everyone to work instead of welfare; legalize the sex trade; crack down on the street sex trade; etc.

Certainly this competition and confusion doesn't help. But there is an underlying problem that appears with even the briefest analysis of the proposed solutions --- each scenario deals with a different specific problem and is aimed at dealing with a specific problem group. However the V6A neighbourhood is not a social experiment run on a grand scale. V6A is a community.

The above rhetoric is not meant to diminish the problems faced by too many area residents. These problems are intensely real. However the 'social experiment' analogy does point to a very real and rarely discussed question: namely, how much of the current situation results from problems caused by *the system* itself? Are there underlying reasons why so many initiatives implemented over the past 20 years have basically failed to change the situation or even made things worse for the community itself and for its most marginalized residents?

This paper incorporates a historical review of the frames of reference used by governments and bureaucrats in developing the many programs and implementation strategies. It is based on extensive

research of documentation collected from various sources, including community organizations, web-based sources, and the author's historical records; plus dialogue with relevant individuals. Repeatedly concerns have been raised that the strategies chosen may have set up these initiatives for failure. In essence, four areas of concern were commonly cited:

- Programs were developed in isolation of other initiatives and targeted to one specific problem or even to one specific approach to the problem --- eg, addiction programs responded specifically to addiction issues (and sometimes only one part of these, such as 'harm reduction' to lessen disease), not to the reality of the whole person, and/or responded to the addicted population in isolation from the rest of the community.
- Funding was awarded to deal with individualized issues rather than to support comprehensive strategies. In more recent years, funding was often subject to a competitive process which placed community-based organizations at odds with each other, while resulting in a significant disruption in the continuum of community supports.
- Strategizing on solutions for issues in the area tended to occur among professionals, mainly in isolation from community residents, businesses and structures. These solutions frequently ended up at odds with community planning and priorities, resulting in unnecessary opposition, flawed implementation, unintended consequences, and too often failure.
- The philosophy adopted by governments and other senior partners was to develop strategies targeted to address community deficits rather than building on community capacities, resulting in symptom management rather than community healing.

An examination of certain key issues --- homelessness and housing, addiction and mental illness, the health crisis, crime, community planning, the business community --- based on the roles *the system* played in determining appropriate responses, demonstrates why even arguably successful programs too often failed to really alter the community's realities.

This historical review has pointed to the need for a paradigm shift in the systemic approach to community planning. Promising and best practice strategies build on the community's strengths and successes to better evaluate the issues, develop a realistic community vision (reflecting broad community engagement) and implementation strategies.

The current problems faced by the Downtown Eastside can only be truly understood within the contexts of the neighbourhood's history and demographic make-up. The seeds of dysfunction were sown in the 1980s with the deinstitutionalization of the Riverview complex. A number of significant compounding initiatives arose during the 1990s. Since then advances made have been overshadowed by top-down bureaucratic 'problem-solving', which often made things worse, and by a lack of any true community-wide planning.

In their 2010 book *The Abundant Community*, Peter Block and John McKnight discussed at some length the faults inherent in how *systems* address issues, noting that "*one reason why systems cannot deliver what they promise is that they market their promises by the celebration of deficiencies..... by the belief that we are a diagnostic category; that we are a need, not a capacity, and that only a system, a product, a professional service can satisfy that need." Or to phrase the problem more succinctly:*

> *"By their nature as systems they say to us, 'You are inadequate, incompetent, problematic, or broken. We will fix you. Go back to sleep'."*[1]

Surely 25 years is time enough to prove that a new approach to community development in the Downtown Eastside is long overdue.

[1] John McKnight and Peter Block, *The Abundant Community. 2010*

II. Introduction to the Downtown Eastside (DTES)

The DTES neighbourhood, for the purpose of this analysis, is defined as being bordered by Cambie Street to the west, Clark Drive to the east, Venables Street/Prior Avenue to the south, and the waterfront to the north. The DTES includes many sub-areas, making it one the most diverse neighbourhoods in Vancouver. These areas include; Gastown, Victory Square, Chinatown, Thornton Park, Oppenheimer, Strathcona, and the Industrial area. The center of the neighbourhood runs along Hastings Street.

The DTES is Vancouver's oldest neighbourhood and contains many important heritage sites. The area was the centre of Vancouver at the beginning of the 20th century and remained for many years a major hub for the City's commercial and industrial activity. The Carnegie Community Centre, built in 1903 at Main and Hastings with funds donated by steel magnate Andrew Carnegie, housed Vancouver's first public library and remains an active community centre to this day. Vancouver's first City Hall also was located at Main & Hastings. The City's first department store, Woodward's, opened on Hastings Street in 1903. Hastings Street was also home to the Vancouver's oldest theatre, the Pantages, founded in 1908. Canada's first permanent cinema was believed to be the Edison Electric Theatre, opened in 1902 on Cordova Street. The DTES was also the major transportation hub for the city, housing among other amenities the BC Electric Interurban Station (the City's streetcar terminus) at Hastings & Carrell Streets ; the North Shore Ferries terminal at the foot of Columbia Street; and the coastal steamship piers between Carrell and Main Streets. The neighbourhood had a flourishing retail business environment that created jobs for local residents. [2]

Eventually, as Vancouver developed, the City Centre began to relocate around Granville Street. The process was gradual, beginning with the 1906 relocation of the Courthouse to a new building on Georgia Street. However the DTES maintained its vibrant character for the next half century, anchored by Woodward's, Vancouver's primary retail location, which was a destination for shoppers city-wide. Numerous hotels were built in the area to accommodate commercial travelers and tourists; these later began to serve as permanent housing for single men who worked in the resource industries. The area also became home to a vibrant Japanese community, many of whom worked in the fishing industry.

[2] City of Vancouver. "Downtown Eastside, History & Heritage." 11 Sept. 2006. <http://vancouver.ca/community_profiles/downtown_eastside/history.htm>.

The character of the neighbourhood changed dramatically with the discontinuation of the City's streetcar service in 1958, and the shutting down of the North Shore Ferry Service the following year. The end of these transportation hubs meant that the thousands of people who had flowed through the neighbourhood on a daily basis now travelled through other parts of the City instead, which in turn crippled many local businesses. The local Japanese community had been largely dispersed by internment policies during the Second World War. By the 1970s many of the Single Room Occupancy (SRO) Hotels had become the homes of single middle-aged men with modest fixed incomes.[3]

The situation in the neighbourhood began to seriously deteriorate during the1980's, resulting in part from the deinstitutionalization of patients from mental health facilities in British Columbia. The lack of proper support services for these newly released patients led many to the Downtown Eastside's affordable rental housing units. This influx was compounded as a number of shelters and some housing for these ex-patients were built in the neighbourhood at the same time. Lacking proper supports, many were unable to cope in community settings and stabilize their lives. They became easy targets for predators, especially those in the drug trade.

During the early 1990s the downward spiral of the neighbourhood was completed when the Woodward's department store went out of business, to be followed soon by other stores and restaurants in the area. Meanwhile the worldwide increase in illegal drug production led to both an increased availability and reduced cost for street drugs in the area. The primary drugs of choice were heroin and cocaine. Vancouver was unusual in that both were primarily taken through injection, placing far more users at risk of disease transmission through sharing injection equipment. The epidemic of crack cocaine use (in which the drug is primarily smoked rather than injected) that hit much of North America at that time did not fully take hold in Vancouver until the end of the decade.[4]

The scale of drug use in the area created a serious epidemic in the spread of HIV among injection drug users. As testing for Hepatitis C became available, it also became quickly apparent that this virus had been spreading among drug users during the previous decades and that almost 90% were now infected. Even ex-drug users who had stopped using in the 1980s were found to have acquired this insidious disease.[5]

Problems caused by the de-institutionalization of the mentally ill and the increasing availability of street drugs were now further compounded as funding for the construction and operation of supportive housing disappeared and welfare rates across the country began to be cut. The Vancouver problem was further exacerbated for a number of years, as BC remained the only province to maintain relatively high welfare rates, adding to a gradual – and at times not so gradual – influx of drug users from across the country seeking cheaper drugs, a better climate, and reasonable welfare supports. Finally in 1995, some restrictions began to be imposed on BC's welfare eligibility; eligibility was significantly slashed further in 2003. Overall rates, including the housing allowance, did not increase from 1995 to 2007, and then only moderately. At least partly due to lack of funding for proper upkeep, many local SROs became dilapidated. Taken together, these conditions - a perfect storm of social dysfunction - created an increasingly chaotic street environment.

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[3] City of Vancouver. "*Downtown Eastside, History & Heritage*." 11 Sept. 2006. <http://vancouver.ca/community_profiles/downtown_eastside/history.htm>.

[4] Personal observation of the author who ran Vancouver's Needle Exchange and other programs at the Downtown Eastside Youth Activities Society from 1993 to late 2005.

[5] Individuals known to the author. Specific blood screening for HCV did not begin in Canada until 1990.

It is important to place these problems in context. Viewing the community through the lens of its deficits does not present an accurate reflection of the entire Downtown Eastside. According to City of Vancouver[6] statistics from 2005, the area is home to approximately 16,590 individuals. While a number of these are certainly the visible street-involved population, more than one-third are aged 55 or older (22% are 65+) and slightly less than 15% are under 19. Approximately 62% live alone (close to half of whom are likely in the 55+ age range). 38% live in a family structure (an estimated 24% as single parents). Over 60% of those in Strathcona live in families. Strathcona and Chinatown house a high immigrant population, while the rest of the Downtown Eastside is primarily non-immigrants. Both Strathcona and Chinatown have large Chinese-speaking populations. The neighbourhood also houses a successful business community of approximately 2,300 establishments employing more than 20,000 people.

The city's urban Aboriginal population has been overly affected by the area's problems. Exact numbers are difficult to determine. According to Statistics Canada, approximately 10% of the City's Aboriginal population lives in the area, although many more visit on a regular basis.[7] Other estimates range as high as 30%-40% of the area's residents at any given time. What is clear is that historical poverty and cultural dislocation have tended to place this group among the most marginalized, making them particularly vulnerable to the social dysfunctions evident in the neighbourhood.

Over the past decade many solutions for the area's problems have been suggested and some have been implemented. However the street scene in the neighbourhood remains chaotic. Drug use is rampant. Housing is being built but the problems of poverty and homelessness continue. According to a 2008 report from the Vancouver Police Department[8], more than one-half of all their calls in the DTES involve people with mental health issues. Despite claims that the situation is improving, these improvements show few signs of resolving the neighbourhood's most serious problems.

[6] City of Vancouver, 2005/06 , *Downtown Eastside Community Monitoring Report*, Based on Statistics Canada reports

[7] Ibid.

[8] *Lost in Transition*, 2006, Detective Fiona Wilson-Bates, Special Investigation Section, Vancouver Police Department

III Homelessness and Housing

It has long been said by many who live or work in the area that the problems of the Downtown Eastside did not begin just there and will not be solved just there. This observation is certainly true when it comes to considering the problems of homelessness and the ghettoization of SRO and social housing.

As has been noted above, in the early days of the neighbourhood, it became a hub for the development of commercial (SRO) hotels and over the years, these establishments evolved into housing primarily single men on low or fixed incomes. As the character of the community changed in the 1980s and 1990s with the influx of deinstitutionalized people dealing with mental health issues and with the explosion in the availability of low-cost street drugs, the uses and condition of the SRO hotels increasingly changed as well. General visitors to the City chose not to stay in the uncomfortably chaotic environment, which meant that hotel owners were usually able to find tenants only among people on welfare or with similar low incomes. The 'ghettoization' of the neighbourhood was further compounded as housing stock in Vancouver became increasingly scarce and low-cost housing and SRO hotels began to disappear throughout the rest of the City. Ultimately the local housing stock was insufficient to cope with the influx of those in need; by the late 1990s, the area 'housed' a visible homeless population.

The lack of affordable housing is not unique to Vancouver. Changes to federal tax system in the 1972 drastically reduced the private construction of rental housing. In 1992, the federal government compounded the problem by transferring all responsibility for social housing to the provinces, ending its financial involvement in this and other areas constitutionally under provincial authority. Although BC maintained its own housing program until the end of the decade, a change in government then led to cancellation of this last support. Across the country, welfare housing subsidies did not keep pace with rising rental costs. Homelessness became a visible norm in most Canadian cities.

The situation in Vancouver continued to worsen after 2000. Some social housing and shelters were developed but still not enough to cope with the demand. Further, the vast majority of those were also located in the Downtown Eastside, compounding the problems faced by a neighbourhood already overburdened with high-impact individuals. Ongoing street drug dealing and drug use continued to make much of the area feel unsafe and even many of the homeless themselves felt at risk if they remained in the community. By mid-decade, homelessness had become a problem for the entire city.

Statistics tell the tale. The results of the 2010 Vancouver Homeless Count show of 1,715 homeless individuals living in the city, a 9% increase over 2008. Shelters, including safe houses and transition houses, accommodated 75% of the city's homeless, compared to 49% in 2008."[9] 45% of the homeless had been homeless for a year or more. 57% of them called Vancouver their home. 79% had one or more adverse health conditions. Although the percentage staying in shelters gives the appearance that these individuals are less street involved, it should be noted that many shelters only open overnight, forcing those sleeping there to spend their days on the street and/or using community facilities.

The scope of the housing crisis goes well beyond individuals who are visibly homeless. Particularly in Vancouver, which has seen an explosion in condo development, rents are becoming increasingly high as rental units become increasingly scarce. Many who still have housing are inadequately housed or are only one crisis away from joining the ranks of the homeless.

[9] *Vancouver Homeless Count 2010*." 30 June 2010. <http://vancouver.ca/commsvcs/housing/homelessness.htm>

The problem is finally being addressed by the provincial government and the City of Vancouver, at least in part spurred by concerns for Vancouver's image during the 2010 Olympics. As of June 30, 2010, the provincial government had funded approximately 26,700 units of subsidized housing in the Vancouver area through a variety of programs, including providing more than $30 million annually to subsidize over 7,000 units of social and supportive housing, managed by non-profit societies, housing co-ops or BC Housing in the DTES. Approximately 180 additional units of supportive housing are expected to be completed in the next few years. Additionally, the province has invested in approximately 1,400 long-term, supportive housing units on 14 sites owned by the City of Vancouver, several of which are located in the DTES. Part of the province's commitment to providing social housing has included the purchase of 24 Vancouver single room occupancy hotels, protecting and rehabilitating 1,474 units of affordable housing (including 1,226 in the DTES) for people in greatest need.[10]

City Council's approval to allow the development of 'laneway housing' has the potential to provide at least some relatively affordable rental housing, although to date much of the housing so developed has tended toward targeting the higher rental market. Local funders, such as the Streetohome Foundation, are also taking on the housing challenge and have developed specific programs to increase low-cost supported housing, while working to effectively harness support from the private sector.

There is wide agreement that providing more affordable options is necessary to fully deal with the region's housing problem. However there is substantially less agreement on how best to accomplish this goal. Five separate issues are relevant to the DTES situation:

A. Housing Location:

While it is generally acknowledged that affordable housing is needed throughout Metro Vancouver, the issue – particularly in the City of Vancouver -- is quite contentious. Essentially, there is little agreement between those who argue that the DTES should remain the main location for the city's social housing and those who argue that the DTES is already overrun with social services and the remaining housing needed should be established in other neighbourhoods.

For those living outside of the DTES, while they might accept in principle that their neighbourhoods should 'do their part', they also fear that establishing social housing will bring aspects of the inner city chaos to their communities, lowering property values and potentially endangering their families. Most people, despite their fears, are willing to work towards reasonable compromises on types of housing, number of residents, etc. However, a movement has also sprung up in recent years, calling itself *Not in Anyone's Backyard*, which argues that the types of facilities being built and populations being housed under current models bring risks to all residential communities.

[10] *Housing Achievements in British Columbia*, BC Ministry of Housing and Social Development, 14 September 2010 <http://www.gov.bc.ca/fortherecord/achievements/ac_people.html?src=/people/ac_people.html>

For those living in the DTES, this issue is incredibly polarized. A very vocal group of housing providers and local residents argues quite forcefully that the neighbourhood should remain the repository of social housing and social services for Vancouver and that other business and condo developments should be discouraged in this area. An equally concerned, if somewhat less vocal, group of residents and businesses argue that the community should not be maintained as the epicentre for supportive and SRO housing and that the area must take on the mixed housing character of other city neighbourhoods. The majority of the area's families, seniors, working people, schools, community centres and business already feel oppressed by the neighbourhood's level of street dysfunction, open drug use, rampant crime and lack of safety. They argue that no neighbourhood can remain healthy when populated by an over-abundance of high-impact individuals.

Decades of experience with concentrated social housing 'ghettoes' in much of the United States and in some Canadian cities backs up the case for diversification. The issue is more obvious in certain US cities where racial ghettoes and poverty ghettoes came to be seen as virtually the same thing. There, movements towards racial equality in the 1960s and 70s and the widening of economic opportunity brought earlier focus to the dysfunction inherent in providing large tracts of social and low-cost housing in isolation from housing targeted to middle and upper income earners. Unlike in the US, most poverty ghettoes in Canada were not planned as such, making it in some sense easier to accept the low-income concentrations in these neighbourhoods as matters of 'choice', rather than 'necessity'. Lack of intent notwithstanding, Canadian urban ghettoes have also tended to house disproportionate numbers of racial minorities, and in the case of the DTES more Aboriginals and immigrants/refugees.

Much of the research on best practices in dealing with concentrations of poverty in urban areas has also been done in the United States. In 1995, the Mayor of Minneapolis, Sharon Sayles Belton, observed, "*We know that poverty by itself doesn't cause urban problems. It's the concentration ... that eventually strangles those neighborhoods economically, making it impossible for residents to have access to jobs, good schools, health care, transportation. These are living conditions that can, and too often do, foster hopelessness, despair, and antisocial behavior."*[11] This opinion was echoed by Howard Husock, Director of the Manhattan Institute's[12] Social Entrepreneurship Initiative: "*Housing projects radiate dysfunction and social problems outward, damaging local businesses and neighborhood property values. They hurt cities by inhibiting or even preventing these rundown areas from coming back to life*."[13]

Research such as that quoted above and years of experience in other urban centres make it clear that maintaining the DTES as a high or special needs social housing enclave, over the long term will not help to stabilize either the community or the city as a whole. The route to revitalization involves the area moving to a more mixed development model while affordable housing is concurrently developed in other neighbourhoods and communities.

B. Housing First:

In March 2002, U.S. President George Bush appointed Philip Mangano as the Executive Director of the Interagency Council on Homelessness, giving him the daunting task of implementing the President's commitment to end homelessness. Before moving ahead to carry out strategies and disperse funding, Mangano did his homework. When he talked with service providers across the country, many said they

[11] Quoted in *Clearing the Way: Deconcentrating the Poor in Urban America*, by Edward G. Goetz, is available in paperback from the Urban Institute Press

[12] <http://www.manhattan-institute.org>

[13] Quoted in *Gentrification is Good for the Poor and Everyone Else,* by Richard L. Cravatts, American Thinker, August 01, 2007

needed more resources to keep providing more interim services: shelters, outreach, food programs, transitional housing, etc. When he talked with the homeless, most simply said they wanted a home.[14]

'Housing First' is the model that responds to that wish. The idea is simple. Those who are homeless are linked to housing that is expected to be stable and long-term --- they are given a home. It is accepted as a matter of principle that whatever other issues these new residents will have to deal with, achieving a stable place to live must be their first step.

Mangano did not develop the Housing First model, although he deserves much credit for its widespread adoption and funding. This approach has been used effectively for a number of years in some centres, most notably in New York City where it was pioneered by organizations such as Common Ground. However, since its initial inception, the acronym Housing First has actually been used to describe a number of different approaches to meeting the needs of the homeless. It is important to clarify those issues.

C. Housing or Home?

Despite Mangano's research and the experience of groups like Common Ground, Housing First has come to represent a number of different strategies designed to get people housed in some form or other. The term is now used locally to describe any strategy that gets the roof over the head of a homeless person. While not all providers would consider that shelters should be designated as housing, some do. Certainly transition housing --- ie, housing where the expectation is that the resident will ultimately move somewhere else to permanent housing --- is included under the Housing First umbrella.

It is hard to argue that, given Vancouver's rainy climate, any type of housing isn't preferable to being homeless. Even a modicum of stability is hard to achieve when living on the street. Research on the best model for housing the homeless is still somewhat mixed and tends to produce somewhat varied outcomes, depending on the location involved. However, certain best practices are becoming clear. A study presented at the 2007 US National Symposium on Homelessness Research [15] observed that while more research would be necessary to form definitive conclusions, there was sufficient evidence to support the efficacy of certain 'best practices':

- *Outreach* to homeless people who are living on the street and in shelters is often a first step in the process of engagement in the service system, but outreach cannot end homelessness unless it is tied to housing placement and support.
- *Case management and assertive community treatment* have been established as optimal techniques for the delivery of mental health and substance abuse treatment services to people with severe mental illness and histories of residential instability. It has proven more cost effective for a single provider to directly deliver all services to homeless people with dual disorders as opposed to dealing with individual issues through separate, parallel systems.
- *Permanent supportive housing* increases housing stability and decreases use of costly institutional services such as shelters, hospitals, emergency departments, and prisons.

[14] Presentation to the Vancouver Board of Trade, 9 May 2007.

[15] People Who Experience Long-Term Homelessness: Characteristics and Interventions ; Carol L. M. Caton, PhD, Columbia University, New York, NY; Carol Wilkins, MPP, Corporation for Supportive Housing, Oakland, CA; Jacquelyn Anderson, MPP, Corporation for Supportive Housing, Oakland, CA

Practices by innovative organizations such as Common Ground in New York City have demonstrated significant success in developing scatter-site mixed-population housing models which place individuals with varying degrees of risk together in single residences, rather than using a model which places a significant number of people with similar problems into the same multi-unit building. They have also separated housing management (which they provide) from support services (which they contract from others), tying supports to the individual rather than the specific building. As a result, individuals have housing that they can keep as long as they want, no matter what their other circumstances. The assumption is that they are tenants, not clients. They are not expected to transition unless they choose to move on for their own reasons. This particular model has proven particularly effective in stabilizing very high-risk individuals. [16]

D. Costs:

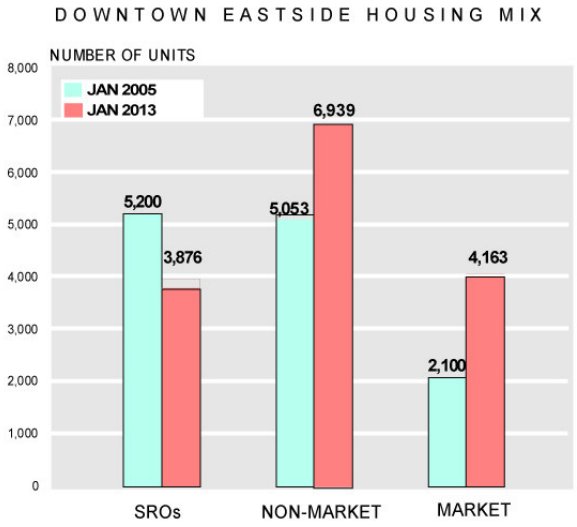
Numerous studies have very clearly indicated that it is cheaper for governments and taxpayers to fund housing than it is to cover the costs of services used by the homeless. For example, according to a 2001 study by the BC government, the impact of providing shelter and services for one homeless person costs the public up to $40,000 annually compared with up to $28,000 for a person who has housing.[17]

The cost of homelessness to the public goes well beyond the actual supportive services provided due to the attendant negative impacts on neighbourhoods and businesses. The sight of people living on the streets and panhandling negatively affects retail businesses and perceptions of community safety, as well as impacting tourism which is a major economic driver for Vancouver.

Homelessness also has a direct effect on unemployment. People living on the streets are usually unable to obtain regular work because of their pre-occupation with finding food and shelter, to say nothing of facing obstacles to gaining employment due to issues such as hygiene and lack of a permanent address. Instability begets instability.

E. Community Amenities:

In 2005, the City of Vancouver launched its Downtown Eastside Housing Plan which set out a clear direction for City development in the area, one that has been followed since that date. The intent of the plan was to maintain approximately 10,000 units of low-income housing in the DTES, with SROs being replaced by new self-contained social housing units *for singles* with supportive services provided to a portion of those units. It was assumed that market housing, including rental housing, would double to approximately 4,000 units after 10 years. According to a May 15, 2009 report to City Council, Housing Policy was on track to achieve these goals. It was projected that by 2013, the mix of housing in the area would be comprised of 3,876 SRO units, 6,939 non-market units, and 4,163 market units.



[16] www.commonground.org

[17] *The Cost of Homelessness in British Columbia*. BC Ministry of Social Development and Economic Security and BC Housing Management Commission, February 2001

The housing mix in the DTES included other specialized units. According to the City's 2009 survey of low-income housing stock in the Downtown core, the DTES was home to 13 community care facilities which provided 844 beds. A further two buildings, providing 268 beds, were located in the Downtown South area. The DTES also housed nine year-round shelters providing 287 beds. Winter response HEAT shelters housed at least a further 280 beds in the Downtown core. According to the March 2010 homeless count, 923 individuals were housed in shelters in the Downtown core and a further 231 were sleeping outside.[18]

Despite the Plan's vision of maintaining a vibrant neighbourhood with mixed housing, the reality has proved otherwise. The implementation of the plan, although not entirely within the control of City Council, has focused almost entirely on the homeless and shelter populations while basically ignoring the 38% of area residents who report living in family units, as well as the third of residents over 55. The vast majority of social housing units – both those newly built and renovated -- have not only been targeted to the highest risk, street-involved individuals but indeed have deliberately excluded more stable elements within the population. Further, many other high-impact individuals have been moved into area housing previously reserved for low-income families and seniors. Parts of the neighbourhood once home to primarily low and medium income families now also house high-impact individuals whose mental health and addiction issues and attendant behaviours severely distress those living around them. With the exception of 70 family units in the Woodwards complex (which is not located in the family-oriented part of the neighbourhood), no non-market family units are currently being built in the area. It is notable that in 2010 the Vancouver Police Department reported 730 assaults in the Strathcona area – second only in frequency to the Central Business District and over twice as many as those reported in any other City neighbourhood.[19]

Even in 2005, the community infrastructure was struggling to keep pace with population needs. The three neighbourhood community centres in the DTES tend to deal with different population groups. The Carnegie Centre at Main & Hastings caters mainly to the street-involved and SRO/social housing population that live in the area. The Strathcona Community Centre, co-located with Strathcona Elementary school, provides programs for surrounding neighbours, school children, and area seniors. The Ray-Cam Cooperative Centre draws mainly local residents, primarily families and seniors. Community park space is less than is needed, particularly given that many residents do not have yards. At least one park, Oppenheimer, is judged by most as unsafe for families and seniors because of the active drug trade therein.

Community resources are also facing increasing pressures. People using shelters and social housing, like residents in every other part of the city, seek to use community amenities. The Ray-Cam Centre is under particular pressure due to its location on Hastings Street and the increasing number of high-impact individuals being housed and sheltered in close proximity. It is notable that Ray-Cam houses the only public washroom, public computers, and open phone between Main Street and Clark Drive, as well as offering a well-equipped workout room – all services which are used extensively by those now housed in the area.

The community is seriously out of balance and current City development policies and guidelines are actually making the situation worse. Over the years, the City has taken pains to ensure that Vancouver construction projects include 'amenity funds' from developers to support the community infrastructure needed to service new residents. By and large, this policy has been very successful in producing vibrant, balanced neighbourhoods. However there is one large gap in the policy -- one that has

[18] Housing Policy, Community Services Group, City of Vancouver, *2009 Survey of Low-Income Housing in the Downtown Core*. April 2010

[19] Vancouver Police Department, *Statistical Reports by Neighbourhood*. http://vancouver.ca/police/organization/planning-research-audit/neighbourhood-statistics.html

significant impact on the DTES – which is that amenity fees are not charged for social housing, heritage housing, or community facilities. The DTES Housing Plan overwhelmingly targets the development of exactly such housing, with no mention of how supporting community amenities will be provided. By policy, amenity funding is targeted for locations in which the construction occurs. The exemptions noted above short-change DTES residents, particularly resident families and seniors who are not clients of the locally concentrated service sector and who receive support primarily through the Ray-Cam and Strathcona Community Centres.

The City also has access to a second pool of targeted amenity funds through Development Cost Levies (DCL). These funds are charged on all City developments and are allocated on a City-wide basis. It is notable that once again, such levies are not charged on the development of social housing and can be amended due to heritage considerations. Again, this covers much of the housing mandated for development under the DTES Housing Plan. That said, some DCL funds have been used to support infrastructure in the area. Projects supported have included the Woodward's development, including some housing for singles, seniors and families; the dedication of 30,000 square feet in Woodward's for nonprofit use; some support for childcare facilities in Strathcona; improvements to Carrall Street, Pigeon Park and Victory Square; and redevelopment of Oppenheimer Park. All of these amenities are valuable. However it is notable that other than the childcare facilities in Strathcona, none provide needed support to already existing community centres nor ameliorate the pressures caused by newly housed and sheltered high-impact individuals now using more easterly neighbourhood facilities.

It is within the City's power to manage many of these unintended consequences. Strategies could include working with BC Housing to ensure that families and seniors in social housing are not placed at risk by co-housing them with high-impact individuals dealing with untreated addiction and mental health issues. A better analysis of neighbourhood demographics would ensure that not all redeveloped housing is targeted to individuals based on their deficits but more accurately reflects the entire community. The relatively stable poor in the area also need better and renovated housing. Equally, it should be appreciated that newly housed individuals do not simply remain in their suites, no matter what supports might be put in place, but also use facilities throughout the neighbourhood. Maintaining neighbourhood balance is a key to successful community development.

City DCL funding should be dedicated in part to providing infrastructure support for the existing facilities servicing the long-ignored parts of the community. The coming wave of seniors needing support will hit this neighbourhood particularly hard as affordable rental housing becomes increasingly hard to find throughout the city. The face of the poor will continue to age. Many families have strong ties in the community; their children more than most need early childhood programs, parks, and supports. Parents need assistance and various types of training. Many who live in the DTES are new immigrants or refugees. The newly planned community library will help but will provide only certain types of services; its presence will not take pressure off local community centres.

The City could also reconsider the collection and use of Amenity Contributions. Policy could be amended to allow funds to be used anywhere in the City where need is paramount. This could be particularly valuable in conjunction with development projects in the Downtown Core, where family supports are not needed at the same level. The City could also reconsider the current exemption for social housing developments from amenity charges. Residents in these projects impact communities every bit as much (and at times more) as do residents in other neighbourhoods. It is notable that the City of New Westminster, for example, only exempts places of worship from paying development levies.

IV. Mental Illness and Addiction

It is impossible to consider the situation in the Downtown Eastside without placing the issues of addiction and mental illness front and centre. While the two conditions do not by any means always affect the same individuals, too often they do – with destructive results for the individuals themselves, for their families and for the communities in which they reside. The impact on the Downtown Eastside has been devastating.

A. Drugs and More Drugs

It is an unfortunate norm that the poor inner-city cores of large urban centres house the epicentre of that city's drug culture. There is a strong symbiotic relationship between poverty and drug use; no matter which is the primary cause, the other often ensues. At least some street disorder and urban decay often follow.

The DTES has long been known as drug central of Vancouver. A 1955 article in Maclean's magazine, *The Dope Craze That's Terrorizing Vancouver*, estimated that Vancouver had approximately 2,000 drug addicts and noted the centre of the city's drug trade as East Hastings and Columbia Streets.[20] A large number of premises in the area were known to be selling drugs. Between 1946 and 1965 half of all drug convictions in Canada occurred in Vancouver.[21] Drugs of choice varied over the years, with heroin, Talwin & Ritalin (known as poor man's heroin), and various pills holding major sway until the 1990s.

Beginning in 1993 a number of factors began to change the DTES scene for the worse. Heroin purity began to soar as higher potency Columbian heroin flooded the US and parts of the Canadian market. Vancouver remained primarily supplied by Asian heroin but purity also increased to meet the Columbian competition and to attract more users. The situation was further complicated by the increased availability and price reduction of cocaine, particularly fostered by the inception of NAFTA[22] in January 1994. While many North American cities were quickly challenged to cope with crack epidemics, Vancouver remained unusual until close to the end of the decade with injection remaining the preferred ingestion method for cocaine.

During this same period, SRO and low-cost housing units began to disappear from areas in Vancouver other than the DTES, particularly with the redevelopment of downtown Granville and Yaletown. As alternatives disappeared, impoverished drug users congregated into the Main and Hastings area making the street drug scene increasingly concentrated and visible. A ready market of customers drew an increasing number of drug dealers and the easy and relative inexpensive availability of drugs drew further users, a number of whom came from other parts of the province and from across Canada. This trend was exacerbated as provinces such as Ontario and Manitoba cut welfare rates while such rates were maintained at a higher level in BC until 2002, when drastic cuts were made to rates and to eligibility criteria. By then a high population of dependent drug users already lived in the area, many of whom had no prospect of finding work and were increasingly pressed by circumstances to meet any needs beyond supporting their addictions. The increased availability of crystal meth around this time added to levels of addiction, although crack remained and still is the major drug of choice.

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[20] Source: Lani Russwurm, *The Dope Craze That's Terrorizing Vancouver*. The Tyee.ca,13 August 2008

[21] Catherine Carstairs, *Jailed for Possession.* University of Toronto Press, 2005. Quoted in Russwurm, The Tyee.

[22] Karl Raustiala, *Free trade pact a boon to drug dealers*. UCLA Today, May 22 2001

The other main factor in increasing the number addicted residents in the area was the ever-increasing presence of individuals with psychiatric problems who had been downsized from Riverview or increasingly, had never received any level of ongoing stable care. They became prime targets for predatory drug dealers, while many chose to use street drugs as a form of self-medication. They are among the most vulnerable victims of the Downtown Eastside's social dysfunction.

B. Deinstitutionalization

The deinstitutionalization of BC's mentally ill, most of which took place during the last four decades of the 20th century, is a sorry saga. Indeed BC's official relationship with the mentally ill has always been tenuous, from the passing of the Insane Asylums Act in 1873 – BC's first legislation addressing mental illness – to the current controversy about the medical and support needs of those with psychiatric conditions. The BC experience has mirrored that of most of North America.

To a great extent the treatment choices for psychiatric and brain-related problems reflected the scientific understanding of and medical treatment available for these problems at the time. Up until the mid-1950s institutionalization seemed the only humane option. In 1899, the Provincial Hospital for the Insane housed over 300 -- not only psychiatric patients but also developmentally disabled adults and unwanted, physically handicapped children -- in seriously overcrowded conditions. In 1904, the province purchased 1,000 acres in Coquitlam for what would become the Riverview (originally Essondale) complex and construction of the various residential treatment centres began. Over the next five decades institutional development continued and medical treatment improved. In 1955-56, Essondale reached its peak population of 6,327.[23]

By 1955, medications for the treatment of psychiatric conditions were starting to be introduced and community mental health centres, boarding homes, and general hospital psychiatric wards were beginning to open. Community-based living and care-giving arrangements were increasingly seen as preferable to centralized institutional care and Essondale's patient population began its relentless decline.

The process of deinstitutionalization proved complex and costly. As early as 1972 it was clear the community-based support system was in crisis. Severe hospital staff shortages in the provincial mental health system led to the adoption of early discharge and restricted admission policies. Emergency services available in Greater Vancouver were limited and none of the existing social service agencies in the area had the necessary resources or training to manage complex patient after-care needs. Attempts to redress the issue, such as the Vancouver Mental Health Project, were only partially successful. Housing options remained inadequate; too often patients were placed in welfare hotels despite their lack of basic personal care skills, to say nothing of skills to find food and shelter. This was compounded by a lack of adequate funding for and coordination between various agencies in the city.[24]

Economic recession in the 1980s further deepened the problem. In 1983 the BC government introduced a program of fiscal restraint which resulted in cuts to income assistance, social services and mental health services. The availability of psychiatric beds, transition services and support programs

[23] D. Davies, *Our History in a Nutshell: An Abbreviated History of Mental Health Services in British Columbia*. Coquitlam BC: The Riverview Historical Society, 1988.

[24] Analysis adopted from Susan D. Chalmers, *Implementing the 1987 Draft Plan to Downsize Riverview Hospital: Expanding the Social Control Network*. Unpublished Master's Thesis, School of Criminology, Simon Fraser University, December 1993.

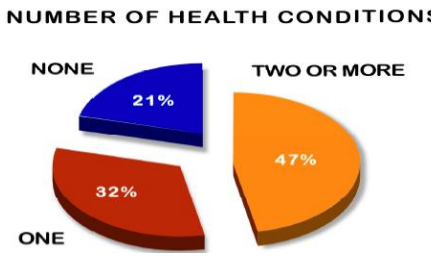
plummeted; mental health care team caseloads increased to the point that staff were only able to provide emergency support. It was also clear by the mid-1980s that an increasing number of mentally ill individuals were continually cycling back and forth through the mental health, criminal justice and social service systems.[25]

By 1990, the provincial government had adopted a plan for further deinstitutionalization from Riverview, based at least in part on the ideological view that community-based treatment was more humane and less expensive – a view that was widely prevalent at the time. The plan called for the seriously mentally ill to be cared for in decentralized medium and long-term inpatient facilities. 550 beds were planned for the province, 300 of which would be in Vancouver/Lower Mainland. Protestations at the time that the projected need for inpatient beds was unrealistic and that funding levels were inadequate fell mostly on deaf ears.

The situation in Vancouver was becoming particularly acute and even before implementation of the plan began, the dangers for the community were well known. In 1988, Vancouver's Director of Social Planning and the Medical Health Officer had urgently recommended that the Ministry of Health "*defer any further downsizing of Riverview until substantial progress [had] been made in addressing the existing deficiencies in Vancouver services.....*"[26]

Their appeal coupled with appeals from many others met with initial success, leading the government to make a commitment in 1990 of $20 million in bridge funding for the transition. However in 1991, after releasing only $4 million of that total, the province announced they were stopping bridge funding, as well as cutting Riverview's budget by $4.1 million and cutting the budget of Greater Vancouver Mental Health Services by $2 million. A storm of protest arose, to no avail. Among the most prescient was Vancouver's Medical Health Officer John Blatherwick who, according to a May 29, 1991 Vancouver Sun article, "*described the government's decision to continue downsizing Riverview without simultaneously providing a long-term financial commitment to mental health spending as a 'recipe for chaos'.*"[27]

Chaos is what has resulted and much of it has played out on the streets of the DTES. Various strategies have been tried but so far have only served to ameliorate, not solve the problem. Some good community housing and resources exist – most notably Lookout Society; Motivation, Power and Achievement (MPA – formerly the Mental Patients Association); and Coast Mental Health – and some deinstitutionalized patients have done very well. Vancouver has recently developed a Downtown Community Court, which provides wrap-around case management support to some those of with mental health and addiction issues who become involved with the criminal court system. Vancouver Coastal Health has also recently opened the Burnaby Centre for Mental Health and Addiction which contains a 30-bed stabilization unit and a 70-bed treatment unit. Mental health support teams do exist in various health units in the city.



However provincial resources are still inadequate and the situation in the DTES is still critical. The City of Vancouver's February 2011 Housing and Homeless Strategy estimates that 80% of the homeless have one or more chronic health issues, including addiction or mental illness. 47% have two or more coexisting issues. It is safe to assume those using shelters and at least some of the area's SRO and social housing face similar challenges.

[25] S. Chalmers, 1993:37

[26] Quoted from S. Chalmers, 1993:46

[27] Quoted from S. Chalmers, 1993:48

According to Dr. Michael Krausz, LEEF Chair for Addiction Research at UBC, World Health Organization statistics indicate that 25% of medical conditions are related to mental health and addictions, while only 5% of relevant resources are going to research and treatment services.[28] As early as 2004, the Strathcona Mental Health Team reported a caseload of 1,200 and an estimate at the time[29] suggested that three times that number lived in the neighbourhood. A 2008 article in the Vancouver Sun[30] recorded that Strathcona mental health clinic staff were seeing 125 people per day, almost all with co-existing mental health and addiction issues. There is a widespread reluctance among medical personnel to treat psychiatric issues until substance abuse issues have been resolved – a difficult, if not impossible barrier for many. Indeed it is often impossible for individuals exhibiting concerning behaviours to obtain a psychiatric diagnosis due to the confounding symptoms caused by substance use. In 2008, the BC chapter of the Canadian Mental Health Association estimated there were 12,000 people in BC who were both mentally ill and drug-addicted.[31]

Individuals with various psychiatric conditions also make up a preponderance of those in the Downtown Eastside encountered in the line of duty by the Vancouver Police Department (VPD) officers. Too often these unfortunates end up in jail because of criminal and/or assaultive actions. More often they end up the victims of criminal predators – drug dealers, abusive pimps, unscrupulous landlords.

The VPD report *Lost in* Transition noted that during one 16-day period in September 2007, 31% of VPD calls across the city involved at least one mentally ill person; in District Two, which includes the Downtown Eastside, 42% of all police-involved incidents were mental health related – this rose to almost half of all calls when only those where contact was made were considered.[32] The report observed that a conservative economic analysis suggested that police time spent dealing with incidents where a person's mental illness was a contributing factor was equivalent to 90 full-time police officers, at an annual cost of $9 million, not including indirect policing costs or the costs to other agencies such as the ambulance service, hospitals, or the court system.

Hospital resources to treat those in crisis are simply inadequate to meet the demand, resulting in medical staff perforce using an overly strict interpretation of '*danger to self or others*'[33] in determining whether or not to commit a person presenting with psychiatric symptoms. Although the Act is broad enough to ensure adequate protection for those in crisis, it is often not fully enforced due at least in part to public and institutional reluctance to mandate compulsory treatment, combined with the significant lack of resources.[34]

Prisons are increasingly taking the place of psychiatric care institutions. Howard Sapers, the Correction Investigator of Canada, reported to the Parliamentary Standing Committee on Public Safety and National Security in June 2009 that mental health problems are now up to three times more common among inmates in correctional institutions than among the general Canadian population, noting that more than one out of ten male inmates and one out of five female inmates have been identified at admission as having significant mental health issues, an increase of 71 percent and 61 percent, respectively, since 1997.[35] It should be noted that Mr. Saper's figures do not include those who cycle in and out of lower-level incarceration, such as pre-trial facilities and Community Court.

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[28] Dr. Michael Krausz, Presentation at Public Salon, Global Civic Policy Society, December 17, 2009.

[29] Zacharias, Y. (2004, August 18). *Desperately seeking asylum: Evils of the institution replaced by brutality of the street* :[Final Edition]; per *Lost in Transition*, by Det. Fiona Wilson-Bates, Vancouver Police Department, 2008.

[30] *A new breed of the mentally ill puts B.C. facilities near chaos*. Vancouver Sun. February 15, 2008.

[31] *A new breed of the mentally ill puts B.C. facilities near chaos*.

[32] Detective Fiona Wilson-Bates, *Lost in Transition*. Vancouver Police Department, January 2008.

[33] *Section 28, Mental Health Act of BC.* Source: *Lost in Transition*

[34] *Lost in Transition*.

[35] Howard Sapers, *Appearance before the Standing Committee on Public Safety and National Security*. June 2, 2009

Retired Senator Michael Kirby, now Chair of the Mental Health Commission of Canada, provided the best summary of the sorry situation during an interview with the Canadian Healthcare Network in December 2009 when he observed, "*We converted the streets and prisons into the asylums of the 21st century and that is just outrageous. The policy decision was correct in that community-based services were better than institutional but that implies you will actually have the community-based services*."[36]

V. Crime

Determining the true level of crime that occurs in the Downtown Eastside is difficult if not impossible, as most incidents are never reported to police. Suffice it to say that crime in the area is pervasive and extensive.

According to the Vancouver Police Department, as of October 2008 the Downtown Eastside accounted for 34.5% of reported serious assaults and 22.6% of robberies in the City of Vancouver.[37] According to VPD statistics, in 2010 the Strathcona area had the second highest number of reported incidents in both categories – second only to the Central Business District. While the reported number of robberies has remained fairly stable for the past three years, the reported number of assaults has noticeably increased every year but one and is now more than double the number reported in 2002.[38]

While the statistics themselves are daunting enough – in 2010 an average of two assaults per day were reported from Strathcona – the reality is that most crime is not reported and not prosecuted. Businesses, organizations and residents in the area often find it impossible to obtain property insurance at an affordable rate, if they can obtain it at all. Those who are insured know well that rates will increase as more thefts are reported. Insurance or not, most will simply replace stolen items as calls to police after the fact rarely produce satisfaction beyond receiving a case number (which is only useful when making a claim against insurance). Statistics Canada's 2009 victimization survey indicates that in general only 31% of crime was reported to police[39], a decline from 34% in 2004. In the case of violent

[36] Joe McAllister, *The Healthcare Interview: Michael Kirby breaks down barriers to better mental health care***.** CanadianHealthcareNetwork.ca, December 21, 2009

[37] VPD, *Project Lockstep: A United Front to Save Lives in the Downtown Eastside*. 4 February 2009

[38] Vancouver Police Department, *Statistical Reports by Neighbourhood*. http://vancouver.ca/police/organization/planning-research-audit/neighbourhood-statistics.html

[39] Statistics Canada, *Criminal victimization in Canada, 2009.*

crime, 29% of incidents were reported to police, while about 36% of household incidents were brought to their attention. These figures are estimated to be much higher in the Downtown Eastside.[40]

Predatory behaviour in the area has tended to target those who are most vulnerable: drug users and low level drug dealers; women, particularly those who are addicted and/or in the sex trade; the mentally ill; and too often the elderly. Predatory behaviour leads to the strong robbing the weak of any item deemed even vaguely valuable. Beatings and assaults with various weapons can occur without warning and for any reason. Beatings are an increasingly common way for dealers to discipline those owing drug debts and women report sexual assaults being used as punishment as well as having their heads partially or fully shaved.

Assaults against street sex workers are far too common – the Bad Date Sheet, which reports attacks on these women, has been published in various forms since the late 1980s. What is less reported is that these same women are also vulnerable to sexual assaults and beatings from men they know as acquaintances, pimps and 'boyfriends'. These women are particularly vulnerable to deadly violence. Over 60 have now been reported as missing to VPD; it is probable that others have disappeared without being noticed. Convicted serial killer Robert Pickton boasted of killing 49 women; it has been proven that others who have been murdered had no connection to Pickton. Although the frequency of assaults reported by these women has varied from week to week, it was not unusual for 20 to 30 different assaults to be reported through the Bad Date Sheet in any given month.[41]

The predatory behaviour in the Downtown Eastside shows signs of becoming worse. It is certainly spilling out into the wider community, as evidenced by the steadily increasing number of assaults from the area reported to the Vancouver Police and by incidents such as the November 2010 hostage-taking of a young boy at the Ray-Cam Community Centre.[42] Staff in local organizations and businesses have reported experiencing threats and in some cases, assaults. Local residents report feeling increasingly unsafe and frightened for their children.

Crime of course includes the constant high level of open drug dealing and drug use that takes place on neighbourhood streets and alleys, particularly in the Main & Hastings area. There are a number of reasons for this. The major one of course is that the Downtown Eastside, as the location of the majority of Vancouver's SRO hotels and low-barrier social housing, provides a readily available stream of customers. These low-level dealers have also profited from a number of criminal justice related decisions made over the years. During the 1990s, there was an increasing push from various systemic and community partners to have drug use dealt with as a health, rather than a criminal issues. The criminal justice system was in step with this trend and by 1992, "there was a significant reduction in the number of drug offence charges that were prosecuted in the federal courts as well as a reduction in the average sentence length for those who were convicted".[43] Then in 2009 in a bid to reduce paperwork and keep more cops on the street, the VPD changed their priority away from arresting and charging people for simple drug possession, including low level dealing, to simply seizing drugs and then going on to dealing with other crimes.[44]

[40] Personal experience with various organizations plus personal communications.

[41] Personal observation. I managed the program that published the Bad Date Sheet for 13 years.

[42] Vancouver Sun. *Vancouver hostage-taking ends after eight hours with police storming building.* 24 November 2010

[43] Vancouver Police Department, *Project Lockstep*. 4 February 2009.

[44] Vancouver Sun, *Vancouver Police propose change to drug strategy.* 19 March 2009.

Although not everyone agrees with these changes in strategy, the reality is, as has been observed a number of times in the past, that we cannot arrest our way out of an addiction crisis. However, a strong argument exists that the approaches taken to community planning over the past 20 years by various governments and other top-level partners have made the whole situation much worse.

VI. Community Planning

For at least the past 25 years, community planning in the Downtown Eastside has been mainly reactive, designed to address perceived crises as they arose rather than to develop a comprehensive strategy for maximizing community capacity and social capital. As such, initiatives have been largely targeted at individuals and issues deemed most at risk and/or having the highest negative impact on the rest of the City and beyond. These have included strategies to deal with the 1997 declared HIV/HCV related 'health emergency'; the City of Vancouver's DTES housing plan (discussed above); the Four Pillars Strategy; the Vancouver Agreement; and various initiatives designed to deal with addictions. Numerous other individual programs and/or agencies have been funded along the way.

As one considers these approaches to community planning, one might ask: where is the community?

It is important to remember that out of a community population of 16,590 individuals, more than one-third are aged 55 or older (22% are 65+) and slightly less than 15% are under 19. 38% in the entire neighbourhood live in family structures (an estimated 24% as single parents), a figure which rises to over 60% in Strathcona.[45] There is no universally accepted calculation of the number of active drug users in the community at any given time. Estimates range from as low as 1,200 to 10,000 or so. It seems likely that on a daily basis there are more users coming to the neighbourhood beyond those who live there in order to access services, buy drugs, and/or to use shelters.

Whichever figures are adopted for comparison, it remains clear that the majority of planning by government agencies and partners has been prioritized to address the deficits of a minority of the community. What is equally clear to anyone who lives in, works in, or even visits the Downtown Eastside is the planning based on problems has led to a problematic neighbourhood.

[45] Statistics Canada, 2005 figures. Accessed from City of Vancouver website.

A. The Health Crisis

In the mid 1990s, two overlapping health emergencies turned what had been an attitude of more-or-less benign neglect into one of fear bordering on panic. The first event was the extraordinary rise in heroin overdose deaths in Vancouver in 1993. Five people died in one weekend alone that May; throughout BC 361 died of heroin overdoses that year.[46] Although further research has shown that numerous factors beyond heroin use, such as coincident alcohol use, were generally involved in these deaths,[47] at the time the deaths were entirely attributed to an extraordinary and rapid increase in the potency levels of street heroin. All of a sudden, overdoses were a health epidemic. The Ministry of Health reacted quickly, requesting the Chief Coroner at the time, Vince Caine, to investigate the causes. The Caine Report, submitted in September 1994, was an extremely thorough analysis of the issues involved and offered a number of far-reaching recommendations. The report was tabled for consideration and then for the most part, disappeared into the mists of government bureaucracy.

In 1995 the BC government, following a trend being implemented in a number of provinces, moved away from delivering services through a centralized Ministry of Health bureaucracy into utilizing a decentralized regional health delivery system. The move was justified, at least in part, as a response to the 1994 Seaton Commission on Health Care, which advocated delivering care through a *Closer to Home* model. However the intent and the implementation differed in some significant ways. Much of the report advocated for an approach that was essentially more patient-centred, one which facilitated the ability of individuals to obtain timely, local care. The health authority model did not so much change the patient care model as establish another level of bureaucracy which took more hands-on, localized control of health services and funding. It was noted by a few cynics then and since that in the process, the Ministry of Health absolved itself of the major responsibility for controlling and delivering health care. Arguably, this decision more than any other has skewed community development in the Downtown Eastside.

The core problem with the implementation of the health authority model, at least in the Vancouver Coastal area, arose from a misguided, if well intentioned philosophy which began to treat the community as a patient first requiring triage and symptom management prior to undertaking longer term treatment and care. It was an understandable attitude from health authority staff many of whom were medically trained personnel. They saw, and continue to see their job as managing patients and medical conditions. The part of the community which required less medical care automatically became less of a priority for attention. The frame of reference for community planning became one of setting priorities on the basis of problems and deficits.

The movement to health authorities came hard on the heels of the rapid rise in heroin purity and resulting spate of overdose deaths. With the focus of medical attention beginning to turn to illicit drug users, particularly visible in the DTES, another problem soon added to their concerns. In the mid-1990s, what could almost be termed a health panic ensued when HIV testing among injection drug users (IDUs) showed a significant increase in the number testing positive for the virus.

Province wide, positive tests rose from 172 in 1993 to 229 in 1994, 338 in 1995, and 387 in 1996, before beginning to fall off to 253 in 1997 and 190 in 1998. From 1994 to 2000, injecting drugs remained the highest risk category in BC for acquiring HIV infection.[48]

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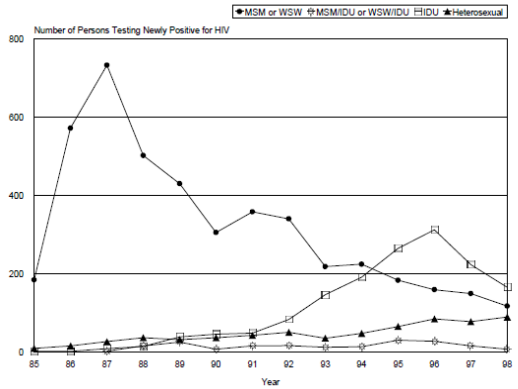
[46] Canadian Community Epidemiology Network on Drug Use (CCENDU). *Vancouver Drug Use Epidemiology June 2005*.

[47] Michael Brandt, *Opening the Casket: An Analysis of Alcohol and Heroin Overdoses – Myths, Misattributions and Misunderstandings.* MA Thesis, School of Criminology, Simon Fraser University. July 1996

[48] BC Centre for Disease Control, *HIV/AIDS Annual Report 1998*, *www.bccdc.ca/util/about/annreport/default.htm#heading4*



The picture took on added significance when the newly establish Vancouver Injection Drug Users Study (VIDUS) established in 1997 that of the 1,006 drug users studied (primarily in Vancouver's inner-city), 23% were positive for HIV. Hepatitis C infection, measured at the same time, was found to be present in 88% of everyone tested.[49] Vancouver was widely reported to have the worst HIV infection rate among IDUs in the Western World.

It could be argued that the statistical picture reflected more than just needle sharing behaviour. For example, heterosexual transmission was also rising significantly, from 35 positive tests in 1994 to 102 in 2001. While the numbers themselves were not significant, it was a corresponding growth in risk for a second group which had a certain risk overlap with IDUs, particularly for women. In other words, just because individuals injected drugs did not rule out that they might also be having unprotected sex. A telling statistic which lends credence to this scenario is that syphilis infections rose significantly in Vancouver in parallel with HIV infection rates, from less than 20 in 1992-96 to 115 in 1998.[50]

During that time period, there was also a large influx to the area of IDUs from other parts of Canada, which reflected generalized restrictions and cuts to welfare rates taking place in many provinces at that time, while BC welfare rates were not being similarly affected. While this influx would add to, not subtract from overall risk of HIV transmission, it also had the potential to artificially boost the rates of those testing HIV and HCV positive as well as deepen the overall prevalence of infections in the IDU community. Finally, the reports that Vancouver HIV rates were substantially higher than those of other communities may not have been entirely justifiable. There is no clear evidence that other cities were measuring infection rates in high risk populations in the same way as in Vancouver. Highest risk users tended to be those least likely to actively seek testing; they also tended to be the most likely to be infected. Epidemiologists in Vancouver were actively seeking out this high risk group; in many other cities, this concerted outreach and testing strategy did not exist.

Nonetheless there is no question that the figures were serious and it was obvious that action needed to be taken. On September 23, 1997 the Vancouver/Richmond Health Board (V/RHB) passed a motion declaring the HIV/AIDS epidemic in the Downtown Eastside to be a public health emergency. The Board directed V/RHB staff to immediately develop a detailed action plan with the goal "*to reduce the spread of HIV/AIDS amongst street-involved injection drug users, who live in or spend time in the Downtown Eastside, and those with whom they come into close contact*."[51] The plan recommended an

[49] *Needle exchange is not enough: lessons from the Vancouver injecting drug use study.* Strathdee SA, Patrick DM, Currie SL, Cornelisse PG, Rekart ML, Montaner JS, Schechter MT, O'Shaughnessy MV. British Columbia Centre for Excellence in HIV/AIDS, St Paul's Hospital, Vancouver, Canada.

[50] Canadian Community Epidemiology Network on Drug Use (CCENDU). *Vancouver Drug Use Epidemiology June 2005*.

[51] Vancouver/Richmond Health Board, *Action Plan to Combat HIV/AIDS in the Downtown Eastside – Media Backgrounder.* October 23, 1997

allocation of a $3 million fund as well as approval of $700,000 from V/RHB's annual budget to be spent on outreach service enhancement, substance abuse service enhancement, community development and evaluation, additional V/RHB nursing services, and staff training and education. Essentially that translated into increased needle availability, increased staffing levels, and increased hours of operation for some services. A further $950,000 was committed from the Continuing Care budget to add 10 hospice beds to the Dr. Peter Centre and to provide additional home care services in the Downtown Eastside. The plan also called for improving HIV/AIDS testing and medical protocols and for working in collaboration with all three levels of government, the community, and other organizations.

The V/RHB 1997 HIV/AIDS Action Plan then called for the implementation of a number of longer term strategies designed to address the broader determinants of health related to drug users vulnerable to HIV infection. The strategies proposed were to:

- Work with BC Housing, other provincial ministries, and the City of Vancouver to develop housing for Downtown Eastside residents.
- Start immediately with a renewed sense of partnership to work with the City and the Ministry for Children and Families on creating additional detox and treatment programs.
- Begin working on social planning issues with City of Vancouver and the police department.
- By December 15th, develop a plan to distribute nutritious food to Downtown Eastside residents.
- By December 15th, develop a transportation plan for Downtown Eastside residents to access services outside of the area.
- Ensure HIVIAIDS education is included in the school health curriculum.

There was nothing particularly wrong and a great deal that was laudable about the proposed strategies. However by framing and coordinating community development issues within the context of a medical model – preventing disease transmission and treating vulnerable or already affected individuals – the action plan deliberately moved community planning toward a model of prioritizing risk management and planning by shortcomings.

It is also notable that the primary response to addressing the dual problems of drug addiction and HIV infection provided little analysis on the role played by public policy decisions in creating or ameliorating the factors leading to the '*health emergency*'. One major exception was an Abstract presented at the 1998 International Conference on AIDS by Dr. Michael O'Shaughnessy and colleagues from the BC Centre for Excellence in HIV/AIDS titled *Deadly Public Policy*. Collecting data through the Centre's ongoing VIDUS study, the Abstract reported:

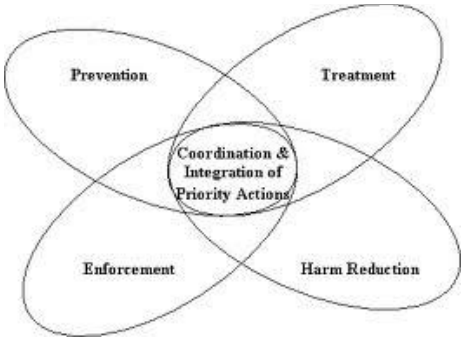
> "*Our investigation of the environmental context indicated that the following factors contributed to the HIV epidemic in Vancouver. As federal government support for social housing disappeared, low income housing vanished and more than 6500 individuals were forced to use single room occupancy (SRO) accommodations. Addicted individuals were refused access to social housing facilities. This concentrated IDUs in a 10 square block area. Occupants were charged ($5-10) exit fees at night and this practice further concentrated the IDUs. More than 85% of the places dedicated for individuals with mental health illness were closed yet 30% of the VIDUS seroconverters reported a diagnosis of mental illness. Detoxes were eliminated as budget reductions were imposed. 25% of the VIDUS participants were women yet there are no detoxes designated for women. Social assistance was denied to individuals with outstanding police warrants. The Canadian prison system did provide needle exchange yet, 76% of the VIDUS participants have been in jail. Funding for needle exchanges was variable and at one time vans had to be removed due to budgetary short fall. Monthly welfare payments were synchronized and may influence sharing behaviour. CONCLUSION: Our results indicate the HIV epidemic in injection drug users in Vancouver is primarily caused by needle sharing. However, government policies contributed to the dangerous environment of the downtown eastside. We postulate this*

lack of critical services and the negative effects of deadly public policies facilitated an epidemic of HIV in IDUs."[52]

While public policy to some extent responded to the criticisms noted above, over the years it has remained singularly unsuccessful at achieving primary symptom management (in the broadest sense) for those most at risk, while continuing to increase risk for many healthier parts of the neighbourhood.

B. FOUR PILLARS DRUG STRATEGY

As the depth of the drug problem became increasingly worrying, the City of Vancouver responded, collaborating with other partners to develop the *Four Pillars* strategy, a "*coordinated, comprehensive approach that balances public order and public health in order to create a safer*, *healthier community*"[53] The Four Pillars cited in the strategy as necessary to properly deal with addiction and related issues were Prevention, Harm Reduction, Enforcement and Treatment. Based on similar strategies which had been developed in parts of Europe and Australia, this strategy was released as *Framework for Action: A Four Pillar Approach to Vancouver's Drug Problems* by Vancouver Mayor Phillip Owen in 2000 and was formally adopted by Vancouver City Council in May 2001. The City also formed the *Four Pillars Coalition* to "*engage the community in addressing Vancouver's drug problem and drug-related crime*". [54]



The holistic approach to addressing addiction issues was initially warmly welcomed by many sectors within the community. It was recognized that Enforcement by itself could not stop drug addiction, that Prevention was less than fully effective, that Treatment services were inadequate, and that Harm Reduction was a stop-gap rather than a full solution. It was hoped, and perhaps by some expected, that identifying the factors to be addressed to fully deal with the problem would result in governments providing the funding to properly do so.

The reality proved to be less encouraging Despite optimism and the establishment in particular of some fairly high profile Harm Reduction initiatives, it became obvious within a couple of years that simply identifying the necessary Four Pillars had not made much difference to the area's environment. Open drug use persisted, boarded up buildings spoke to the lack of business investment, petty crime within the City continued to be a major problem. Enforcement too was visible but police services themselves acknowledged that society could not arrest itself out of the situation. Criticism of the strategy's effects began to increase, while arguments about how to succeed began to polarize between those promoting the need to accept drug use to help stabilize the users and those arguing that the goal had to be abstinence. Treatment was acknowledged as necessary but governments continued to fund far too few detox and long-term stabilization resources. The meaning to Treatment itself became a matter of argument, with some service providers seeing providing methadone to heroin users as a form of treatment, while others argued that only completely ending drug use was a proper goal. Even Prevention came into dispute, with some seeing the acceptance that people used drugs and thus

[52] *Deadly public policy*. O'Shaughnessy MV, Montaner JS, Strathdee S, Schechter MT; International Conference on AIDS. *Int Conf AIDS.* 1998; 12: 982 (abstract no. 44233). BC Centre for Excellence in HIV/AIDS, Vancouver, Canada.

[53] *Four Pillars Drug Strategy Fact Sheet*, City of Vancouver website.

[54] *Four Pillars Drug Strategy Fact Sheet*, City of Vancouver website

should use safely as a form of Prevention, while others argued that Prevention's goal had to convey the message that illicit drug use was destructive.

While the *Four Pillars* has been touted as a major success by its proponents, there is far from universal agreement that this is the case. Discussions touting conflicting positions continue in the media with competing statistics being presented to support philosophical positions. The argument on how best to support and deal with addicted drug users continues, with no collaborative solution in sight.

C. The Primacy of Harm Reduction

One of the failures cited in the lack of overall success for the Four Pillars Strategy has been the overwhelming emphasis given to harm reduction initiatives, particularly in the DTES. Given the medical paradigm of symptom management for those at highest risk that has been used to determine priorities, this is not particularly surprising. It is questionable however whether doing so has accomplished much more than maintaining the status quo.

In and of itself, 'harm reduction' is a logical concept. It is possible to argue that reducing the harm associated with any activity is a positive strategy. That said, the practice of harm reduction has taken some odd turns during its over 23 year history in the Vancouver community.

The inception of the harm reduction movement began with the establishment and subsequent growth of needle exchanges in various parts of the world. The concept of reducing harm – specifically of reducing disease – had by then taken some hold within the public conscience. For example, while AIDS was still stigmatized as a disease essentially caused by lifestyle choices and restricted to certain groups, it was increasingly accepted that strategies of providing and encouraging the use of condoms protected not only those who might otherwise participate in unprotected sex but also their current and future partners – hence much of the wider community. In another health area, it was increasingly accepted by this time that smoking cigarettes could cause cancer and early steps were underway to minimize such risk by reducing potential carcinogens in the cigarettes themselves and by encouraging smoking cessation strategies.

It is worth noting that both activities cited were and remain entirely legal. The strategy of harm reduction is not necessarily tied to the legality of the activity being targeted. Over time, the distinctions between harm reduction strategies and the legality of activities involved have become increasingly blurred.

The rationale behind providing needle exchanges and other harm reduction strategies for illegal drug users is intimately tied to the goal of HIV infection prevention. The scientific rationale for this is sound: used needles virtually always contain some blood from the original user and by injecting that blood, a second (or subsequent) user self-injects any blood-borne pathogen(s) harboured by previous injectors. Needle exchanges have been shown to be very effective in minimizing HIV and hepatitis B & C transmission while, despite some notions to the contrary, not increasing drug use. So far so good.

The question then arises whether harm reduction strategies should exist in isolation. In the case of cigarette smoking for example, it has long been accepted that the only fully effective strategy to prevent harm is for smokers to cease smoking. There is no safe way to use this product. And strategies have been developed over time, such as limiting advertising and controlling places to smoke, which have proven effective in reducing use. However, cigarette smoke also affects others. As the medical profession has very effectively shown, second hand smoke is a potential danger to anyone near enough to breathe it. In other words, the instruments of disease transmission – cigarettes – have the

potential to not only harm the direct user, who presumably has some choice, but also to harm anyone else who comes in contact with them. Physicians have been in the forefront of promoting zero tolerance for smoking in public places to ensure as much as possible that non-smokers do not come in direct contact with cigarettes.

The same rationale can be applied to needle exchanges. Distributing clean needles to drug users is an effective strategy to minimize disease transmission. However, used needles are much like second-hand smoke, in that their presence can expose non-users to potential harms. Some potential harms are direct, such as the possible transmission of HIV (a harm studies have shown unlikely at best), hepatitis B and/or C, and any other infections harboured by previous users or acquired where the needle was discarded. Other potential harms are less direct, such as community impacts of needles being discarded in parks or playgrounds, placing children and families at possible risk, or needles being discarded in commercial areas, potentially affecting business income. As the second-hand smoke movement has shown, people will avoid areas and situations they fear will place them in harm's way.

So the question becomes, harm reduction for whom? Harm reduction for one group should also incorporate harm reduction for anyone else who may be affected. Certainly harm reduction for one group should never increase harm for anyone else. Unfortunately in the case of needle provision, harm has been caused in the wider community. The current policy of providing needles through a distribution/recovery model rather than through one-for-one exchange has resulted in needles being discarded in parks, school yards, and numerous other public places in the community. There is always a time lapse until they can be picked up. Children have been injured by handling used needles.

The reality is that many harm reduction strategies have developed in isolation and with narrow goals. Issues have become confused. Probably the key issue that gets lost is that there is no safe way to illicitly use drugs, any more than there is a safe way to smoke cigarettes. And as the narrow-cast goal to keep a user as well as possible while continuing to use becomes the over-arching aim, the fact that using itself is causing damage tends to be minimized.

It has been argued that illegal drugs are harmful precisely because they are illegal. There is some truth to that allegation in that the lack of standards for potency, purity and contents can lead to often severe medical consequences for users, including overdoses. Equally, the fact that drugs must be acquired illegally drives users into crime to pay for their habits. So would legalization help? To begin with, there is already a strong black market among drug users for legal, prescription medications such as morphine, sedatives, oxycontin and even methadone. These are perfectly legal controlled substances, but rightly are not prescribed without a specific medical reason to do so. Cigarettes are legal; smokers are no healthier because they can get their fix at the corner store.

What we really have is one of the areas where criminal consequences and medical consequences are being confused. And we are becoming confused in the process. Illegal drugs are unhealthy – true. Providing them feeds an incredibly large, world-wide crime network – also true. It would likely be true that legalizing drug provision would undercut the criminal market and reduce some measure of crime. However, unless this were to happen world-wide, it's hard to imagine that doing so in Vancouver would make much difference. And again, health issues and criminal issues become confused. Would we want to have crack available at the corner liquor store? Marijuana might be easier to accept but likely at a lower potency than currently is being cultivated, leaving room again for a black market. Would doctors be expected to prescribe to users their drug of choice regardless of potential medical consequences? That scenario would give us legalized pushers of predictable drugs but in and of itself would do little to improve the health of the users.

It has also been argued that drug use is a 'victimless crime'. For the user maybe, although it's pretty easy to accept the user is also a victim if they have too few resources available to get help them to get 'clean'. But certainly drug use victimizes others. It is true that some of this victimization comes because users need to obtain money – they steal; they mug people; they sell drugs to others, at times creating new 'clients', often addicting the weak and the needy. Sometimes drug users victimize themselves; self-medication is a core cause of addiction and can be found among the mentally ill, street-involved youth, sex trade workers – indeed most users started using drugs as a solution to or sometimes a mask for some problem. And undoubtedly they victimize the community – directly through thoughtless public drug use and the discarding of drug paraphernalia, particularly needles – indirectly by costing tax payers millions of dollars in medical, enforcement and economic expenditures. And too often, the system victimizes the users themselves by giving them no way out.

Harm reduction initiatives such as methadone maintenance and the supervised injection site can be helpful to some individuals. Multiple studies have demonstrated they have some efficacy to the individuals who use their services. Within a wider context and given economic realities, the question remains whether the millions of dollars invested in such programs produce the best outcomes for the individuals themselves and for the communities in which they live.

Ultimately, the only real way to reduce the harm caused by drugs is not to start taking them in the first place or once started, to get the necessary help to stop. This is true for cigarettes, for alcohol, and for addictive drugs. There are a number of strategies which can successfully accomplish these goals, strategies which may at times include some level of drug maintenance as occurs with smoking cessation programs. However to be clear, the only truly safe goal is to stop the use of all medically unnecessary substances – legal or illegal.

The key to real harm reduction is providing a complete continuum of care offered in a full community context. In other words, harm reduction becomes a step on the road to ending unnecessary drug use – a way to keep healthy long enough to move beyond drug dependence. Reducing harm should include all aspects of reducing harm, including ensuring that the mentally ill have proper medical supports; that youth are properly taken care of and supported; that all the health needs of users are attended to, not just their addictions. And reducing harm should emphasize also reducing direct harm to the community – ensuring needles are immediately returned to exchanges and not wantonly discarded; developing strategies to minimize street use, with an emphasis on safe and stable housing; helping users to minimize drug use for their own health and as a way to minimize the need for criminal income generation.

D. The Next Generation

The challenges faced by children and youth in the DTES are daunting. Based on 2005 Statistics Canada figures, there are approximately 2,500 children and youth under the age of 19 living in the area. Many – but not all – are poor. A significant number live in single-parent families.

In 2006, the Vancouver Board of Trade produced a study entitled *Kids 'N Crime*, which analyzed the precipitating factors that could lead children into criminal involvement as they became adults. This report, along with a follow-up economic analysis published in 2010, provided an in-depth overview of the many aspects involved. Most will not be discussed in this paper, although virtually all have some applicability to the challenges faced by DTES young people. One of the report's key findings emphasized the importance of environmental factors to fostering good childhood development:

> "*From birth, the child's environment will affect all facets of development. For example, parental addiction to substances or a low level of parental education, among other factors, can lead to low socio-economic conditions for the child. Poor socio-economic conditions can deprive a child of opportunities for sensory stimulation at this early age, when they are most necessary. Issues*

like poor nutrition, parental illness, single parent status and recent immigrant status can affect a child's development. Moreover, such an environment can cause parental depression, which may further affect parenting techniques, creating an adverse home environment." [55]

The chaotic environment and lack of investment in proper supports for DTES neighbourhood children has indeed taken its toll. The harsh reality for these young people is that:

- Over 66% are vulnerable according to UBC research;
- They are not school ready and drop out of school before high school graduation;
- They consistently fail to achieve the economic security of peers in other communities who complete secondary and post-secondary education.
- They fail to meet crucial developmental milestones
- They lack access to primary health care and face food insecurity.
- They live in a hostile environment with daily exposure to criminal activity, homelessness, drug abuse, domestic violence and social disorder.[56]

Measurements from UBC's Human Early Learning Partnership[57] clearly indicate that children in Strathcona are the most vulnerable group in the Province on every scale and their level of vulnerability has been steadily increasing over the past 9 years. They are now at highest risk of school failure among groups measured in all BC urban centres. To further compound the problem, there has been a recent upward surge in the population of vulnerable infants to 6-year olds living in the area, compounded with a net loss over the past few years of over 40 local childcare spaces.

These children do not receive sufficient pre-school support and many enter the school system already marginalized due to previously undiagnosed developmental disabilities. DTES children are in crisis. Families are pressured by low-incomes, language issues, few social supports, insufficient food and shelter, and health challenges. Community childcare providers are completely under-resourced, working within a system that too often bases resource allocation on equal access for all neighbourhoods, rather than equitable access for all residents. Simply put, resources are completely inadequate to meet the needs of local families. The Ray-Cam Community Centre alone has over 200 children waitlisted for their early childhood programs. This number does not include a large waitlist for out-of-school care for ages 6 to 12.

Local children and families are also incredibly short-changed by the overwhelming focus of community health resources on meeting the needs of high impact, street-involved individuals. There is currently no health clinic within walking distance for local families where they can receive medical care in what they perceive to be a safe environment. BC Children's Hospital and UBC Nursing have responded to this need by working in partnership with local organizations to provide accessible medical care through sponsoring nurse practitioner and physician services in community locations such as Ray-Cam and the Network of Inner City Community Services Society. Many local families are now receiving medical care for the first time in years. It is a step but it is far from enough.

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[55] Alasdair Maughan & Dave Park, *Kids 'N Crime: Report on the Development and Prevention of Criminality Among Children and Youth.* Vancouver Board of Trade, October 2006

[56] *Inner City Response Initiative*. Ray-Cam Cooperative Centre and the Network of Inner City Community Services Society.

[57] UBC Human Early Learning Partnership, http://www.earlylearning.ubc.ca/maps-and-data/local-maps/sd39/

Abandoning these children makes little sense personally, socially nor economically. In a follow-up report to *Kids 'N Crime -- Economic Aspects of the Development and Prevention of Criminality among Children and Youth* – the Vancouver Board of Trade further enhances the case that society will pay, either now or later, for the problems caused to children in disadvantaged chaotic neighbourhoods. Noting that "*The timing of investment is critical. Efforts to influence development are far more effective in early life than in later years*." the report went on to quote Nobel Prize-winning economist James Heckman:

> ""*A dollar invested in early childhood yields three times as much as for school-aged children and eight times as much as for adult education*."[58]

The situation does not get better for these youth as they get older. Children who are not school-ready when they enter the classroom increasingly disengage from a system not able to cope with their overwhelming needs. Other personal problems such as generational abuse, addictions, family homelessness or unstable housing, or displacement can further lead youth towards high risk behaviours and ultimate street involvement.

Children at particular risk are those who become involved with the government agencies, particularly those who are removed from their families and absorbed into the foster system. Problems within the Ministry of Children and Family Development are multiple and complex; they are also fairly well-known and will not be discussed at length here. What is crucial to understand within the context of this paper is that many of these children become increasingly street-entrenched over time and often drift to the Downtown Eastside -- at times because they are seeking family members living in the area; too often because they have little or no funding to live anywhere else.

A particularly disturbing scenario is the habit of the Ministry of Children and Family Development to actually house street-involved youth in this very high risk community. Youth who are in Ministry care and who for one reason or another are resistant to remaining in foster care are being housed under independent youth agreements in DTES SROs, right next to pimps, johns and drug dealers. One could argue that Ministry policy and cost-cutting measures have curtailed many other options for these youth. Unused foster beds tend to be termed 'abandoned' and the child loses the placement after as little as three days away. Underage safe houses have been closed. Barriers to services (such as needing to be drug-free for 72 hours) restrict housing options for youth once they are on the street. There is insufficient scattered site and interim staged housing for these youth. A recent proposal to open modular housing in the DTES targeted to street-involved young women aged 16 to 19 once again sets these children up as potential victims. No amount of support can protect already vulnerable children from dangers that remain right outside their front door.

[58] Dave Park, *Kids 'N Crime -- Economic Aspects of the Development and Prevention of Criminality among Children and Youth.* Vancouver Board of Trade and Justice Institute of British Columbia, September 2010

VII. A Business Community in Survival Mode

To say the least, the Downtown Eastside business community tends to go unnoticed and many would be surprised to learn that the area houses a strong component of Vancouver's economic engine. A Vancouver Agreement assessment in 2004 noted 2,300 Downtown Eastside establishments employing more than 20,000 people. Area businesses are represented through four collaborative Business Improvement Associations (BIAs): Chinatown, Gastown, Strathcona (the second largest BIA in the city), and the newly-formed Hastings Crossing.

The neighbourhood supports a very diverse economy. It contains much of the City of Vancouver's industrial lands, including a major part of the Port of Vancouver and the port terminus for the rail yards. Industrial sectors include clothing, food processing, furniture and household goods, industrial products, marine services, restaurant supplies, and safety equipment. Some of the more well-known include BC Sugar, Ming Wo Ltd., and Happy Planet. Firms such as Eclipse Awards International and Jean Larrivée Guitars have international reputations. The area has equally strong service sectors: automotive, awnings & signage, catering services, cleaners, construction & contractors, courier services, sports & hobbies, plumbing & heating, printing, recycling.

There is a thriving arts scene, featuring a variety of art galleries. The yearly Eastside Culture Crawl gives art lovers a great opportunity to meet many of the visual artists and craftspeople who make the neighbourhood their home. The area houses a vibrant, cutting edge music scene and theatre is well represented by the venerable Firehall Arts Centre.

The City of Vancouver's 2005 Core Business Survey found that the three most common activities of DTES companies were retail trade (20%), wholesale trade (11%), and design, scientific, technical services (11%). 74% of businesses were established from 1980 onwards and most had been at their current location for almost 12 years.[59] Vibrant retail districts tend to be localized in sub-areas such as Chinatown, Tinseltown, and Gastown. With impetus from the new Woodward's development, new cafes and retail stores are beginning to open closer to East Hastings Street, albeit slowly, and the fractured nature of the retail community is beginning to change.

The neighbourhood has also become a springboard for a new form of business -- social enterprises. These are ventures run by nonprofit organizations which provide affordable services to and often hire local residents, and the earnings from which are used to support social goals. It should also be noted that a significant number of private businesses in all categories also go out of their way to hire local residents when at all possible.

Not surprisingly, given the chaotic street scene and level of drug use and dealing that continues to prevail in the area, the most common difficulties reported by area businesses in the City's Core Business Survey are safety and security, cited by over 58%, followed by parking and cleanliness. These issues are of particular concern to retail establishments, which depend strongly on walk-in traffic. Potential customers tend to stay away out of discomfort, if not outright fear, with the surrounding area.

There is also a huge impediment to business expansion in the area due to the current City of Vancouver Official Development Plan for the area. Any development above a floor space ratio of 1.0 is mandated to include 20% social housing in that development. While based on good intentions when

[59] *City of Vancouver Metropolitan Core Business Survey – Phase Two, Downtown Eastside*. Ipsos Reid Corporation, July/August 2005.

passed in 1982, the restriction has become a major impediment to further business development in the community. The result is that this policy is actively discouraging establishments from investing in the area, driving commerce and jobs to other parts of the Lower Mainland. Businesses cannot thrive when their needs are ignored.

It remains a huge challenge for even the most committed businesses to create economic viability in the inner city. The few targeted initiatives designed to help the situation, such as the Vancouver Agreement, have ultimately made little difference to the business climate.

A.

The *Vancouver Agreement* was an innovative strategy that ultimately fell far short of making much difference in the DTES. According to the Agreement's website:

> "*The Vancouver Agreement is an urban development initiative of the governments of Canada, British Columbia, and the City of Vancouver. The Agreement began in March 2000 for an initial five-year term and has been renewed until March 31, 2010.The Vancouver Agreement commits these government partners to work together, and with communities and business in Vancouver, on a coordinated strategy to promote and support sustainable economic, social and community development.*
>
> *Through the Vancouver Agreement, the three governments collaborate and coordinate resources on projects and initiatives to make the city a healthy, safe and economically and socially sustainable place to live and work for all residents. The Vancouver Agreement is transforming traditional silo-based approaches to governance and service delivery into a more-integrated horizontal model based on collaboration and progressive problem-solving strategies*."

It was a good idea. The proposal at least implied that all levels of government would pool their resources, giving Downtown Eastside residents, organizations and business a single body to work with to implement community initiatives. The ideas of full inclusion and coordinated planning were attractive when the Agreement began and they remain so today.

Government partners working through the agreement did a very good job of promoting the initiative within their structures and through the governing system at large. Among kudos received were the Institute for Public Administration of Canada's highest annual prize for innovative management; a United Nations Public Service Award for improving transparency, accountability and responsiveness in the public service; and a Partnership Award from the Association of Professional Executives of the Public Service of Canada.[60] In terms of profile and recognition, the Agreement was a success.

Unfortunately from a community perspective implementation of the Agreement did not work out as hoped. There were three major flaws:

- The 'more-integrated horizontal model' mainly included the three levels of government and at times, whatever community agencies Agreement personnel found comfortable to work with. Their overall policy and planning group was made up entirely of government representatives. There was no automatic or easy way for community groups with their own ideas to work with Agreement bureaucrats. Residents were too rarely consulted on proposed initiatives. Research has shown that community planning is best done by the community itself, supported by the

[60] Vancouver Agreement website, http://www.vancouveragreement.ca/the-agreement.

necessary funders and government representatives. Agreement personnel took a top-down approach instead – one focused on the institutional operational needs and comfort levels -- an approach which for the most part failed to respond to the common goals rooted in the inner city as a place and focused on its revitalization, health, hopes and well-being.

- Bureaucrats may have coordinated their planning to some extent but they did not pool their funds nor did they develop a joint process for groups to access funding. As then Vancouver City Manager Judy Rogers noted in 2004, "*The partners provided funding for initiatives within their own areas of jurisdiction utilizing existing funds. These funds often came with strict program criteria and little flexibility.*"[61] For community organizations seeking to fund programs or proposals, the initiative simply added another level of bureaucracy to get through. For initiatives that were designated as falling under the Agreement, proposals first had to go to an Agreement table for approval. Once endorsed, organizations had to rework the proposal to fit within the guidelines of whatever level (or levels) of government were going to provide the funding. In many cases, the bureaucrats had their own ideas on what should be done and occasions arose where they dictated to community organizations which initiatives they were expected to deliver.[62] For the organizations themselves, there was little or no chance to protest the process; many feared that raising these issues would mean losing access to much-needed funding.
- Despite rhetoric about using an integrated approach in developing the Downtown Eastside, the reality was that many government initiatives affecting the area did not go through the Vancouver Agreement at all. For example, the BC government developed a Request for Proposal (RFP) process to awarding contracts for the delivery of community services that placed organizations in competition with each other and in many cases with for-profit businesses. It was not uncommon for groups with no ties to the Downtown Eastside to be the successful recipients of contracts, despite having no resident base and being new to dealing with community dynamics. A further consequence was that local groups began to lose funding for programs, severely disrupting program continuity built up over many years, in many cases leading to fewer supports overall for neighbourhood residents.

In the end all of the time and money spent on and through the Vancouver Agreement has not significantly changed outcomes for the community and its residents. And the money invested was significant: $27.9 million dollars. [63] Certainly many initiatives were funded and much work was done. However it is arguable that many of these would have still come to fruition in the absence of the Agreement structure. Ultimately, it was a worthy idea which fell short due to having a structure that worked primarily to align the policy and funding objectives of participating government ministries and allied institutions and the inability of that structure to exercise leadership by aligning government collaborations, public policy and funding with local knowledge and capacity.

What is most telling is that 11 years after the inception of the Vancouver Agreement, there is little visible change in the Downtown Eastside. As noted by Andrew Graham of Queens University:

> *"It is clear that the factors converging to produce a DTES crisis by the late 1990s were driven by that decade's massive provincial and federal social policy cutbacks and restructuring in key fields such as social assistance, affordable housing, and mental health services. Here the VA's micro projects often have been swimming against a hostile macro policy tide."* [64]

The Vancouver Agreement expired in March 2010.

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[61] Quoted in Andrew Graham, *Case Study: The Vancouver Agreement*. School of Policy Studies, Queens University

[62] Personal experience. Name of agency involved in this case is omitted for privacy reasons.

[63] Vancouver Agreement website

[64] Op Cit, Andrew Graham

B

Building Opportunities with Business

Building Opportunities with Business (BOB) began under the Vancouver Agreement as an initiative to foster Downtown Eastside economic development and employment. At least, that's how it was promoted. How it actually evolved was a different story.

BOB began life as a very successful community-developed initiative called *Fast Track to Employment (FTE)*. FTE was developed by a number of local organizations who determined that they would have better success in getting local people back to work by collaborating through a single, coordinated mechanism. It worked like a charm. FTE quickly became one of the prototype initiatives demonstrating how good community development and coordinated planning can really work.

FTE also reached out to the business community, developing an innovative collaboration called the *Social Purchasing Portal (SPP)*. The idea behind it was simple. To be listed in the SPP, companies had to make a commitment whenever possible to train and hire local residents. In turn organizations, other business and residents were encouraged to buy products and services from SPP businesses. The initiative was so successful that SPP was soon being copied in other locations across the country. FTE was on a roll, governed by a board made of up representatives from community organizations and fostering community training, employment and business development, including working with nonprofits interested in creating social enterprises.

By 2005, it had become apparent to Vancouver Agreement representatives that to date, they had been singularly unsuccessful in stimulating economic development in the DTES. In determining what to do to remedy the situation, they soon realized that they already had a successful model, FTE, in their midst. They decided to take it over. The process was a simple one from a bureaucratic standpoint. They simply told FTE that they wanted to 'amalgamate with' FTE and take over the services under the name of BOB. It was made clear to FTE staff and board that if they did not agree, they would receive no further government funding. Initially the agreement was that two community representatives from the FTE board would immediately become part of the BOB board. Ultimately it was only after over a year of wrangling and protesting that the community finally managed to have a single representative elected to the BOB board.[65]

For the first few years, BOB spent a lot of time sorting out its structure and priorities and trying to determine how best to move ahead. On the whole during that time, it didn't manage to accomplish much in terms of actual economic development or employment initiatives. Continual staff turnover was notable during this period. The community involvement that did exist was mainly as petitioners for funding.

Eventually, under new leadership, BOB began to show signs of resurrection. Community representatives became more involved on the board and the organization became much more innovative, achieving some significant successes. Despite this latter spurt of activity, BOB is now in the process of winding down as a major initiative, maintaining some business development activities to fulfil contract commitments while devolving employment and training initiatives back to community agencies. It is interesting to note that community organizations have reformed a collaborative mechanism under the name of the Fast Track to Employment Coalition.

[65] Based on personal involvement with the process and conversations with others similarly involved.

VIII. A New Approach

Albert Einstein is frequently quoted as observing that, "*Insanity is doing the same thing, over and over again, but expecting different results.*" There may be no more apt summing up of the past 25 years of community planning in the Downtown Eastside. Despite many millions of dollars invested and the myriad of strategies applied, little has really improved for the people living in the neighbourhood.

It does not take a comprehensive review to appreciate that all the various '*strategic*' initiatives targeted to deal with multiple community '*problems*' have resulted in a neighbourhood that is seriously out of balance. City and Provincial Government policy has resulted in the location of thousands of units of social housing and shelter beds within an overly small geographic area. Harm reduction services from Canada's only supervised injection site through drop-in centres targeted to high impact individuals to medical clinics that specialize in treating street-involved people have multiplied, creating what is basically a service ghetto.

Methadone maintenance outlets have proliferated, not only supporting local users but drawing others to the neighbourhood due to the current policy that proactively matches consumers to suppliers who have open slots – whether or not the consumer actually lives in that area. It is a lucrative business. According to the Canadian Institute of Health Information, as of October 15, 2010 pharmacists in BC received $9.60 per occasion in dispensing fees plus a $7.70 methadone interaction fee.[66] In 2009, the BC College of Physicians and Surgeons listed 11,033 patients registered throughout BC for methadone maintenance.[67] The BC College of Pharmacists reports that there are currently 24 pharmacies dispensing methadone in the DTES; an audit by Ray-Cam staff and volunteers recently counted 10 in an 8-block walk from the zero to 800 blocks of East Hastings. Many of these are small-scale pharmacies which offer little beyond drug dispensing. This count does not include other outlets such as medical marijuana dispensaries in the area or close by.

It is questionable how much has even really changed for the at risk groups who have been the main focus of systematic interest. Some issues have certainly improved. HIV infection rates and overdose death rates have both fallen, not just in the Downtown Eastside but throughout the city – although spikes of unexpected heroin purity still place users at unexpected risk. How much that change can be attributed to DTES initiatives is impossible to know, as many other complex factors (such as better medications to treat HIV infection which in turn have been shown to drastically reduce further viral spread) have come into play during the same time.

There is now more social housing available, particularly in the DTES. Opinions are mixed on whether this has actually improved outcomes for the people involved. It is notable that homeless totals have continued to rise until recently and have not yet dropped significantly. Reports – many anecdotal – from some staff and individuals housed in the numerous social housing units in the area describe drug use and dealing now occurring in these residences, as well as incidents of violence. In cases where higher impact individuals are mixed with more stable families and seniors, accounts of threats and robberies are far too common. Increasingly residents are fearful for their safety in their own homes. Such incidents do not always get officially reported, as residents are also fearful of losing their housing.[68]

For other community residents, the concentration of housing and shelters in such a small area raises justifiable concerns about the potential impacts from this increasingly unbalanced neighbourhood. The

[66] Canadian Institute for Health Information, National Prescription Drug Utilization Information System Database—Plan Information Document, January 1, 2011

[67] BC College of Physicians and Surgeons, *2009/10 Annual Report*

[68] Anecdotal reports are given by individuals to various community agencies and workers.

current harm reduction approach of generally isolating and addressing issues individually does not account for what can happen when people or areas have a combination of linked problems such as low incomes, poor housing, health challenges, compromised safety, crime etc – a toxic mix which erodes the social fabric at expense of childcare, grocery stores, seniors' well-being, family safety, locally-owned small businesses.

A huge amount of research has been done in the United States on how best to address the problems that arose from concentrating housing for the poor in what became service-dependent urban ghettos. Among those studying the complexities involved in finding workable solutions has been Rutgers University Doctoral Candidate Natasha O. Fletcher, who observed:

> "*Poverty concentration has long been viewed as a leading problem associated with urban areas in the United States. Adverse effects span a variety of social, economic, and political outcomes for residents trapped in high-poverty neighborhoods. Agents of social policy reform have been concerned with the proliferation of these neighborhoods throughout past decades, particularly since the phenomenon has spread to inner-ring suburbs, and can no longer be viewed as a city problem alone*." [69]

The Center for Disease Control and Prevention in Atlanta has noted that:

> "*The social, physical, and economic characteristics of neighborhoods also are increasingly recognized as having both short- and long-term consequences for residents' quality and years of healthy life. Among the most prevalent community health concerns related to family housing are the inadequate supply of affordable housing for low-income persons and the increasing spatial segregation of households by income, race, ethnicity, or social class into unsafe neighborhoods. The increasing concentration of poverty can result in physical and social deterioration of neighborhoods as indicated by housing disinvestment and deteriorated physical conditions and a reduction in the ability of formal and informal institutions to maintain public order. The ability of informal networks to disseminate information regarding employment opportunities and available health resources and promote healthy behaviors and positive life choices might decline as well.*" [70]

The vast majority of research into this issue points to the problems that arise from the overconcentration of poverty and housing into a single neighbourhood. As a result, for the past 30 years communities in the US have been systematically demolishing ghetto housing and rebuilding on a more scatter-site or at least more dispersed model. There is no clear reason why Vancouver should now choose to adopt a housing model so roundly rejected in other cities.

For far too many years, the Downtown Eastside has been viewed more as Vancouver's Emergency Ward than as a community. As a result, virtually all government, bureaucratic, service and media attention has concentrated on 'fixing' those at highest risk. This triage approach to community development has effectively marginalized and ignored the most stable aspects of the neighbourhood. The Downtown Eastside has basically become everyone's 'patient' and planners have become metaphorical physicians, seeking a cure. Research by John R. Logan has demonstrated the failure inherent in this ideology:

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[69] Natasha O. Fletcher. *Poverty Concentration and Deconcentration: A Literature Review*. LBJ Journal of Public Affairs, Spring 2008.

[70] Center for Disease Control and Prevention, *Community Interventions to Promote Healthy Social Environments: Early Childhood Development and Family Housing*. A Report on Recommendations of the Task Force on Community Preventive Services. Atlanta, 2002

> "*Developments in urban theory in the past 25 years provide another view. New thinking emphasizes instead how "un-natural" processes, such as the exercise of political power and public protest, alter the operations of the housing market..... From this point of view, the concentrations of crime and disease are created by decisions that are mainly taken outside the neighborhood itself*."[71]

Logan has further observed that:

> "*Some people are unnaturally squeezed into risky places. The misdirection of state power contributes to the unequal fortunes of disparate neighborhoods..... It matters, because even in the era of cyberspace, most of us are affected by the risks in the places where we live. It matters more widely because the public as a whole pays a price when crime or disease is concentrated anywhere*."[72]

A more fruitful approach would be to build on the community's strengths and successes. Many area problems, particularly those faced by children and seniors, arise from poverty not addiction. Dealing with their issues as a priority would be relatively simple and doing so would do much to strengthen the already stable parts of the community. Changing the view of the community to one that is functional, albeit with problems, would go a very long way toward building a truly healthy neighbourhood.

The Downtown Eastside requires a full place-specific development process involving all residents, businesses and organizations from all neighbourhoods that comprise the widest definition of the area. This plan must address not just housing issues but also crime prevention, street chaos, business enhancement, resident safety, health promotion, childhood development, and strategies for harnessing and increasing community capacity ***as defined by the community itself***.

Governments continue to have a key role to play in community development, not as policy developers or program specific funders but as conveners of broad community processes. They can bring community members together across lines that divide them: facilitating shared experience in identification, visioning and planning of a desired attainable future in the community. By supporting collaborative governance, multi-organizational management systems and advancing the implementation of community plans and by funding these systems through cross-organizational grants, governments can not only support community aspirations but help them achieve measureable outcomes.

Significant work in this area has been done by John McKnight and colleagues at Northwestern University. An observation by John McKnight effectively sums up this discussion:

> "*.....citizens are the primary assets and activators of assets in local communities. Citizens are, of course, the producers of democracy. And strong local communities are created when citizens are also the producers of the future. They cannot be replaced. No professional, institution, business or government can substitute for the power, creativity or relevance of productive local citizens*."[73]

The challenges faced by the Downtown Eastside are not insurmountable. It is time to give the community a true opportunity to find stability and sustainability for everyone.

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[71] John Logan, *Life and Death in the City: Neighborhoods in Context*. University of California Press, Spring 2003

[72] Ibid, John Logan. [NOTE: quoted out of order used in article]

[73] John L. McKnight, *Forward: When People Care Enough to Act*. Inclusion Press, 2006