

Victoria Cool Aid Society Community Health Centre: Social, Political and Historical Context*

Prepared by EQUIP Research staff on behalf of Victoria Cool Aid Health Centre

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Overview

This document outlines the socio-historical, political, and geographic contexts of Victoria, British Columbia, in general, and Victoria Cool Aid Society's Community Health Centre in particular. The city of Victoria's history has been largely shaped by the marginalization of people: displaced Aboriginal citizens and early Chinese settlers who were labelled disreputable; intoxicated 'vagrants' of the city's early years considered criminals; the institutionalized mentally ill; and the transient adolescents of the 1960s hippie culture, looked down upon with disdain. These groups – deemed undesirable, and often unproductive, by those in power – and their unique histories have continued to impact the face of homelessness, marginalization, and poverty in Victoria today.

As is so often the case, the most vulnerable and marginalized struggle with complex and chronic health problems, health issues that are socially determined and historically shaped by traumatic pasts, the legacy of colonialism, the ongoing criminalization of mental health problems, and racialization of poverty. Individuals living with mental health issues and those suffering from problematic substance use, notably alcohol, have experienced varying degrees of discrimination, which are often traumatic in and of themselves. The dire and vulnerable living conditions that these communities often experience put them at risk for further health issues, including but not limited to smallpox, tuberculosis, and HIV/AIDS. State responses to these populations have included both harmful and appropriate strategies.

While state responses continue to vary in efficacy, nongovernmental agencies fill in the gaps by addressing the basic needs of citizens. Charitable organizations have provided for citizens' basic needs since the 1870s, and the role of nongovernmental agencies has increased and diversified significantly, most notably as providers of housing, and in some cases health care and social supports. Many of these organizations originated from within the communities most affected by marginalization, such as the AIDS service organizations of the 1980s, various Friendship Centres for urban Aboriginal populations, and the Victoria Cool Aid Society (VCAS) itself, which originated as a community-based youth-helping-youth organization in the 1960s.

Terminology

Our use of the terms *marginalization* or *marginalized* refers to the socio-political conditions, policies, and processes that sustain structural inequities and structural violence resulting in a disproportionate burden of ill health and social suffering for particular populations, and is also inclusive of people's *agency*, *resistance*, and *resilience* in the face of challenges.

Throughout this document, the term *client* is used in lieu of *patient*. This is done with intention, and represents the purposeful way in which Cool Aid understands and engages with the population they serve. To have *clients* implies a partnership, a collaboration that avoids the hierarchy implicit in a *patient*- professional relationship. While a patient may be narrowed down

to a body system or medical diagnosis and passively objectified, clients, as complex individuals, actively engage with services. This choice of words is symbolic of the foundational values of the Cool Aid Community Health Centre, an organization that strives to “[be] an environment of trust and mutual respect,” (Victoria Cool Aid Society, 2014b) and to “treat all people with respect, dignity and fairness” (Victoria Cool Aid Society, 2014a).

Finally, the Victoria Cool Aid Society is also referred to as the Cool Aid Society or VCAS in this document. For clarity, and to differentiate the overall society from the medical and dental clinic it operates, the clinic is called the Community Health Centre, CHC, ACCESS Health Centre, or merely Cool Aid.

Context of the City of Victoria

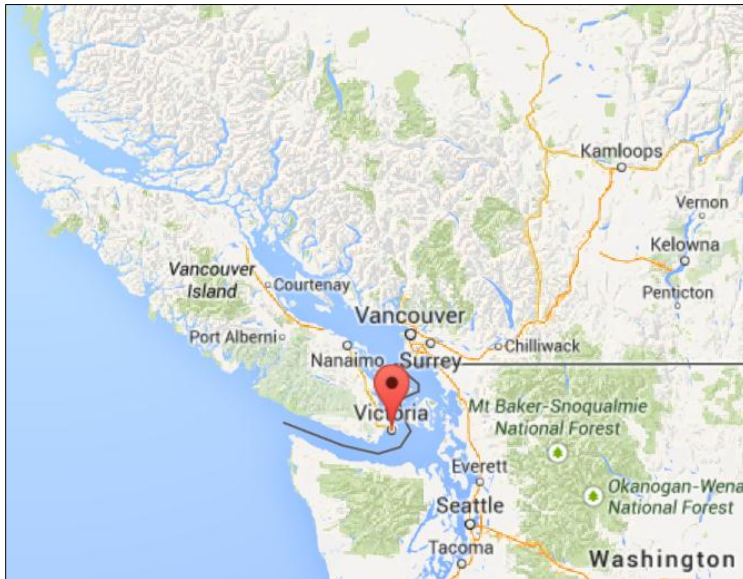


Figure 2: Map of Victoria, British Columbia (Google Maps, 2014)



Figure 2: Victoria Neighbourhood Map (City of Victoria, 2014)

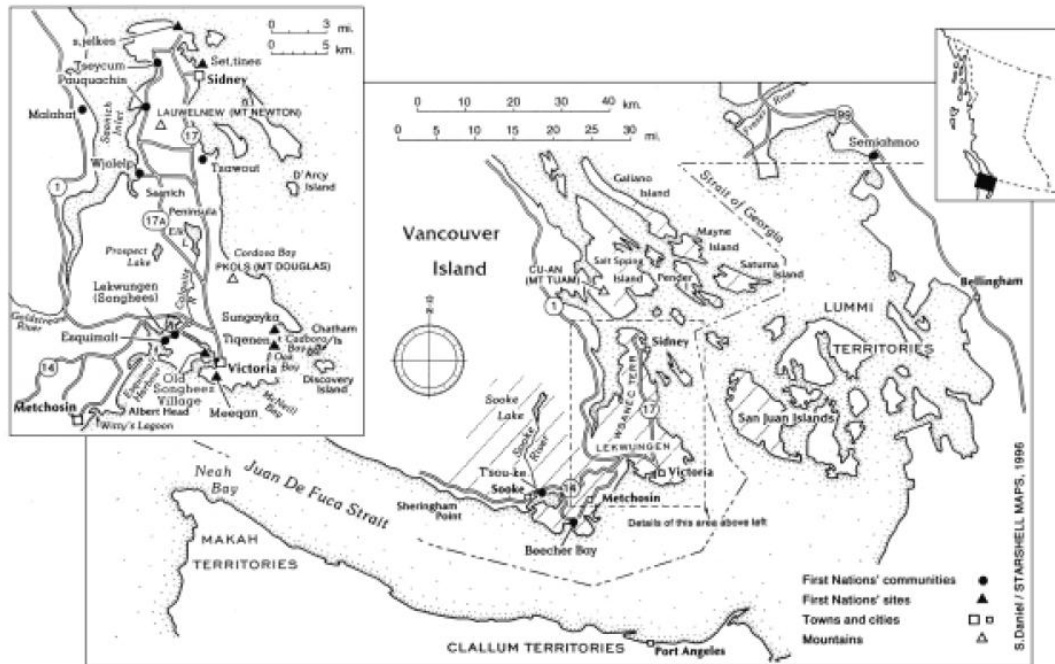


Figure 3: View of Victoria's Inner Harbour (Wikipedia, 2014)

Cultural-historical context

Victoria, the capital of British Columbia, is situated at the southern tip of Vancouver Island, approximately 69 km southwest of Vancouver. The city is located within the territory of the Coast Salish language group, a diverse group of linguistically similar First Nations (see Figure 4: Indigenous map of Vancouver Island and surrounding area (Lutz, 2008, p. 65)), and the urban core of Victoria occupies the ancestral territories of the *Lekwungen*, now legally known as the Esquimalt and Songhees bands. Tseycum, Pauquachin, Tsarlip, Tsawout, and Malahat First Nations make up the bands that constitute the *Wsanec* or Saanich Nation on the Saanich peninsula, north of the Victoria core, and the T'souke, Beecher Bay, Pacheedaht and Penelakut Nations each have reserves west of Victoria.

Historically, these territories included many valuable resource-gathering sites, such as reef net fishing locations, seal rocks, and camas¹ beds. These sites were ‘owned’ in common by extended families, rather than individuals, and in truth, the concept of ownership fails to capture the intricacies of the sustainable and respectful relationship that Coast Salish peoples had with the land and its resources. Open fields of camas, proliferated by regular controlled burning to cultivate the sweet and starchy bulb, and abundant salmon runs sustained the First Nations for centuries, and were what first attracted European settlement to the area (Lutz, 2008).



MAP 4.1 Straits territories

Figure 4: Indigenous map of Vancouver Island and surrounding area (Lutz, 2008, p. 65)

Historian John Lutz (2008) argues that, considering the long-term negative consequences, it may seem ironic that the Lekwungen actively welcomed and assisted James Douglas in 1842. Douglas was the colonial fur trader who would go on to become the Governor of Vancouver Island, and was instrumental in the building of Fort Victoria, the trading centre for the Hudson’s Bay Company and the colonial capital. However, throughout the first years of European contact, Indigenous people profited economically from reciprocal exchange. The blankets that Aboriginal peoples used prior to contact were created with fur from dogs bred on nearby islands; the making of these blankets required large amounts of time and effort, and the gift of these blankets represented family wealth and spiritual prestige in potlatch ceremonies. The Lekwungen people traded logs, transportation, and labour in exchange for the Hudson Bay Company’s wool

¹ Camas was, and continues to be, an important root food source for the Indigenous peoples of the Pacific Northwest coast. The bulb of the plant was specifically utilized, and is considered the most widely available food source apart from salmon and salmon products (Stevens & Darris, 2006).

blankets, which vastly increased both individual and community wealth. By 1844, a new village site was constructed next to Fort Victoria. This new site acted as a trading post, which allowed for increased trade between the Lekwungen and the colonialists, both locally and overseas (Lutz, 2008).

In 1850, the Hudson's Bay Company (HBC) was appointed authority by the colonial office in London to establish the new colony of Vancouver Island. James Douglas, the newly appointed governor, was responsible for fourteen land-based treaties, including several that formed Native reserves in and around the town of Victoria (see Figure 5). In the treaties, Douglas formalized an agreement for Indigenous chiefs and their communities to "surrender, entirely and forever," (Bowsfield, 1979) most of their territories to the Hudson's Bay Company. "Village sites and enclosed fields" were kept as well as the right to "hunt over the unoccupied lands, and to carry on their fisheries as formerly" (Fort Victoria Letters, 1850). For their land, First Nations communities received blankets or pounds sterling.

In a single Lekwungen-Wsanec account from 1934 in the *Times Colonist*, Chief David Latisse describes Douglas:

He stressed the desire of the white men to be friends with the tribes. He assured the chiefs that trade in furs with peaceful use of enough land to grow food, were the only reasons for establishment of the settlement. His statement was welcomed by the peace-loving tribes, whose view of the settlement had it been voiced at all, would have been that there was lots of land and no harm could come from letting the whites use some of it... We all understood that similar gifts would be made each year, what is now called rent (Pagett, 1934, p. 8)

Nicholas Claxton, a Wsanec academic and activist, describes some of the tensions that have since emerged:

From an indigenous perspective, entering into agreements with the colonists represented an agreement where indigenous nations and the white people could live side-by-side, together sharing the land. Conversely, it can be alleged that the colonial principles of land ownership and use were imposed onto the indigenous peoples who signed these agreements, with the presumption that the indigenous peoples were to be domesticated into Canada (Claxton, 2003, p. 20).

Different scholars have offered varying interpretations of these contested agreements, and First Nations groups have taken different strategies to address treaty issues, including court battles, reaching settlements, or refusing to engage in what is deemed an unfair process. For example, in 2006, a land claim settlement was reached between the federal and provincial governments and the Esquimalt and Songhees First Nation. The settlement related to a parcel of land in downtown Victoria, and resulted in \$31.5 million to be shared between the two nations (Minister of

Aboriginal Relations and Reconciliation, 2007).



Figure 5: A map of the Douglas treaties, retrieved from:
http://www.canadiana.org/citm/imagepops/douglastreaties_e.html

Throughout the 19th century, the Victoria area grew steadily in population, instigated in part by a grand potlatch, in 1853, that brought thousands of Indigenous people to Victoria for the first time. Until the 1880s, opportunities and wealth made available by lucrative trading relationships resulted in a mass influx of between 2,000 and 4,000 Indigenous seasonal workers each year (Lutz, 2008). Growth of the Indigenous workforce resulted in a heterogeneous population. However, the gold rushes of 1858 and 1866 inundated the town with non-Indigenous settlers, and initiated a shift to a cash economy throughout the province. Lekwungen and other First Nations people continued to work transporting and supplying miners, ferrying passengers and freight, and providing building materials to the booming city. However, the increasing European presence resulted in a growing racialization and marginalization of Aboriginal peoples (Edmonds, 2010).

The gold rush also brought a steady increase in the illegal trade of alcohol – “of the vilest and most destructive kind, manufactured on the site from pure alcohol... diluted with salt water, and flavoured [with]... camphene, creosote, and even sulphuric acid... to give strength and flavour” (British Colonist in Lutz, 2008, p. 87) – resulting in a reported four hundred Indigenous deaths from alcohol-related causes in the Victoria area.

As throughout the rest of Canada, Christian missionaries made up an integral part of early colonial contact, with Catholic, Anglican, and Methodist baptisms and conversions becoming

increasingly more prevalent. Missionaries aimed to forcefully assimilate Indigenous communities into the European way of life, an undertaking poignantly evidenced by a lobby of missionaries, Indian Agents, and I.W. Powell, the first superintendent of the Department of Indian Affairs, that resulted in the Anti-potlatch law of 1885. Powell argued that “potlatches, not only retard civilizing influences, but encourage idleness among the less worthy members of the tribe” (Lutz, 2008, p. 94). The Anti-potlatch law was yet another technique of colonial power intended to speed up the forced assimilation of Indigenous communities through the destruction of this foundational social institution. Thomas Crosby, a Protestant missionary working amongst the Lekwungen, noted that “the potlatch relates to all the life of the people, such as giving names, the raising of social position, their marriages, births and deaths” (Lutz, 2008, p. 94). By banning the potlatch, the government was attempting to destroy hereditary ownership to key resource sites and the prestige economy.

We, like the white people, want to have some fun. We know they have their dances – they have their celebrations during which lots of money is spent... Therefore we humbly petition the government not to interfere with our celebrations – we let the white people have theirs, therefore we expect to have ours. We are oppressed from all sides. We never have any satisfaction given to our many petitions sent in – we notice that all the times the white people are listened to but we seem forgotten. Now our patience is coming to an end.

Cowichan Chiefs, to Superintendent of Indian Affairs, 1914 (in Lutz, 2008, p. 105)

As populations of Aboriginal peoples continued to decline and colonial power increased, there was a discursive shift in the construction of the Aboriginal individual, from a “hostile savage ... [to] the noble savage to be pitied and protected” (Furniss, 1995, p. 19). Missionaries had long been working to ‘save’ Aboriginal souls, and religious education and practice soon became viable colonial techniques to indoctrinate Indigenous people to the values of white settler society. The state was interested in capitalizing on Evangelical enthusiasm for providing education at a low cost, and the missionaries were given “access to a population of children to proselytize without the coming influences of either Indigenous religion or rival denominations” (Kelm, 1998, p. 60). However, the establishment of schools on reserves was ineffective at persuading Aboriginal families to abandon their patterns of seasonal migration, and their own educational and governance practices. While many had an interest in developing English and trade skills and supported the early industrial schools, by the 1860s, residential schools were regarded as hostile towards Aboriginal culture and divisive to communities (Furniss, 1995). Day schools were having issues with poor student attendance, and in 1884 the Department of Indian Affairs noted that “the progress of Indian children at day school [...] is very greatly hampered and *injuriously affected by the associations of their home life*, and by the frequency of their absence, and the indifference of their parents to the regular attendance of their children at such schools” (Furniss, 1995, emphasis added). The ineffectiveness of these schools to assimilate Aboriginal people

eventually culminated in *The Indian Act* of 1876, giving the government of Canada the power to: define Aboriginal identity; demarcate Aboriginal land; limit traditional sustenance practices; undermine Aboriginal community governance practices; and (forcefully) educate and care for Aboriginal children.

In 1879, Nicholas Flood Davin, a lawyer, journalist, and politician, published *The Report on Industrial Schools for Indians and Half-Breeds*, colloquially known as *The Davin Report*, in which he advised the federal government to create boarding schools for Indigenous youth. Davin based his recommendation on the assumption that assimilation would only be effective if Aboriginal children were immersed in settler culture at a young age (de Leeuw, 2009). These schools opened across Canada starting in the late 19th century, and the last schools, two in Saskatchewan and one in the Northwest Territories, were closed in 1996. On Vancouver Island, children were taken to residential schools set up in several locations, including Flores Island, Meares Island, Kuper Island, Port Alberni, and Alert Bay. Some Wsanec children were taken to the Kuper Island school, while others may have gone even farther away to schools in Mission and elsewhere (Leslie McGerry, personal communication, October 11, 2013).

The residential school system effectively isolated Aboriginal children and youth from their families and cultures; systematically and systemically oppressing through the enactment of symbolic, physical, and sexual violences upon Aboriginal children and youth. While the residential school system in Canada is often considered well-intentioned policy gone awry, it has also been called genocide. The United Nations Convention on the Prevention and Punishment of the Crime of Genocide defines genocide as “any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious groups, [including] forcibly transferring children of the group to another group” (United Nations, 1948). The impacts of this institutionalized cultural genocide on the First Nations, Métis, and Inuit peoples of Canada are vast and intergenerational. Children were torn from their families and cultures, denied the opportunity to learn parenting skills, and in some cases used in eugenic and medical experiments. While experiences of residential schools were diverse, each and every school was meant to promote “the final solution to the Indian problem” (Aboriginal Healing Foundation, 2002, p. 7, quoting Deputy Superintendent of Indian Affairs Duncan Campbell Scott), and today, survivors continue to experience post-traumatic stress disorder, anxiety, depression, and shame.

Smallpox, influenza and other diseases

Prior to British contact, First Nations communities had already been devastated by disease, and subsequent waves of illness followed shortly behind each influx of settlers, devastating British Columbia’s Indigenous populations. From 1782, smallpox spread overland from the south, killing “one-third of affected communities in BC, mostly in Salish territories. By 1840, smallpox, influenza and other diseases kill[ed] roughly 65 to 95 per cent of Indigenous populations in the area” (Union of British Columbia Indian Chiefs, 2005, p. 14). The spread of disease throughout

Aboriginal communities was expedited by forced displacement and relocation by the colonialists, as well as the gradual destruction of Indigenous health and healing practices.

In 1862, a massive smallpox outbreak devastated Indigenous communities near Fort Victoria. Huge efforts were made to segregate the city, and many Indigenous people were forced to leave, further spreading infection through communities up the Northwest coast as they fled.

The equation of Aboriginal shanties, and camps at the northern end of the town and in the reserve with the outbreak of disease came to a head with this outbreak of smallpox in Victoria. Of course, with such poor living conditions created by the effects of colonialism, Aboriginal peoples were more vulnerable to infection. However, this moral environmentalism, or fear of Aboriginal peoples and spaces they inhabited, meant that they were evicted from Victoria through nuisance and sanitation laws. The focus was therefore on limiting contact between white and Aboriginal peoples. But this was nigh impossible, [due to] the legacy of the fur trade's mixed marriages and the presence of Aboriginal peoples in the town as labourers, servants, purveyors of food and goods, and consumers. Such neat partitions, in reality, were not possible (Edmonds, 2010, p. 14).

Waves of illness, including measles, influenza, venereal disease and tuberculosis, continued to decimate the population and limit growth until well into the 19th Century.

Commerce in context

Victoria was incorporated in 1862, taking control from HBC and the colonial legislature. Rate-paying residents and property owners were shareholders, and petitioned the city to improve infrastructure and regulate town space (Edmonds, 2010). When ethnologist Franz Boas arrived in Victoria in 1886, he described the streetscape:

The stranger coming for the first time to Victoria is startled by the great number of Indians living in this town ... we met them everywhere. They dress mostly in European fashion. The men are dock workers, craftsmen or fish vendors; the women are washerwomen or working women ... certain Indian tribes have become indispensable to the labour market and without them the province would suffer great economic damage (Boas, Rohner, Rohner, & Parker, 1969, pp. 6,9).

This view of indispensability was contrasted with a view of Indigenous people as an unclean public nuisance. As the population grew, spaces inhabited by Indigenous communities became increasingly valuable to colonialists, and with these rising tensions, language describing Aboriginal individuals shifted:

As the fear and anxiety of settlers in the town grew, Aboriginal shanties and slum areas at the northern edge of town and the Aboriginal reserve were increasingly represented as a place of madness, degradation, and savagery. Aboriginal space was often described as chaos or Bedlam to the ordered civil space of the growing city. As Mary Ellen Kelm argues, such living conditions (slums, reserves, etc.) were made “through colonization and were neither natural to the First Nations, nor necessarily Indigenous to the environment of British Columbia (Edmonds, 2010, pp. 10-11).

Industries of salmon canning and hop farming initially required many Indigenous workers, providing opportunities for seasonal work that could co-exist alongside traditional times for gathering for potlatches. During labour shortages in the boom times, all able-bodied Indigenous people from the local area would be employed, as well as recruited from other Indigenous communities on the island; however, these individuals were invariably turned away when economies shifted.

In the gold-rush days of the mid- to late-1800s, street prostitution was reportedly ‘rampant’, with one report from 1868 stating there were “some 200 Indian prostitutes living in filthy shanties owned by the Chinese and rented for four or five dollars a month in the Cormorant and Fisgard streets area” (Baskerville, 1986, pp. 39-44). Historical research indicates that in the 1870s and 1880s, the sex trade in Victoria was primarily street solicitation by predominantly Aboriginal women on the outskirts of the city (Hansen-Brett, 1986). Hospital records from 1860 to 1870 show approximately 20% of the men had syphilis, syphilitic rheumatism, and gonorrhea, and that most of these men were local residents, not sailors or transients (Green, 2000).

The first recorded prostitution house was in the Chatham-Herald Street district in 1894. In 1889, the local Women’s Christian Temperance Union established a Refuge Home on Work Street for “the rescue of the fallen and the care of the unfortunate woman” (Hansen-Brett, 1986, p. 22). By the 1910s, it was reported that sex trade workers were primarily white or Chinese. In the 1920s, the sex trade moved from brothels to hotels, and with prohibition in effect, some hotels evolved into bawdy houses (Hansen-Brett, 1986).

The 1885 completion of the Canadian Pacific Railway introduced labour competition to Victoria, as laid-off Chinese labourers were hired into the fish industries (e.g., cleaning and canning), replacing Indigenous workers and competing further for work picking berries. Indigenous people were ‘last hired, first fired’ cyclically throughout economic downturns (e.g., after the gold rush, the Great Depression, post WWII) (Lutz, 2008). Racist policies undermined Indigenous employment, leaving subsistence economy and/or state-funded relief as the only available options.

In 1913, the federal Fisheries Department created new salmon fishing regulations that prohibited Indigenous people from acquiring independent fishing licenses, forcing them to apply for

limited licenses, which were heavily controlled by the canneries. The introduction of knitting during early contact, and the increased availability of wool coming from the mainland, made Cowichan sweater production one strategy that women and families could use to supplement their earnings while caring for children.

During the Great Depression, salaries for registered Indians plummeted to 37% of the 1929 level, compared to 61% of the average Canadian income. Relief payments in kind – just four dollars per month – were supplied by the Indian Agent. This was less than a quarter of what non-Indigenous people received from the province and municipalities (Lutz, 2008).

Dispossession and Indian reserves

Pressure to remove the Lekwungen from the reserve located across the harbour from downtown Victoria relentlessly increased, and came from the City of Victoria, the province, and the Department of Indian Affairs (DIA). In 1911, Michael Cooper, the first Lekwungen chief to be elected after the Indian Act came in to effect, negotiated a relocation to the current Songhees reserve at the far end of Esquimalt. He insisted that the money be paid directly, rather than held in trust by the DIA as was required by the Indian Act. Each of the 41 families was paid \$10,000 in cash that many put towards houses, furniture, livestock and investments. The Esquimalt and Songhees reserves continue to exist within the urban portion of Greater Victoria today.

Victoria, like other Canadian urban centres including Vancouver and Toronto, continues to be a place where Indigenous people from many nations relocate to reside, even those from beyond the territories of Vancouver Island. There are presently 14,200 people listed in Greater Victoria who identify as Aboriginal – 8,900 First Nations, 4,805 Métis, 95 Inuk and 145 multiple identities (Statistics Canada, 2012). In the 1970s, Native Friendship Centres were increasingly established across BC in urban areas, as awareness of the needs of urban Aboriginal communities grew. The Victoria Native Friendship Centre (VNFC) was established in 1970, and has been providing services locally for over 40 years; VNFC now operates with a \$2.5 million annual operating budget. After years of providing Aboriginal Homeless Outreach services, the VNFC partnered with the City and others to transform a hotel into supportive Aboriginal housing.

People who self-identify as Aboriginal are over-represented among those who use emergency shelters in Greater Victoria. Those who identify as Aboriginal account for just 4.2% of Greater Victoria's population (Statistics Canada, 2012), yet on average they represent 19-21.5% of shelter users (Eberle, 2001; Pauly, Cross, Vallance, Wynn-Williams, & Stiles, 2013). Aboriginal community leaders suggest that this figure is low, and that once the reality of Indigenous under-housing is taken into account, the Aboriginal housing and homelessness situation in Greater Victoria will be acknowledged as a crisis. The Coalition to End Homelessness has recognized this and has identified the need for a coordinated and thoughtful response to this crisis (Greater Victoria Coalition to End Homelessness, 2014).

In the 1980s, the Victoria Native Indian Housing Society was established, and has provided safe, affordable housing for families of Aboriginal ancestry in core housing need. The name was changed to M'akola Housing Society in 1988, and has continued to provide support and services to Indigenous people living in Vancouver Island's urban centres (M'akola Group of Societies, 2014). In 2010, Hulitan Social Services Society left the M'akola Group of Societies to become Hulitan Family & Community Services Society. Their mission is to provide social and emotional support, programs, and services to Aboriginal families in the Greater Victoria area (Hulitan Family and Community Services Society, 2014).

In 1986, the Open Door, an inner city ministry of the United Church of Canada, was established, becoming the 'living room of downtown', a place where people could get off the street and out of the weather, and receive non-judgmental and unconditional love (Our Place Society, 2014). It is estimated that a quarter of the 'Open Door Family' are Aboriginal.

Socio-political context

Since its incorporation as a city in 1862, Victoria has been a picture of prosperity, shadowed by the systemic marginalization of poverty. In 1890, *The Daily Colonist* included reports from local charities, such as the Friendly Help Association and the Benevolent Society of British Columbia, who were struggling to cope with the needs of people looking for relief while living in "utter destitution" (Helps, 2005). Established in 1873, the British Columbia Protestant Orphan's Home, later changed to The Cridge Centre for the Family, was a non-profit society operating, from the 1890s to the 1960s, a 100-bed orphanage in the Hillside area (Issit, 2008).

Lisa Helps' (2005) critical analysis of city building in Victoria between 1871 and 1901 illustrates how the city's progress included new laws and enforcements intended to clear downtown streets and public spaces of 'vagrants', 'drunks', and 'prostitutes'. People were arrested, often not for violations committed against the public, but simply because they were being a certain kind of person, and/or were engaging in certain types of activities, in a public space (Helps, 2005). These marginalized groups experienced a "lack of shelter, want of employment, need of food, addiction to alcohol, [and] displacement from traditional lands" (Helps, 2005, p. 116), and in turn faced fines and arrest in the early decades of the City of Victoria. These same characteristics continue to define homelessness in Victoria today.

Helps (2005) cited reports as early as 1890, of shanties and hovels on Johnson Street occupied by Aboriginal and Chinese citizens, as well as other 'disreputable characters'. These individuals were systematically evicted and the shelters dismantled as building progressed throughout the downtown core. In parallel, there were reported complaints of 'street loafers', and in 1901, the City established both street and park by-laws that prohibiting 'vagrants' from remaining in public spaces. Historical records show that under these by-laws, individuals were charged for "being a rogue and a vagabond" and of "being of unsound mind" (Green, 2000).

When the police force was established in 1858, public drunkenness was the most prevalent infraction committed in public space (Green, 2000), however vagrancy and prostitution were other frequent charges. Indigenous people generally, and Indigenous women in particular, were targeted by the police and disproportionately charged. Those arrested for public drunkenness were frequently described as being idle, poor and/or dirty, emphasizing how Victoria was open and welcoming for some people, but not others.

Health and health care

A brief historical report by the Vancouver Island Health Authority (VIHA) (2012b) described how in 1859, a committee consisting of representatives from the Hudson's Bay Company, the police, and the City took possession of a piece of land on the Songhees Indian Reserve and built a small hospital. It did not take long for demand to outgrow the limited facilities, and in 1874, the Marine Hospital was built on the Songhees Reserve, providing care to mariners for nearly 20 years. Meanwhile, the Female Infirmary, established on Pandora Street in 1864, was amalgamated with the Royal Hospital in 1869. The current Royal Jubilee Hospital was built in 1889, in time for the small pox epidemic, which hit Victoria in 1893. The Capital Regional Hospital District was established by the Hospital District Act in 1967 (Vancouver Island Health Authority, 2012b).

The regionalization of health care services in British Columbia was a prominent issue by the 1990s. In 1991, the BC Royal Commission on Health Care and Costs (aka The Seaton Commission) recommended a regional health system for BC (British Columbia Royal Commission on Health Care and Costs, 1991). The Commission recommended a 'Closer to Home' approach to health care restructuring, including a movement away from the hospital acute care system towards providing care in the community, with greater focus on addressing prevention, health promotion, and the various determinants of health. Regionalization in BC included twenty Regional Health Boards and eighty-two Local Community Health Councils .

By 1997, as part of the Province's 'Better Care, Better Teamwork' approach, the number of Regional Health Boards had been reduced from twenty to eleven, and of the eighty-two Local Community Health Councils, only thirty-four remained. In 1997, health care services in Victoria – including hospital, community, home, environmental, and public health services – were provided through the Capital Health Region, an amalgamation of seven organizations that provided services to approximately 350,000 people over a 2,300 square kilometre area.

A decade after the Closer to Home initiative, there were 52 regional authorities across British Columbia that the Province considered complicated, confusing, and expensive. In 2001, these were amalgamated as a result of the 'New Era for Patient-Centred Health Care' initiative (British Columbia Ministry of Health Planning, 2001). This new model delivered health services through five separate health authorities, which included 16 health service delivery areas, and one Provincial Health Services Authority to coordinate as well as administer all provincial programs

(British Columbia Ministry of Health, nd). Victoria was situated under the Vancouver Island Health Authority, which was renamed Island Health in 2013. Island Health provides care to more than 765,000 people over a 56,000 square kilometre area on Vancouver Island, the islands of the Georgia Strait, and the mainland communities north of Powell River and south of Rivers Inlet (Island Health, 2013). In 2011, the First Nations Health Authority (FNHA) was established in BC (British Columbia First Nations Health Authority, 2014).

HIV/AIDs, substance use, and harm reduction

According to VIHA (2006), HIV is really a series of epidemics affecting different populations at different rates. In recent years, HIV increasingly affects marginalized populations, such as injection drug users, women and Indigenous people, while continuing to affect gay men and men who have sex with men. The initial epidemic of the early 1980s in North America primarily affected gay men and other men who have sex with men. By 1994, a second epidemic emerged among people who injected drugs, and to a lesser extent among heterosexuals. By 2004, injection drug users accounted for a substantial portion (44%) of newly identified HIV infections in VIHA (Vancouver Island Health Authority, 2006). By 2012, it was estimated there were 888 people knowingly living with HIV/ AIDS in the health region, and about 200 unknowingly infected island residents (Dedyna, 2013).

In VIHA, there were approximately 6,000 hepatitis C virus (HCV) cases reported between 1998 and 2004, and one study (the I-Track) found a 79% prevalence rate for HCV among injection drug users in Victoria (Health Canada, 2003). I-Track studies were piloted in Victoria in 2002, and repeated in 2003, 2005 and 2009 to monitor the prevalence and trends of both risk behaviours and infection (notably HIV and HCV) in people who inject drugs as part of a larger national surveillance program. The 2009 survey (Vancouver Island Health Authority, 2010), reported that while almost all (98%) of respondents had used the needle exchange, 23% reported sharing needles (although this is a decrease since previous surveys). Public injecting is common among those surveyed, with about 75% reported injecting in the street at least once in the previous six months and over 40% report most often injecting in a public place. As in past surveys, almost half (44%) of those surveyed had visited an Emergency department in the last six months (Vancouver Island Health Authority, 2010).

In 1985, five men saw the need for an information- and service-oriented response to the local HIV/AIDS epidemic, leading to the establishment of AIDS Vancouver Island (AVI) (AIDS Vancouver Island, 2013a). AVI opened a needle exchange in the downtown core, and harm reduction services, programs and supplies expanded over the years with syringe quantities increasing significantly. In 1996, AVI Street Outreach Services (SOS) had 545 clients and distributed 128,000 syringes; by 2006, the client-base had increased to 5,000 and over a million syringes had been distributed across Vancouver Island (AIDS Vancouver Island, 2013b). In Victoria alone, the 2005/06 program distributed 830,000 syringes with over 1500 clients

registered with SOS. Unfortunately, in 2008, Victoria's downtown needle exchange was closed due to community pressure and efforts to establish a new site continued to face extreme public opposition. The site's closure resulted in a sharp decrease in the numbers of clients reached and needles distributed (MacNeil & Pauly, 2011); thus, mobile services were established and responses by Assertive Community Treatment teams were increased. Island Health recently began establishment of two service hubs for those vulnerable individuals hardest to reach, hoping to improve their access to health and social services and reduce harm (Vancouver Island Health Authority, 2006, 2012a).

Over the years, other agencies (along with primary health care services from Cool Aid and street nurse programming) played roles in harm reduction in Victoria including but not limited to, the Victoria AIDS Respite Care Society (VARCS); the Victoria Street Community Association (VSCA) in the early 1990s; the Prostitute Empowerment and Education Society (PEERS) in 1997; and in 2003, the Society of Living Intravenous Drug Users (SOLID) was established as a drug-user union and peer-based service agency.

In the early 2000s, public visibility and concern over homelessness and 'public disorder' was heightened, leading to the 2003 launch of the Downtown Health Initiative Action Plan by the City of Victoria, VIHA, and the Victoria Police Department. This initiative was intended to "intensify law enforcement of drug trafficking and provide additional supports to address addiction and mental health problems within the City" (City of Victoria, 2003). In 2004, the City of Victoria formally endorsed a harm reduction policy framework and in 2005, the City released the report *Fitting the pieces together: Towards an integrated harm reduction response to illicit intravenous drug use in Victoria, BC* (2005). Developed in consultation with VIHA, the Victoria Police Department, service providers, and drug users, the report proposed a "comprehensive continuum of harm reduction services, including increasing access to harm reduction supplies, including crack pipes" (City of Victoria, 2005, p. 4). Unfortunately, public opposition was strong, and the fixed site needle exchange was forced to close in 2008, as noted above.

In 2013, VIHA establishment of two service hubs began to improve the access of vulnerable, marginalized, and hard to reach populations to health and social services (Vancouver Island Health Authority, 2012a). VIHA estimated that in downtown Victoria there were approximately 100 individuals who, because of their mental health and/or substance use, are vulnerably housed and often unable to access health and social services. It is therefore necessary that services geared to this population are culturally safe and easily accessible. One such 'care hub', to be located at the Access Health Centre, will include expanded peer supports, increased distribution of harm reduction supplies, and improved screening for blood borne diseases.

Each year, the number of homeless or vulnerably housed individuals who die in Victoria is often alarmingly high. For instance, in 1993, in Greater Victoria, there were forty-one overdose-related deaths, many of which were attributed to heroin being consumed following 'welfare Wednesdays' (Cain, 1994). More recently, during a four-month period in 2012, thirty vulnerable

people well-known to local street-based agencies died of various causes, many of which were related to poverty (Roy, 2013). In 2011, Our Place's Reverend Al reflected on how he typically hosts two memorial services a week for members of the 'street family', many of whom die of natural causes related to homelessness (Cardone, 2011).

Responding to mental health issues²

In the late 1800s, treatment for mental illness was virtually nonexistent. Many people with mental health issues were imprisoned, while immigrants were often deported (BC Mental Health & Substance Use Services, 2013). One historical document describes this lack of support:

Victoria was the usual port of arrival and departure for the gold rush of 1858. Many men suffered mental break-down under the hardships of that period. Patients were locked up in the Victoria jail and then sent to State asylums in California. When the Americans began to request payment for the care of these patients the practice of sending these out had to cease (History of Madness, 2009, p. 1).

Menzies (2001) argues that the emerging mental health system functioned within, and was in fact subservient to, the larger social system, a system whose core ideology centred on the ideal of well-regulated and industrious citizens. The psychiatric patient population continued to increase until 1950, when approximately 5,000 patients were housed in mental health facilities across the province. Overcrowding, intolerable conditions, and at times barbarous treatment occurred throughout the province, propagated in part by a custodial model of care that centred on institutionalized routines and social isolation. This model of care began to shift to recovery-based care positioned around normalization and community re-integration, however even within this new framework the medical model continued to dominate (Morrow et al., 2010).

In the following years, the amount of patients began to decrease, as improved medication-based treatments were paired with a movement to community mental health centres, boarding homes, and general hospital psychiatric wards (BC Mental Health & Substance Use Services, 2013). In British Columbia between 1965 and 1981, the number of beds in psychiatric hospitals declined by 63.9%, from 6,371 to 3,372; and from 1986 to 1999, the number of days of care in psychiatric hospital per 1,000 population fell from 214 to 77 (Issit, 2008; Sealy & Whitehead, 2004).

For decades, Riverview Hospital in Coquitlam, BC was the province's central psychiatric institution. Following a period focused on deinstitutionalization and drastic downsizing, Riverview ultimately closed in 2012, at which point the majority of the facility was empty. As the final patients left Riverview they were met, as those that had left before them, with a general lack of supports and resources, and effective transition and continuation of care were essentially

² For more details about the evolution of mental health responses, and the creation of facilities to house mentally ill individuals in BC, see Appendix A: Selected Timeline of Social and Mental Health Services in British Columbia and Victoria.

impossible (Ronquillo, 2009). Continual cut-backs to community mental health services and a narrow focus on acute and hospital-based care mean that British Columbia's current mental health services focus exclusively on those with the most serious forms of mental illnesses, while offering limited preventive or pre-crisis support (Morrow, Frischmuth, & Johnson, 2006). This lack of support is poignantly felt by the most marginalized and vulnerable members of society, and mental illness and problematic substance use are more prevalent among people experiencing homelessness (Zapf, Roesch, & Hart, 1996). In some ways, mental illness and problematic substance use are pathways to homelessness, while it is also recognized that homelessness can cause mental health problems and problematic substance use.

Deinstitutionalization occurred within the larger context of health care regionalization across British Columbia (Morrow et al., 2010), which was perceived as a progressive move that could facilitate the 'closer to home' principles integral to community mental health, increase local control of service delivery, and enable greater family involvement in mental health. However, health care regionalization also occurred within a wider political climate of government disengagement in community-based services, and social assistance program restriction designed to reduce eligibility, and subsequently costs (Morrow et al., 2010).

Homelessness³

The growth of homelessness is often perceived as something that affects only a small, 'deviant', sub-population; however, political and socio-economic changes have greatly increased the diversity found in the homeless and at-risk populations in Canada. These changes have included: rising inflation, rents, and unemployment levels; the loss of rental housing stock; the federal government's withdrawal from social housing; and restricted eligibility and reduced benefits from both provincial welfare programs and federal unemployment programs. Drastically reduced investments in affordable and social housing in the 1990s, combined with shifts in income supports and declined governmental spending power, have increased the breadth and width of the homelessness crisis. It is a crisis experienced disproportionately by those experiencing mental health conditions, problematic substance use, and/or traumatic events or crisis, such as family break-ups or violence (Gaetz, Donaldson, Richter, & Gulliver, 2013).

In the late 1980s, a local report estimated that between 200-250 individuals formed the core group of downtown Victoria's 'hard to house', and predicted that these numbers would continually increase, "if pressures continue[d] on the existing housing stock and should deinstitutionalization fail to be matched by increased 'purpose-designed' accommodation in the community" (Downtown Inter-Agency Meeting, 1988, p. 2).

³ For more information on the establishment of shelters and supportive housing in Victoria, see Appendix A: Selected Timeline of Social and Mental Health Services in British Columbia and Victoria.

In 1990, the report *The Deinstitutionalization Policy and Impact on Victoria* was released, as the City's Social Planning Advisory Committee continued to place deinstitutionalization as its top priority. The report highlighted the relationship between deinstitutionalization and homelessness, and recommended increased housing to "alleviate the very noticeable problems deinstitutionalized individuals [were] experiencing in our community" (Rabinovitch, 1992, p. 10).

In 1991, between 500 and 600 adults reported being homeless; this term was defined as those who were without shelter, living in hostels, single room occupancy hotels, or rooming houses (Rabinovitch, 1992). During the winter of 2001, the Open Door distributed 500 hampers to people located within walking distance of the downtown drop-in (Our Place Society, 2014).

In 1992, a social activist working for the city's social planning department, Jannit Rabinovitch, was contracted by the city to address the widespread homelessness impacting the downtown core in particular, and the city in general. Rabinovitch was a firm believer that social change starts with engaging those most affected, and her work had far reaching impacts, including: (1) the establishment of the Victoria Street Community Association, which was made up of men experiencing homelessness and lead to the creation of the Medewiwin housing project, and; (2) building the Sandy Merriman women's shelter alongside a crew of homeless women. Rabinovitch's report (1992) also recommended that Cool Aid's Swift Street Clinic be augmented with a 24-hour emergency health service for street engaged adults and youth.

In 1997, it was estimated that 2,050 unique individuals had accessed shelter beds in Victoria within that year. This was a 23.5% increase from the previous year (1,660 in 1996) (Eberle, 2001). On the night of January 15, 2005, Cool Aid conducted a Homeless Count; they estimated that 700 people were sleeping on the streets or in shelters on that night (including 168 people sleeping outside and 500 sleeping in a shelter) (Victoria Cool Aid Society, 2005).

In 2007, the Victoria Cool Aid Society led a Homeless Needs Survey which estimated that, at the time of the survey, 1,242 individuals were homeless or unstably housed; of those surveyed, 48% reported active alcohol or drug use, 42% reported mental health issues, and 27% reported both (Victoria Cool Aid Society, 2007). For 80% of participants, health was noted as a factor in their unstable housing, including physical health (58%), mental health (42%), and drug and alcohol use (42%). A third of those surveyed had gone to a hospital emergency department in the last three months, and 9% had stayed in a hospital in the last month. Forty percent reported being unable to work due to poor health, substance use problems, mental health issues, or a lack of dental care. The report concluded with a recommendation to support the VCAS' previously proposed ACCESS Health Centre, a single fixed support site providing a variety of primary health care and social services (Victoria Cool Aid Society, 2007).

The costs of homelessness in BC increased throughout the late 1990s and 2000s, with archetypal health care costs leading the way across the province. In 2001, Vancouver's St. Paul's Hospital

estimated a 300% increase in the number of patients with no fixed address since 1994. Homeless patients represented both a growing share of total patients as well as total patient days at the hospital (Eberle, 2001).

By the mid-2000s, homelessness was identified by residents as the city's most pressing issue, with ongoing complaints from business and tourism organizations regarding the visibility of homelessness, panhandling, and drug use. In 2012/13, there were 1,477 people waiting for social housing in Victoria, and 1,659 people accessed an emergency shelter *at least once* that year; on one night in February 2013, 1,069 people were homeless or unstably housed (Pauly et al., 2013). In response, the Mayor's Task Force on Breaking the Cycle of Mental Illness, Addictions and Homelessness was established in 2007, and estimated that there were 1,500 homeless people in Greater Victoria; within this population, approximately 650 had a substance use disorder, 420 had a mental illness, and 430 were considered to have co-occurring disorders (City of Victoria, 2007). A further 10% were classified as potentially developmentally delayed and up to 10 percent considered developmentally challenged with a borderline IQ. The Task Force calculated that without the addition of sufficient supportive housing units, the homeless population in Victoria could be expected to increase by 20 to 30% per year, resulting in an additional 300 to 450 people living on the streets and in shelters each year (City of Victoria, 2007).

The Task Force also found that there were over 200 local organizations responding to homelessness, and an estimated \$76 million was spent by 20 of these agencies in response to homelessness, while an additional \$62 million was spent on policing, jails, hospital services, emergency shelter, and clean-up costs related to homelessness. Unfortunately, such spending has continually failed to reduce the number of homeless and at-risk individuals in Victoria, causing a "perfect storm of unprecedented social challenges", which were identified as follows (City of Victoria, 2007):

1. Federal withdrawal from social housing
2. Housing costs up, earning power down
3. Policy changes to federal transfer payments
4. Changes to BC's income assistance policy

Faced with these contributing factors, the Task Force recommended the implementation of a 'Housing First' approach. This strategy would quickly place people in supportive housing, and specifically recommended immediately housing 1,500 people, with an additional 1,550 units of housing to be built in the following five years (City of Victoria, 2007). Based on their research, \$1 million was committed to the development of the ACCESS Health Centre, and housing was immediately provided for 50 of the most 'difficult to house'. The ACCESS Health Centre is a partnership between Victoria Cool Aid Society and AIDS Vancouver Island (AVI). AVI's lease on the Cormorant Street building had not been renewed due to issues related to the needle exchange, and this partnership offered AVI a new home.

The Greater Victoria Coalition to End Homelessness was established in 2008, to sustain the goals of the Task Force, and subsequently four reports were prepared on the state of housing and support in the Greater Victoria area (Pauly & Austen, 2010; Pauly et al., 2013; Pauly, Jackson, Wynn-Williams, & Stiles, 2012; Pauly & Wallace, 2009). In the last of these reports, homelessness is described as the outcome of a complex interplay of three main factors (Pauly et al., 2013):

1. *Structural Factors*, such as the gap between wages and income assistance to the cost of housing and living, as well as structural inequities such as stigma and discrimination
2. *Systematic Failures* that occur when the social safety nets are inadequate or unable to provide for, and protect citizens, including health, welfare, education, child protection, safety, etc.
3. *Personal Circumstances* of individuals and families, such as job loss, illness, trauma and violence, health issues, and other problems that may put people at risk when adequate incomes and affordable housing are scarce.

Since 2006, the overall rental vacancy rate in the Greater Victoria area has risen from 0.5% to 2.8%, which is on par with both national and provincial rates (2.8%) (Pauly et al., 2013). In 2013, vacancy rates within the City of Victoria, where the majority of homeless support services are located, had the lowest rental vacancy rate (2.3%) of the Greater Victoria region. Bachelor units had the lowest overall vacancy rate when compared to other housing types and areas at 1.3%, and for a bachelor with rent less than \$700, the rate was 0.9%, which is a decline from 2009 (1.3%) (Pauly et al., 2013). This is largely due to the declining supply of low end of market suites.

There are many economically vulnerable residents at risk of homelessness in the region. The poverty rate, using Low Income Cut-Offs⁴, for Greater Victoria was 8.6% in 2013, an increase from 2010 but lower than the BC overall (at 10.7%) (Pauly et al., 2013). However, some groups, such as single-parent families, face greater poverty (30.8% living in poverty), which was much higher than the provincial (21.8%) and national (19.7%) rates (Pauly et al., 2013). Twenty seven percent of those renting their home in the region are in core housing need (paying more than 30% of their income on housing costs) and 10.9% are in severe housing need (those paying more than 50% of their income on housing) (Pauly et al., 2013). The living wage⁵ for families had increased from \$15.63/hr in 2006 to \$18.73/hr in 2013 (Community Social Planning Council, 2013). Based on this, the cost of a rental market bachelor suite and food for someone on basic assistance would mean a monthly deficit of \$337, and approximately \$37 for a person on disability assistance.

⁴ An income threshold below which a family will likely devote a larger share of its income on the necessities of food, shelter and clothing than the average family. The approach estimates an income threshold at which families are expected to spend 20 percentage points more than the average family on food, shelter and clothing.

⁵ This is the hourly rate that two parents with two children would need to earn in order to pay for basic requirements (not including vacations, future savings for education, etc.).

In 2012/13, there were 1,477 people on the BC Housing Registry waiting for social housing in Victoria. In that same time period (2012/2013), 1,659 people accessed an emergency shelter at least once (Pauly et al., 2013). On one night in February 2013 alone 1,069 people including 63 families and 106 children were homeless or unstably housed (Pauly et al., 2013). Fifty-five of these individuals were turned away from accommodation. In that year, 20,524 people used a food bank, most of whom who were renting and receiving social assistance. No new subsidized housing units or rental supplements had been added in the previous year (2011/12) for Aboriginal people or people experiencing homelessness. Since 2009, 291 subsidized units have been built for seniors, families, Aboriginal peoples, and persons experiencing homeless. In addition to the Rental Assistant Program (RAP) and Shelter Aid for Elderly Renters(SAFER), there would be 150 rental supplements available through the homeless outreach program operated by BC Housing (Pauly et al., 2013).

Social Safety Net

While the Canadian rise in homelessness is often attributed to the closing of psychiatric hospitals, the largest increase occurred in the 1990s, when many provinces, including BC, lowered welfare rates and limited investment in social housing; also, fewer funds for health and social services were available (Riordan, 2004). This lack of available funding for assistance is inextricably linked to the provincial political scene.

The history of provincial income assistance, housing and related social and health policies in BC over the last several decades is highly influenced by shifting provincial politics. As the governing party in Legislature changes, newly elected governments often introduce social policy reforms, which are often antithetical to the previous governments', as highlighted in a report from the Canadian Council on Social Development (Graham, Atkey, Reeves, & Goldberg, 2009), and detailed in Appendix B: Selected Timeline of Governing Parties in British Columbia.

Victoria Cool Aid Society and Community Health Centre

The Victoria Cool Aid Society (VCSA) originated in the mid-1960s, born from the foundational concept of ‘youth helping youth’. The society established a Free Medical clinic in 1970, co-sponsored by the YMCA. In 1971, Cool Aid established itself on Fernwood Road, operating a hostel and medical clinic supervised by Dr. Joe Haegert. The first dental clinic was established at the hostel in 1972, delivering free dental care and providing a model for communities across Canada. By the 1980s, the focus began to shift from travelling and transient youth to providing a safe haven for people with nowhere else to go. In 1985, the hostel changed its name to Streetlink Emergency Shelter to better reflect the change in clientele and services. In 1987, a downtown outreach position was established to provide more mental health supports. Then in 1988, funding was secured for the downtown location to house the Streetlink shelter, lifeskills programs, the medical clinic, and outreach programs, in recognition of the support being provided for those with severe drug and alcohol problems.

The group acquired a nearby house and established the Cool Aid Psychiatric Boarding Home in 1981. An administrator of the Eric Martin Institute stated that this new facility would be far less expensive than the psychiatric hospital, adding that “psychiatric boarding home programs are ideal, but [are] unfortunately in short supply [...] the programs need expansion” (Hume, 1981).

By 2013, VCAS had become the largest supportive housing provider in BC, outside the Lower Mainland. In Victoria, the agency operated five out of six existing emergency shelters (125 beds) and provided 374 apartments for the formerly homeless (Victoria Cool Aid Society, 2013b). A recent Housing Development Plan proposed opening new housing programs annually to provide an additional 360 apartments by 2018 (Victoria Cool Aid Society, 2013a).

Cool Aid Community Health Centre

In 2000, the Cool Aid Society’s Swift Street Medical Clinic received funding to expand into a Community Health Centre (CHC). In 2002, a dental clinic was developed on site, providing basic care at reduced fees to underserved populations. In 2009, after years of space constraints, the clinic relocated to the ACCESS Health Centre on Johnson Street, with one building housing the CHC, dental clinic, pharmacy, AIDS Vancouver Island, and other health service providers.

Cool Aid’s Community Health Centre (CHC) provides low-barrier access to interdisciplinary primary health care services geared towards economically vulnerable clients with complex medical needs and multiple barriers to accessing care. Through clinical services and outreach programs, Cool Aid serves those experiencing marginalization, homelessness and poverty, and those with HIV/AIDs, severe mental health issues, problematic substance use and/or chronic illness.



Figure 6: Victoria Cool Aid Community Health Centre

Currently, Cool Aid's health team includes physicians, nurses, counsellors, a nutritionist, psychiatrist, acupuncturist, dentists and dental hygienists, and pharmacists and pharmacy technicians. Funding is provided by Island Health with additional funds coming from fundraising, donations and research. Cool Aid has an estimated 4,000 clients.

In 2012/13, physicians and nurses conducted 23,250 patient visits in the clinic and over 3,500 patient encounters through outreach services. In addition, there were 4,800 visits to the clinic's integrated care providers (i.e., dietician, acupuncturist, clinical counsellor, and psychiatrist). There were over 5,500 patient visits in the dental clinic and approximately 75,000 prescriptions filled at the on-site pharmacy. With a mandate of enabling access, the clinic accepted nearly 600 new patients at the medical clinic, 530 new pharmacy clients, and 536 new dental clients in that year.

Clinical reporting from the CHC indicates:

- Almost half of patient encounters were with individuals known to have a chronic infectious disease.
- Approximately two-thirds of patients were perceived to be living with mental health issues or problematic substance use, and over a third of all patients were perceived to be living with concurrent disorders.
- Three of every four encounters were with a client with mental health and/or problematic substance use issues, and in almost all instances the client was experiencing concurrent disorders.
- The majority of clients reported accessing multiple health care services in the ACCESS centre and one in five clients were referred to the CHC through the VCAS shelters.

- Less than 10% of clients surveyed were in an ED in the past month, and the majority of these visits were in hours when the CHC was unavailable (nights and weekends).
- Approximately one of every four patients were identified as homeless or unstably housed.
- Most patients (71%) reported daily smoking and half reported some problematic illicit drug use, while about a third reported an episode of problematic alcohol use in the past year.
- Almost a third (30%) of patients were known to live with Hepatitis C and 13% were known to be living with HIV. There are 250 HIV+ active patients registered at ACCESS.
- 300 “Seek and Treat” HIV tests were conducted in outreach settings, which was a 76% increase in testing from the previous year.
- 81% of HIV+ patients had plasma viral load testing in the past four months and 97% of HIV+ patients were reportedly engaged in antiretroviral therapy.
- In a typical month, the CHC’s nurse-led Hepatitis C Program provided approximately 124 case management appointments to clients with HCV, as well as a twice-weekly support group. On average, there were 35 individual patients with Hepatitis C actively engaged in treatment at the CHC.
- Over the year, over 50,000 clean needles and over 2,000 safer crack-smoking supplies were distributed by CHC staff as part its harm reduction services.

List of Abbreviations

AIDS	Acquired immunodeficiency syndrome
AVI	AIDS Vancouver Island
CHC	Community Health Centre
DIA	Department of Indian Affairs
FNHA	First Nations Health Authority
HCV	Hepatitis C virus
HBC	Hudson's Bay Company
HIV	Human immunodeficiency virus
PHSA	Provincial Health Services Authority of British Columbia
SOS	AVI Street Outreach Services
VCAS	Vancouver Cool Aid Society
VIHA	Vancouver Island Health Authority
VNFC	Victoria Native Friendship Centre

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Appendix A: Selected Timeline of Social and Mental Health Services in British Columbia and Victoria

BC's first asylum opened in 1872, when the Royal Hospital (a quarantine facility on the Songhees reserve), was converted to be the **Victoria Lunatic Asylum** (Menzies & Atchison, 2009). Six years later the asylum was overcrowded and subsequently closed, and the thirty-six patients were moved to a new facility on the mainland (BC Mental Health & Substance Use Services, 2013).

Within a year, the mainland facility faced intolerable overcrowding. By 1901, a Royal Commission found that "cruelty was scandalous" as "steel handcuffs, leg irons and straitjackets were used by attendants at will. Beatings, kicks and punches were frequently used to subdue patients, [and] some [patients] slept in handcuffs for weeks at a time" (Times Colonist, 2008). In **1909**, the Province built a bigger institution in Coquitlam, the **Essondale Hospital**, later called **Riverview**, which faced the same problems of overcrowding as previous facilities (BC Mental Health & Substance Use Services, 2013).



Figure 7: Essondale Hospital, under construction, 1909 (BC Mental Health & Substance Use Services, 2013)

In **1919**, **Colquitz**, a facility to house the 'criminally insane' and others considered too dangerous for the psychiatric institutions and prison systems, **opened in Saanich and was operational until 1964** (BC Mental Health & Substance Use Services, 2013; Menzies & Atchison, 2009).

The **Eric Martin Pavilion local psychiatric hospital opened in Victoria in 1970** (BC Mental Health & Substance Use Services, 2013; Menzies & Atchison, 2009).

In the **1970s**, **Native Friendship Centres were increasingly established across BC** in urban areas, as awareness of the needs of urban Aboriginal communities grew. The **Victoria Native Friendship Centre (VNFC) was established in 1970**, and has been providing services locally for over 40 years; VNFC now operates with a \$2.5 million annual operating budget. After years

of providing Aboriginal Homeless Outreach services, the VNFC partnered with the City and others to transform a hotel into supportive Aboriginal housing.

In **1975, Pemberton House was opened**, providing a twenty-bed residential detox service in Victoria. A decade later, attention shifted to a dedicated detox service for people, often those experiencing homelessness, who were intoxicated on the streets. In **1989, “The Gateway” opened**, an 18-mat service for street-level detoxification (Wallace & Patterson, 1994).

In the **1980s**, the **Victoria Native Indian Housing Society was established**, and has provided safe, affordable housing for families of Aboriginal ancestry in core housing need. The **name was changed to M’akola Housing Society in 1988**, and has continued to provide support and services to Indigenous people living in Vancouver Island’s urban centres (M’akola Group of Societies, 2014).

In **1985**, five men saw the need for an information- and service-oriented response to the local HIV/AIDS epidemic, leading to the **establishment of AIDS Vancouver Island (AVI)** (AIDS Vancouver Island, 2013a). AVI opened a needle exchange in the downtown core, and harm reduction services, programs and supplies expanded over the years with syringe quantities increasing significantly.

In **1986, the Open Door**, an inner city ministry of the United Church of Canada, **was established**, becoming the ‘living room of downtown’, a place where people could get off the street and out of the weather, and receive non-judgmental and unconditional love (Our Place Society, 2014).

In **1992**, a social activist working for the city’s social planning department, Jannit Rabinovitch, was contracted by the city to address the widespread homelessness impacting the downtown core in particular, and the city in general. Rabinovitch was a firm believer that social change starts with engaging those most affected, and her work had far reaching impacts, including: (1) the **establishment of the Victoria Street Community Association**, which was made up of men experiencing homelessness and **led to the creation of the Medewiwin housing project**, and; (2) building the **Sandy Merriman women’s shelter** alongside a crew of homeless women. Rabinovitch’s report (1992) also recommended that Cool Aid’s Swift Street Clinic be augmented with a 24-hour emergency health service for street engaged adults and youth.

In **December of 1992**, Michael Williams, a prominent business person and property owner took initiative and erected a tin shack on Coast Guard land by the Johnson Street Bridge to provide shelter for the homeless during the cold winter. The shack provided warmth and shelter for a core group of individuals experiencing alcoholism and homelessness, nicknamed the **Apple Tree Gang/Group**. The next month, in **January 1993**, the shack burnt down, and one individual trapped inside suffered serious burns (Wallace & Patterson, 1994).

With increased public attention to this small group of predominantly Aboriginal, panhandling street-entrenched drinkers, there were ongoing recommendations that the Gateway Sobering Centre allow daytime access in addition to their usual nighttime hours. By **1994, cheap, potent heroin** was widespread throughout Victoria, **claiming the lives of many Apple Tree Group members**. In **March 1994, the Victoria Street Community Association** transformed a former hotel into a **16-unit supportive housing project** for those experiencing homelessness called **Medewiwin House**. In **April of that same year**, the **Tonto-Rosette house** was opened, providing housing for eight Aboriginal people experiencing homelessness; the house was named after Tonto and Art Rosette, both local homeless people who were among the 38 heroin deaths in Victoria that year (Wallace & Patterson, 1994).

The needs of women experiencing homelessness were one of the issues raised in the **1990s**. As part of a **community development initiative, women experiencing homelessness were provided training, supports and wages to assist in the development of a shelter with services dedicated to women**. Sandy Merriman was one of the women participating, and was one of the many fatal overdoses experienced by the street community in 1995. **By the end of 1995, Sandy Merriman House opened**, and is now operated by VCAS, providing 25 beds and services that include a daytime drop-in program.

Over the years, other agencies (along with primary health care services from Cool Aid and street nurse programming) played **roles in harm reduction in Victoria** including but not limited to, the **Victoria AIDS Respite Care Society (VARCS)**; the **Victoria Street Community Association (VSCA) in the early 1990s**; the **Prostitute Empowerment and Education Society (PEERS) in 1997**; and in **2003, the Society of Living Intravenous Drug Users (SOLID) was established** as a drug-user union and peer-based service agency.

In **1996, AVI Street Outreach Services (SOS)** had 545 clients and distributed 128,000 syringes (AIDS Vancouver Island, 2013b).

In **1997, the Pandora Apartments opened**, as the Victoria Cool Aid Society responded to the needs for not just shelter beds but supportive housing.

Through the years that followed, VCAS would continue to develop both supportive housing projects as well as its shelter services. Such projects included; **Mike Gidora Place in 2000, Johnson Manor in 2001, Fairway Woods Seniors Supportive Housing in 2003, Cedar Grove in 2006, Desmond House in 2007, Next Steps Transitional Shelter in 2008, Queens Manor Supportive Housing in 2010, Olympic Vista Seniors Housing in 2011, Swift House Supportive Housing in 2012**. In addition, **in 2010, Streetlink Shelter would be replaced and expanded through the development of Rock Bay Landing**, which includes 84 shelter beds, 23 transitional shelter units, two shelter units for families and space for 40 shelter mats during overflow conditions.

In **1998**, the **Ministry of Health released a new seven-year Mental Health Plan for BC**, intended to improve access to care for people with mental health conditions (BC Ministry of Health Services, 1998).

In **2001**, the **BC government announced a new administrative structure for health services**, which was comprised of five geographically-based regional health authorities, plus the Provincial Health Services Authority (PHSA) (British Columbia Ministry of Health Planning, 2001).

By **2006**, the **client-base of AVI Street Outreach Services had increased to 5,000 and over a million syringes had been distributed** across Vancouver Island (AIDS Vancouver Island, 2013b). In Victoria alone, the 2005/06 program distributed 830,000 syringes with over 1500 clients registered with SOS.

In **2007**, the **Victoria Cool Aid Society led a Homeless Needs Survey** which estimated that, at the time of the survey, 1,242 individuals were homeless or unstably housed; of those surveyed, 48% reported active alcohol or drug use, 42% reported mental health issues, and 27% reported both (Victoria Cool Aid Society, 2007). For 80% of participants, health was noted as a factor in their unstable housing, including physical health (58%), mental health (42%), and drug and alcohol use (42%). A third of those surveyed had gone to a hospital emergency department in the last three months, and 9% had stayed in a hospital in the last month. Forty percent reported being unable to work due to poor health, substance use problems, mental health issues, or a lack of dental care. The report concluded with a recommendation to support the VCAS' previously proposed ACCESS Health Centre, a single fixed support site providing a variety of primary health care and social services (Victoria Cool Aid Society, 2007).

The **Mayor's Task Force on Breaking the Cycle of Mental Illness, Addictions and Homelessness was established in 2007** (City of Victoria, 2007). The Task Force recommended the implementation of a 'Housing First' approach. This strategy would quickly place people in supportive housing, and specifically recommended immediately housing 1,500 people, with an additional 1,550 units of housing to be built in the following five years (City of Victoria, 2007). Based on their research, **\$1 million was committed to the development of the ACCESS Health Centre**, and **housing was immediately provided for 50 of the most 'difficult to house'**. The ACCESS Health Centre is a partnership between Victoria Cool Aid Society and AIDS Vancouver Island (AVI). AVI's lease on the Cormorant Street building had not been renewed due to issues related to the needle exchange, and this partnership offered AVI a new home.

Unfortunately, in **2008**, **Victoria's downtown needle exchange was closed** due to community pressure and efforts to establish a new site continued to face extreme public opposition. The site's closure resulted in a sharp decrease in the numbers of clients reached and needles distributed (MacNeil & Pauly, 2011); thus, mobile services were established and responses by

Assertive Community Treatment teams were increased. **Island Health recently began establishment of two service hubs for those vulnerable individuals hardest to reach**, hoping to improve their access to health and social services and reduce harm (Vancouver Island Health Authority, 2006, 2012a).

In 2010, **Hulitan Social Services Society left the M'akola Group of Societies to become Hulitan Family & Community Services Society**. Their mission is to provide social and emotional support, programs, and services to Aboriginal families in the Greater Victoria area (Hulitan Family and Community Services Society, 2014).

By 2013, the **Victoria Cool Aid Society evolved to be the largest provider of supportive housing in BC outside the Lower Mainland**. The agency employed over 260 people and had an annual operating budget of close to \$20 million. In Victoria, the agency operated five of the six emergency shelters with a total of 125 beds. Its housing program provided 374 apartments in ten housing complexes for people who were formerly homeless. The agency had a Housing Development Plan (Victoria Cool Aid Society, 2013a) that proposed opening one or two new housing programs a year to provide 260 apartments by 2018 for people who are currently homeless.

Appendix B: Selected Timeline of Governing Parties in British Columbia

The history of provincial income assistance, housing and related social and health policies in BC over the last several decades is highly influenced by shifting provincial politics. As the governing party in Legislature changes, newly elected governments often introduce social policy reforms, which are often antithetical to the previous governments', as highlighted in a report from the Canadian Council on Social Development (Graham et al., 2009):

BC's first New Democratic Party (NDP) Government (1972-1975)

Through the 1940s, 50s, and 60s, elected governing parties had emphasized free enterprise and opted for minimal government intervention in social policy. In 1972, Dave Barrett's NDP government won the election, marking the introduction of the province's modern 'welfare state'.

The Social Credit Party of Canada Government (1975-1991)

The return of a free market ruling party in BC included government downsizing and welfare reforms to reduce the size and strength of the welfare state that had been introduced during the recession of the early 1980s, when unemployment rates peaked at 14%. A social movement opposing the reforms united a diverse range of groups into the Solidarity Coalition, which would alter the political climate and moderate further reforms.

New Democratic Party (NDP) Government (1991-1999)

In 1996, the NDP replaced the existing welfare legislation, the *Guaranteed Available Income for Need (GAIN)* with *BC Benefits* with an aim to reduce caseload levels, reduce welfare rates and overall make work more appealing than welfare. At the same time, progressive reforms were introduced for families such as the BC Family Bonus and enhanced medical and dental benefits (particularly for children). During this era there was a discourse of the 'deserving poor' (often children) and the 'underserving' poor (often those assumed to be capable of employment) accompanied with 'poor bashing' which blames and stigmatizes the poor (Swanson, 2001).

First Liberal Government (2001-present)

The first Liberal government initiated what it called a 'New Era' for the Province, including new welfare legislation and significant reductions in social spending. *BC Benefits* was replaced by the *BC Employment and Assistance Act* and *Employment for Persons with Disabilities Act*, which would enable the planned 30% cuts to the welfare Ministry during the first four years. The restructured welfare system emphasized employment and made access to disability benefits onerous and restrictive, which effectively reduced the number of people receiving social assistance in BC. While the government attributed the reductions to greater self-sufficiency and employment, evidence indicated that the reductions could be less about moving people off of welfare and into jobs and more a result of denying assistance to people

previously deemed eligible (Wallace, Klein, & Reitsma-Street, 2006). This new Liberal legislation included unprecedented welfare time limits which faced significant public opposition; while most of the welfare restructuring and spending reductions moved ahead, the government capitulated on the time limit policy (Wallace & Richards, 2009).