# HOMELESSNESS IN FREDERICTON, NEW BRUNSWICK: DEBUNKING MYTHS AND WORKING TOWARDS SOLUTIONS

**Dr. Sara Davidson**

Myths surrounding homelessness convince too many people it's an unsolvable crisis and attempting to change it is a futile waste of money. I disagree. Housing people costs *less* than leaving them unhoused, much less. Understanding the drivers of homelessness, and collaborating across the board, will solve it. Reframing myths about people experiencing homelessness will help to re-humanize, de-stigmatize, and de-pathologize them. "Them" will become "us."

I am very adequately housed, yet this topic is personal to me. I treat many patients who need safe housing, including those who are part of the roughly 15 percent[1] of homeless Canadians who require over half of the stop gap emergency measures resources. I see the impact homelessness has on health and wellbeing, and the impact physical and mental health have on the ability to obtain and remain housed. I will use my voice of privilege to share what I have learned about myths that stifle progress, then outline part of the solution to homelessness in Fredericton.

## Myth One – Homelessness is a moral failing.

Homelessness does not come from moral failure. It is not deserved. It is often the easily foreseeable result of childhood trauma. It is hard for those who have grown up with enough physical and emotional safety, with role models who work to support themselves, to look at people who can't seem to keep a job and "get their lives together" and understand why they can't. If we attribute success to individual hard work and moral goodness, we fail to see the role support systems have in helping people succeed.

Adverse Childhood Experiences (ACE), which include childhood abuse, exposure to violence, neglect, and household dysfunction, create toxic stress that predisposes people to poor health and social outcomes in adulthood, and in some cases early death. The higher the score on the ACE scale, the more dire the outcomes and risk factors across the lifespan, and the more likely the person is to be homeless. As many as a third of the people with the highest ACE score struggle with homelessness.[2]

## Myth Two – We provide plenty of services for homeless people.

In Fredericton approximately 150 people are homeless, with sixty shelter beds available. This number includes people who are intermittently "couch surfing," in shelters, or "living rough" (sleeping outside). Of these, about forty-five are rated high acuity plus (HA+). No suitable housing exists for these people. HA+ people usually live with complex substance use and mental health disorders and struggle to conform to conditions required in shelters or housing. The kind of supportive housing they need does not exist here yet.

## Myth Three - Homeless people are drug addicts who should stop using drugs.

Not all homeless people use drugs, but it is true people with substance use disorder are over-represented in the homeless population. People who believe they should (or could) "just stop using" do not understand that addiction is a serious illness that requires treatment, not punishment. Our society treats it primarily as a legal and moral issue, when it is a complex multifactorial healthcare issue. Criminality among those with untreated substance use disorder stems from the need to acquire drugs daily to avoid severe withdrawal symptoms. Imagine how much more crime and homelessness might exist if prescription insulin was hard to obtain legally, and type II diabetes was treated as a personal, moral failure to control sugar intake and weight (rather than the complex intersection of factors like genetic predisposition, lifestyle modelling in families, or food insecurity necessitating high cheap carbohydrate intake).

Some people with opiate use disorder can stabilize on medications such as suboxone or methadone, but 15 percent don't find success with these and experience refractory injection drug use.[3] A vicious cycle of criminality and incarceration punctuates attempts at recovery and continues to destabilize people.

## Myth Four - People can't be housed until they're stable enough to follow the rules.

The traditional "treatment before housing" approach to homelessness results in a patchwork of ineffective emergency responses, such as shelter beds, because it requires people to become sober, compliant and able to adhere to rules and expectations to be "ready" to be housed. It is not realistic to expect people to resolve long standing mental health and substance use issues without the fundamental security of housing. It would be akin to asking a professional to produce some of their most difficult work while living in a leaky tent in a rainstorm and suffering from severe flu symptoms.

## Myth Five – Some people just don't want to be housed.

This myth is pervasive and always takes me by surprise. Perhaps it is difficult to reconcile how we, as an affluent society in friendly New Brunswick, could still have a homeless population. It must be their preference. I have yet to meet a homeless person who doesn't want safe housing. What I do encounter are people who are only offered types of shelter beds or housing that do not meet their complex needs and require jumping through arbitrary hoops, such as abstinence from substance use when they have substance use disorder, to earn or keep housing.

Even if we gave everyone a home, we couldn't guarantee they would successfully stay housed. Location matters, when a bus trip costs $5.75 and bus passes aren't included with income assistance, it is nearly impossible to reach needed mental health and support services. Being housed after years on the street can, ironically, destabilize people who then feel isolated without the social connections of their street "family." They become unmoored without the continual activities required for barebones survival and are alone with their demons and trauma. Long experienced social stigma follows them inside; they do not feel welcome in places many of us take for granted. For others, being housed feels unsafe because of associations with past violence in their homes. None of these unintended outcomes mean people don't want to be housed; they just need additional supports to feel safe and welcomed, and to stay housed.

## Myth Six – We can't end homelessness; it is too expensive to fix.

Solving homelessness will be expensive, but not nearly as expensive as not solving it. We don't know exactly how much money is spent by government and not-for-profit organizations reacting to homelessness in Fredericton, or even in New Brunswick, but a lot of research has been done into these costs across Canada and specifically in several major Canadian cities. A 2013 study estimated that homelessness cost the Canadian economy $7.05 billion annually for reactions to homelessness: emergency shelters, community supports, health care, the criminal justice system, and increased emergency responses (including fire, police, and Emergency Medical Technicians), but that a Housing First policy would cost only $4 billion and have better outcomes.[4]

## Solutions

Housing First is not only housing; it includes:

- Immediate access to permanent housing with no requirements (such as sobriety).
- Consumer choice and self-determination about where to live.
- Recovery orientation, focusing on the wellbeing of the client.
- Individualized and client-driven supports, recognizing the uniqueness of each client.
- Social and community integration that gives clients access to supportive social engagement and meaningful activities.

Housing First saves money by reducing the need for emergency healthcare, social services (including shelter beds), and criminal justice services. The Mental Health Commission of Canada found that every $10 invested in Housing First for the highest needs decile saved $21.72 in healthcare, social service, and justice system costs.[5]

Several not-for-profit organizations are doing good work in Fredericton based on Housing First principles and seeing reduced costs to the province and city. After the first two years of using a Housing First approach, the John Howard Society estimated its supportive housing program reduced overall service costs by 53 percent and saw the following reductions in emergency services for participants:

- 97 percent reduction in Emergency Room Visits.
- 91 percent reduction in hospital stays lasting more than one night.
- 94 percent reduction involving the criminal justice system.
- 88 percent reduction in police services.[6]

The John Howard Society's new City Motel project will provide apartments for thirty-two people, including twelve peer supported units, and additional shelter beds. It's a big step in the right direction. But over 100 people will still be in need of housing, with no real options for the forty-five HA+ people. This is where the proposed Sara Burns Community Outreach Centre (SCBOC) could make a substantial difference.

For the past year I've been helping plan the SBCOC, a proposed innovative hub of mixed income and supportive housing, social inclusion, and entrepreneurship. We plan to provide forty supportive housing units with personalized case management support. We'll offer skills development through the revised Phoenix Learning Centre in collaboration with community partners, in formats of varying intensity, frequency, and duration to meet the needs and capabilities of folks. The scope will build from life skills up to micro credentialing for in-demand roles and trades. Our Social Enterprise Hub will create flexible and adaptable work experiences, training support, and entrepreneurship opportunities, and generate revenue for the SBCOC.

We have energetic people ready to fine tune our plans. We have local business leaders and philanthropists ready to organize a capital campaign and some funders waiting with their cheque books in hand. We have a plan to support programming with rental income from housing units. What we don't have is space. Anyone who followed the news of the original, short lived Phoenix Learning Centre knows that proper location is imperative. We are constantly looking for suitable locations downtown within walking distance to services, but there are very few areas that can meet the needs of our target population without upsetting residents or business owners. Our ask of the province is space to build or renovate at the Victoria Health Centre site on Brunswick St., a location that is both convenient for the vulnerable population and one where they will be accepted.

Not for profits will go a long way in providing solutions for homelessness, but they can't do it alone. We need researchers, social service providers, healthcare providers, government agencies, the criminal justice system, policy makers, community members, and people with lived/living experience of homelessness to design solutions collaboratively. We need the government and community to provide resources and money. We estimate the cost for the SBCOC at $5 million, only $2 million of which will need to come from government sources. It's a substantial amount of money, but given the demonstrated success of Housing First policies we believe it will be a wise investment.

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## Notes

[1] Over 85 percent of Canadians who experience homelessness do so only transitionally, often for less than a month and usually due to some combination of a personal crisis and lack of affordable housing. Existing services, while far from ideal, are generally able to help these people get back on their feet. It's the chronically homeless (who have been without housing for at least a year, but often much longer) who are not well served by our current systems and suffer the most from myths about them.

[2] The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study took place from 1995–1997: https://www.cdc.gov/violenceprevention/aces/about.html.

[3] River Stone Recovery Centre in downtown Fredericton is a pilot project funded by Health Canada's Substance Use and Addictions Program and offers medically supervised injections of prescribed hydromorphone to people who have not had success with oral replacement therapies for opioid use disorder, along with wraparound services. This type of injectable treatment only became legal in Canada in 2019, in response to the staggering number of overdose deaths, often due to an increasingly toxic street drug supply. We are seeing encouraging results with the approximately thirty people who have taken part in the program so far and are expanding to additional locations.

[4] Canadian Observatory on Homelessness and Canadian Alliance to End Homelessness, The State of Homelessness in Canada 2013: https://www.homelesshub.ca/SOHC2013.

[5] The National At Home/Chez Soi research program took place in five major Canadian cities: Vancouver, Winnipeg, Toronto, Montreal, and Moncton: https://www.mentalhealthcommission.ca/English/document/24376/national-homechez-soi-final-report.

[6] The Road Home: A Plan to End Homelessness in Fredericton, 2015: https://www.roadhomefredericton.com/uploads/7/9/9/0/79906692/cagh_plan_english.pdf.