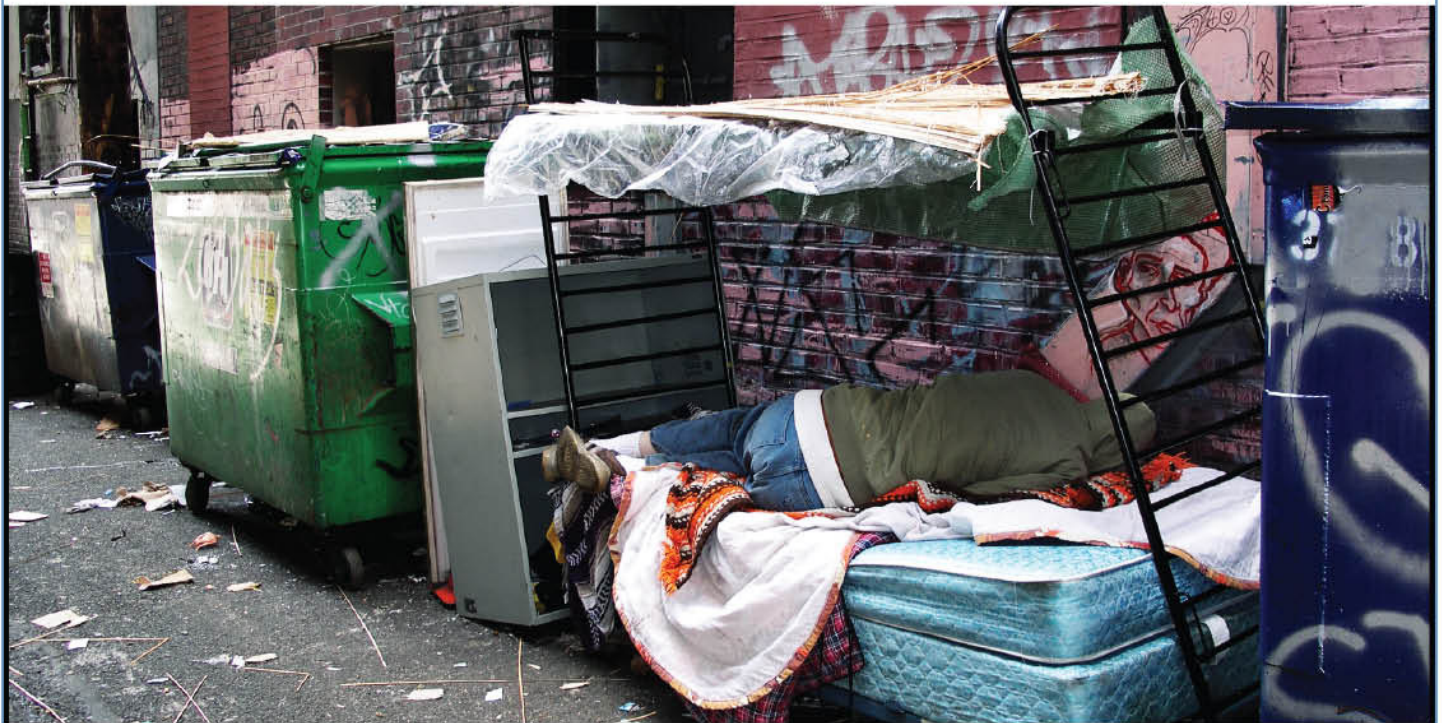


PROJECT LOCKSTEP

A UNITED EFFORT TO SAVE LIVES IN THE DOWNTOWN EASTSIDE



FEBRUARY 4, 2009



VANCOUVER POLICE DEPARTMENT
Beyond the Call

ACKNOWLEDGEMENTS

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REPORT HIGHLIGHTS

- ❖ The lives of many of the people residing in Vancouver's Downtown Eastside (DTES) are negatively affected by mental health issues, illicit and licit substance abuse, drug trafficking, alcoholism, physical health issues like HIV and Hepatitis C infections, substandard and insufficient housing, illegitimate businesses, crime and public disorder, an entrenched survival sex trade, and a historical reduction in police presence. There is a disproportionately high number of aboriginal people affected. These problems, crime and public disorder in particular, harm surrounding Vancouver neighbourhoods, the metro region, and the Province of BC.
- ❖ There have been major efforts to improve the DTES. There have also been deliberate and unintended policies and changes that have played significant roles in the continuation and/or worsening of the problems that are concentrated in the area.
- ❖ Typically, social, medical, police, and other services in the area have been delivered using a discipline-based approach where agencies focus on their own area of mandate and expertise.
- ❖ A change to an integrated client-based service delivery model will utilize existing agency resources more effectively.
- ❖ Interventions need to target those most in need of help and those people "living on the edge" who are in danger of a serious downturn without intervention.
- ❖ An improvement in the DTES requires that the most marginalized and vulnerable people get the assistance they require. This is a necessary condition for other neighbourhood improvement initiatives to succeed.
- ❖ This study proposes a leadership model in the form of a high level Steering Committee comprised of senior City and Provincial stakeholders. The Steering Committee would employ a "Director for the Most Vulnerable" who has the authority to:
 - establish intervention strategies,
 - provide meaningful direction,
 - hold service agencies accountable, and
 - coordinate information sharing and cooperation.

- ❖ The Director would report back to the Steering Committee regarding successes and failures both in terms of increasing collaboration as well as the specific strategies used.
- ❖ Success should be measured on the basis of outcomes rather than activity. Baseline metrics should be established and improvements should be quantifiable and focused on improving the lives of the most vulnerable.
- ❖ The Steering Committee should facilitate an information sharing process between agencies, including the Vancouver Police Department, to identify those individuals who are most in need and then work to improve the lives of those individuals by reducing or removing the barriers to success.
- ❖ Collaboration between public, private and philanthropic service providers is essential. By utilizing existing agency resources more collaboratively, the need for increasing funding can potentially be reduced. This proposal emphasizes that existing resources should be realigned into an integrated and collaborative model with central control.
- ❖ With appropriate prioritization and action, the lives of the vulnerable in the DTES can be improved and a positive “ripple effect” can be achieved in surrounding communities, and the rest of the Province through the reduction of crime, public disorder and improvements in the health crisis.

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EXECUTIVE SUMMARY

The Downtown Eastside (DTES) of Vancouver, once a thriving business district in the heart of the City, is a historic neighbourhood that is home to over 16,000 residents. Unfortunately, a serious public health and public order crisis has overwhelmed the lives of a significant number of people who live in the DTES. The deleterious effects of the high incidence of mental illness, drug addiction, disease, crime, homelessness and poverty have devastated the most vulnerable people in the community. In addition to seriously eroding the lives of the vulnerable individuals, these issues also have a substantial negative impact on all residents and stakeholders in the community. This ongoing crisis, which is well known across Canada and throughout the world, requires immediate action.

Many of those struggling to survive in the DTES suffer from mental illness, drug and alcohol addiction, or in many cases from both. These individuals often fail to find and maintain employment, and thus most live below the poverty line. Often these people become involved in criminal activity, underground economies, or the sex trade as a means to survive and support their addictions. Affordable housing is often found in squalid rooms, run by unscrupulous landlords, surrounded by criminals or is simply unavailable, leaving a growing number of individuals homeless. Health officials have declared that the DTES is in a state of crisis. High risk sex and drug activities combined with deplorable living conditions have led to rates of infection for HIV, Hepatitis C, tuberculosis and syphilis that are higher than many third-world countries.

In recent years a number of policing, social and health initiatives have attempted to address this crisis. However, despite these efforts, the levels of crime, social disorder, drug addiction and disease remain high, and the quality of life for many in the DTES continues to be poor. Efforts by all levels of government and the community to respond to the crisis facing the people in the DTES have been significant but have not added up to the robust response required to realize significant positive change. Certainly, the communities of Strathcona, Gastown and Chinatown have been willing and active participants in efforts to improve the DTES, particularly because they have been so highly affected by the disorder in the area. A number of initiatives within public health, housing, policing and criminal justice reform are underway and still need to be evaluated as to their impact on the DTES. Other current or proposed initiatives, such as the redevelopment of the Woodward's building, an increase in

market housing in the DTES, the location of a new police headquarters on Main Street, and an increase in businesses locating in the adjacent industrial areas may be instrumental in bringing economic vitality to the area. However, for these initiatives to be successful, it is vital that the most vulnerable people are given the assistance they need in order to move forward in their lives. In addition, for significant long term solutions to be achieved, both for the people and the community as a whole, there must be cooperation and collaboration among key stakeholders. It is important that collaboration occur at the local, regional, and provincial levels because the consequences of leaving the people to fend for themselves have implications for everyone in the province, if not the country. Involvement by all these stakeholders from the community and outwards improves the chances of making and sustaining change. Further, while many plans have called for increased collaboration, there has been a lack of effective administrative oversight and there is currently no established body with a specific mandate to improve life in the DTES. This discussion paper is a call for action by all stakeholders to discuss and bring forward resources and creativity in solving the problems faced by the people in the DTES.

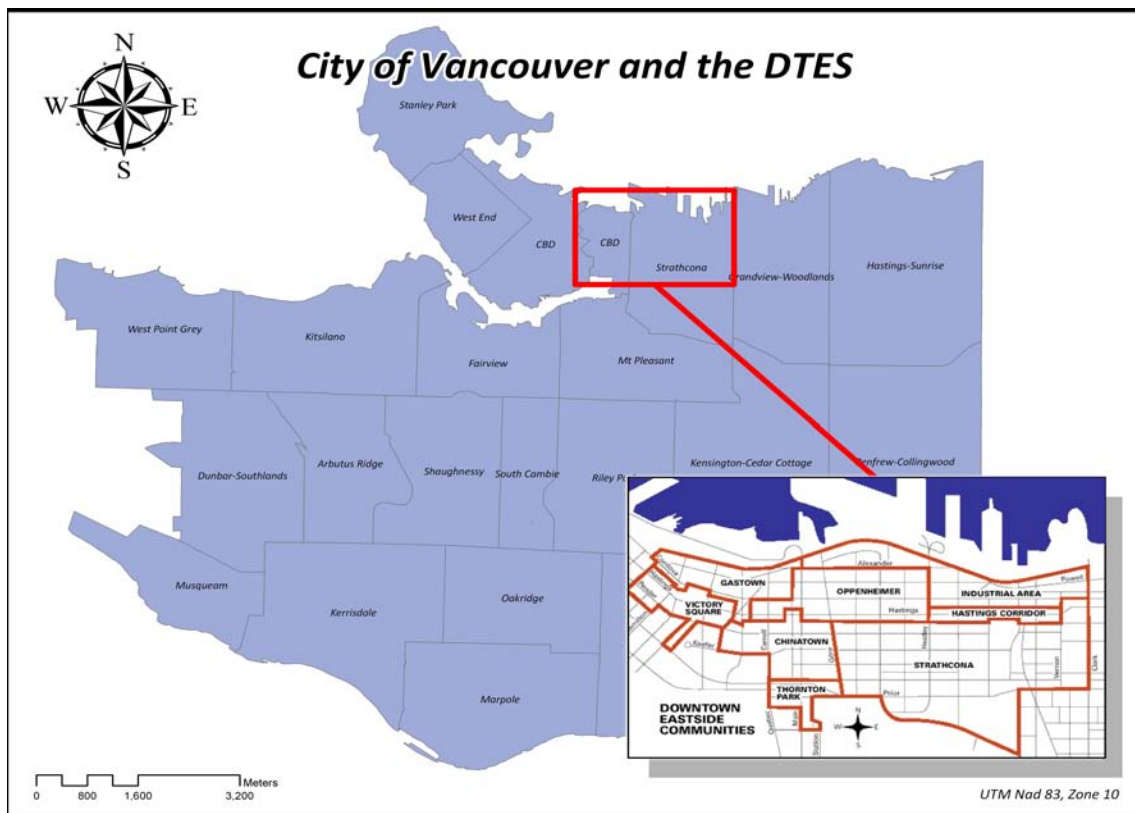
The DTES is in crisis and a mandated, coordinated approach is required to effect change and improve the lives of the people in the community. Reducing the number of people who face significant challenges in their lives by using a client centered approach will create an environment where other initiatives in the DTES will have the best chance of success. This discussion paper recommends that a steering committee of top-level decision makers be formed with representatives from the regional governments as well as the provincial and federal government. The steering committee should hire a Director who is tasked with creating a team of senior practitioners from the various service agencies to address the needs of the most vulnerable individuals in the DTES. The steering committee and its staff would need to operate under agreed upon guiding principles, ensure their actions contribute towards the evolving common vision for the area, design a coordinated plan of action, ensure accountability from government and private support agencies, establish goals, prioritize actions and develop timelines for change. In taking coordinated action, it is imperative that the decision makers involved in the steering committee have the authority and resources available to bring about meaningful change in the lives of those in the DTES.

INTRODUCTION

The Downtown Eastside (DTES) of Vancouver is the oldest neighbourhood in Vancouver and has many positive attributes, including strong community spirit in particular. However, like most neighbourhoods, the community has also identified improvements that are needed and desired. Unfortunately, the DTES has had to grapple with some serious problems that have been difficult to resolve despite efforts by a wide range of people, agencies and governments.

Originally a thriving business district in the heart of downtown, the shift of legitimate businesses to Granville Street in the mid-1900s significantly hurt the DTES. A confluence of factors related to both the people in the area and the economic turns affecting business have led to the gradual degradation of the DTES. Though some areas within the DTES have seen some success with the implementation of various initiatives in raising the quality of life for the residents, these successes have been more difficult to achieve for others.

Figure 1 - Map of the City of Vancouver and the DTES



The technical geographical boundaries of the DTES are Cambie Street to the west, Clark Drive to the east, the waterfront to the North, and Venables/Prior Street to the south. This area encompasses eight distinct areas: Chinatown, Gastown, Oppenheimer, Strathcona, Thornton Park, Victory Square, the Hastings Corridor and a light industrial area to the north. However, a much smaller segment of these eight areas is referred to when considering the problems facing this community. Tragically, the small area of the DTES around Main Street and East Hastings Street is well known across Canada and throughout the world for its drug market, high rate of mental illness, poverty, sex trade and homelessness. Within this area is a significant population of marginalized people. The issues facing these most vulnerable people and the need to improve their quality of life are the focus of this report.

In the past, several efforts to improve the situation in the DTES have been made by the various levels of government and non-profit organizations. These efforts have been successful in a number of communities, such as the new developments in Chinatown and Gastown. Success has been seen in a number of areas, including preserving the heritage of these neighbourhoods.

Vancouver enjoys a beautiful sea-and-mountain setting and some increasingly ugly problems. The Downtown Eastside, a scene of battered and boarded-up buildings, is the most concentrated pocket of poverty and crime in Canada. Despite police crackdowns, an open drug bazaar still thrives on its street corners. Its back alleys, doorways and parks are home to a ragged, swelling tribe of homeless men, women and children.

*-The Mean Streets of Arcadia
November 18, 2004
The Economist*

This desire for improvement and change continues both at the community and government/agency level. Interest in dealing with the issues in the DTES is high and it is recognized that many initiatives are currently underway to contribute to the revitalization of the area. Continuing to build and develop an environment that encourages inter-agency collaboration will ensure that existing plans and efforts have the greatest likelihood of making an impact on the interrelated issues that exist in this community. However, there are many obstacles and barriers to revitalization to overcome. While collaboration is a key component of success, a necessary condition of moving forward with current and future initiatives is to address the needs of the most vulnerable people in the DTES by giving

them the tools and assistance required to improve their lives.

STATEMENT OF INTENT

This report is a working document and as such is not intended as a final statement about either the problems in the DTES or the method by which a solution can be found. Instead, this report is intended to facilitate discussion and build toward consensus on how to collectively improve the lives of the most vulnerable people in the DTES community. As they are often both the cause of and the victim to the problems found in the DTES, improvements in their lives will translate to a healthier community as a whole. While this report outlines an example of how it may be possible to move forward in achieving success, it is hoped that further discussion will bring forward suggestions for improvement of this example and/or new ways to move forward in a collaborative fashion.

EARLY HISTORY OF THE DOWNTOWN EASTSIDE

The DTES community overall has changed dramatically over the last century. In the late 1800s, the DTES was the economic hub of Vancouver, and the area between Cambie and Carrall streets formed the main commercial center.¹ The Chinese community began to settle in the Pender

Street area and the whole of the DTES was a mixture of residential neighbourhoods and commercial premises that were concentrated along Hastings Street. However, after the Hotel Vancouver was built in 1887, development of the downtown area began to slowly shift west towards the Granville Street area. Although the construction of Woodward's on Hastings Street in 1904 brought thousands of people to the eastside until the 1970s, most large scale commercial businesses continued to relocate towards Granville Street.

The Depression in the 1930s hit the DTES very hard. It brought a large number of people to Vancouver seeking work, and most ended up taking refuge in the affordable rooming houses of the DTES. Many of the residents were men who were poor due to the lack of employment opportunities, or suffered from various illnesses, alcoholism being the most prevalent.² The area further deteriorated because of the demise of North Shore Ferries, the removal of the Japanese population from the DTES during World War II, and the closure of streetcar routes through the area.³ Despite the issues in the DTES, Hastings Street continued to enjoy substantial popularity with shoppers. Yet, McRae et al. noted⁴ that the area suffered continual decline throughout the

1940s and 1950s, primarily because of a lack of service development to address the issues facing the transient/migratory men who dominated the area. To help address this issue, many hotels converted their rooms into single room occupancy (SRO) units. These affordable accommodations often attracted resource workers, mostly from the fishing and forestry industries, to the area to spend their disposable income. The location was also convenient to rail yards and ports allowing for increased employment for those resource workers. Though the area was known for its beer parlours and the availability of alcohol, the DTES was considered to be relatively stable and healthy by police working in the DTES at the time.⁵

By the mid-1960s, the City of Vancouver had recognized that there were significant problems in the DTES. The City identified the problems as being related to the high proportion of single, often older, men who were unemployed due to a lack of skills, training and opportunity, as well as suffering from health problems, poverty, homelessness and chronic drunkenness.⁶ A report on the area by a Sub-Committee to the Special Joint Committee on Skid-Road Problems stated:

The phenomenon of Skid Road is unique in the plethora of health and welfare problems facing the city of Vancouver since the area known as

Skid Road is relatively small and well defined and the human problems there are peculiar to the district.⁷

Moreover, W. Graham, the Director of the City of Vancouver Planning Department in 1965, noted that “a police ‘paddy wagon’ cruises the area waiting for something to happen - it usually doesn’t have to wait for long”.⁸ At the time of Graham’s report, a large proportion of arrests for violent crimes and for alcohol-related disorder for the City of Vancouver occurred in the DTES. Clearly, the bustling downtown core of Vancouver had changed dramatically for the worse.

By the early 1970s, the Gastown and Chinatown areas surrounding the DTES were designated as historical sites.⁹ While beneficial for the areas protected, the DTES was hurt unintentionally as legitimate



businesses moved away from the DTES into the historical areas. This left a void that was subsequently filled by pawnshops and adult novelty stores.¹⁰ By the 1980s, the DTES neighbourhood, Strathcona in particular, had almost fully transitioned from a vibrant, though tough, community into an area that was sick and in dire need

Case Study 1: Bill

Bill faces a number of challenges in his daily life. He is mentally ill, diagnosed with schizophrenia and bi-polar disorder. He has a physical disability which limits his functioning and he is also addicted to drugs. He is also a chronic offender; he has had 279 documented contacts with police, and he has been charged 171 times. These factors have made it difficult for Bill to have appropriate housing and care. A coordinated approach to his treatment would assist him in getting access to appropriate treatment for his mental illnesses, his drug addiction and care for his physical disability. If those challenges are managed, he may have an easier time finding suitable housing as well.

of attention. In the 1980s and 1990s, the community was devastated by the introduction of crack cocaine and the increasing deinstitutionalization of the mentally ill exacerbated the problems in the DTES. In addition, the burgeoning drug market in the 1980s discouraged legitimate businesses from remaining in the area and enabled illegitimate businesses to thrive.

These events created a tipping point, pushing the DTES further into despair. The high numbers of single, resource based/blue collar workers, the availability of drugs, the prevalence of mental illness, the concentration of private low-income SROs, and the concentration of services contributed to an over-representation of residents with serious mental health and addiction problems living in substandard conditions. Some have suggested that this was a de facto containment policy whereby all of these problems in the Vancouver region were concentrated in this small area.

The historical context to the DTES has contributed to its current state, in both positive and negative ways. However, for a significant proportion of the population, several critical issues have been difficult to resolve satisfactorily and for many of these people, the issues have become a matter of life and death.

CRITICAL ISSUES

There are several critical issues being dealt with by the most vulnerable people in the DTES. Some concerns are more focused at the individual level, like high rates of drug addiction and mental illness, while other problems are experienced by the entire community, such as the housing crisis and high levels of crime. More importantly, the

people who are dealing with these issues may be dealing with one or several of these problems at once. Though estimates of how many people could be considered most in need, it has been suggested that as many as 2,000 individuals are dealing with any or all of these most critical of issues at any given time. Given that these same individuals typically have more than one issue to address, it follows that multiple agencies are dealing with these same people. Moreover, many of these issues are inter-related and thus a collaborative and integrated approach is necessary to move forward in improving the standard of living for these individuals, and by extension, the community in which they live. Many who are not directly involved in these problems choose to live in the DTES because of the more affordable housing, yet, they are highly affected by the disorder and the poor standard of living.

Mental illness, drug addiction, the health crisis, poverty, housing problems including homelessness, illegitimate businesses, high rates of crime and public disorder, the thriving sex trade, the reduction of police presence and the disproportionate impact of all of these problems on aboriginal people are the most pervasive issues facing the DTES. Of all the problems in the DTES, these present the biggest challenges in



terms of resolution and subsequent improvement.

MENTAL ILLNESS

According to reports written in the 1960s by the City of Vancouver, mental illness and substance use have been prevalent problems since the early 1900s. The transient population and the high levels of unemployment have been linked to alcoholism and health problems for those living in the DTES.¹¹ Treatment for those who were suffering from mental illness and substance use issues has changed quite dramatically in the last sixty years. The biggest influencing factor on the incidence of mental illness in the community has been the deinstitutionalization of the mentally ill that began in the early 1980s. This public policy shift occurred concurrently in many countries around the world and was expected to improve the quality of life for those diagnosed with a

mental illness. In British Columbia, this policy resulted in a province wide reduction of treatment beds at Riverview Psychiatric Hospital from approximately 4,600 at its peak in 1951 to only 1,000 by the early 1990s.¹²

A Vancouver Police Department (VPD) report, *Lost in Transition*,¹³ noted that while the deinstitutionalization was a positive change for many people suffering from mental illness, a small proportion suffered greatly from its effects. As intended, this move into the community was beneficial and improved quality of life for those who did not require the level of supervision given by hospitals. However, for those who required more intensive care and community support, the services were often not available, leading to numerous problems. The lack of, and high demand for, community resources to adequately

care for and supply treatment for mentally ill individuals has been identified as a primary reason for the difficulties in adjusting to life in the community:

It seems the reduction in beds at Riverview and the lack of support services in the community to replace those lost are significant contributing factors to the current crisis. Those individuals with serious mental illness, and frequently with addictions, create considerable demands for police services, and destabilize communities.¹⁴

This group is often homeless or living in dangerous substandard accommodations due to poverty and an inability to work. Because they are a vulnerable population, they are often taken advantage of by unscrupulous landlords or preyed upon by drug dealers. Exposure to drugs in the DTES has been particularly problematic for this group of individuals and has led to a high number of people having to deal with both mental illness and drug addiction.

People in the Downtown Eastside and elsewhere who can't cope will be cared for in safe and secure facilities until they are well. They will not be abandoned or consigned to a life of despair and destitution on the streets.

*-Speech from the Throne
The Honourable Steven L. Point,
Lieutenant-Governor
at the Opening of the Fourth Session,
Thirty-Eighth Parliament of the Province
of British Columbia
February 12, 2008*

Due to the prevalence of mental illness and addiction, social service resources are more commonly found in the DTES than elsewhere in Vancouver and this helps to explain, at least in part, why so many individuals with mental illness frequent the area. Wilson-Bates found that the prevalence of social services and the fact that the DTES provides most of the affordable housing in the region for very

low income individuals attracts those who are dealing with mental illness.¹⁵

DRUG ADDICTION

It has been well documented that the DTES is home to a large-scale open-air drug market. The availability of drugs in the DTES and the “predatory” nature of the drug dealers have led to a co-occurrence of mental illness problems and drug addiction in the area.¹⁶ Because of this, over half the police interactions in the DTES involve individuals who are mentally ill, addicted to drugs or both.¹⁷

Though the DTES was associated with alcoholism for much of its history, the 1970s saw an increase in the use of heroin and the 1980s saw a rise in the use of Talwin and Ritalin. In particular, the DTES was particularly negatively affected by the rise in injection drug use in the 1980s and

further by the introduction of cheap and ubiquitous crack cocaine in the 1990s. Crack cocaine has become the drug of choice in the area; it is now more prevalent than heroin and other forms of cocaine.¹⁸

During the mid-1990s, there was a call for a change in the response to drug addiction. In particular, it was felt that the health system was better placed than the criminal justice system to handle, and stop, the overdoses that were arising from drug addiction to heroin. Moreover, by 1992 there was a significant reduction in the number of drug offence charges that were prosecuted in the federal courts as well as a reduction in the average sentence length for those who were convicted. During that time, drug addiction was often dealt with through enforcement by police action as the health system organized itself to deal more specifically with the drug problem.

In 2001, the City of Vancouver adopted a new policy approach to reduce illicit drug use. The *Four Pillars* approach, as it is known, takes a more holistic view of drug addiction and incorporates prevention, treatment, enforcement and harm reduction in its attempt to address the use of drugs in the community. The approach was meant to highlight each of these areas as being equally important in addressing



drug use. In particular, this approach focuses on partnerships between agencies to address facets of each of the four pillars as well as (and most importantly) between all four pillars. The formation of partnerships to assist in the prevention of

Case Study 2: Angie

Angie is new to the DTES. She has been a ward of the state for a number of years and was considered an at risk youth. She is now addicted to rock cocaine and works in the survival sex trade. She has had numerous dealings with police, but currently is in a grey area because she is still viewed as a child by the Province but is considered an adult by the criminal justice system. Working with Angie to manage her drug addiction may assist her in getting out of the survival sex trade, away from police and the criminal justice system and ultimately back to her home community.

substance use was further endorsed in a 2005 report by the City of Vancouver.¹⁹

Many initiatives have been put in place related to each of the four pillars. Initiatives such as the Drug Court, Downtown Community Court, Insite, Onsite, expansion of detoxification centers and treatment options have all been developed. However, in spite of these efforts, drug use has continued to be a large problem for many people in the DTES

and this has contributed in large part to the health crisis that they also are facing.

HEALTH CRISIS

The health issues of the DTES are not new. In 1997, a public health emergency was declared for the Downtown Eastside by the chief medical officer and that crisis has continued to grow ever since.²⁰ By far the most influential factor in the health crisis is the high level of intravenous drug use (IDU). A 2001 report stated that there were approximately 4,700 intravenous drug users in the DTES.²¹ According to the Canadian Community Epidemiology Network on Drug Use, drug induced deaths in the DTES were more than seven times higher than for any other area of Vancouver in 2005.²² After a peak in both 1993 and 1998 in illicit drug induced deaths, the number of overdose deaths has decreased dramatically, but are still higher for Vancouver than for the rest of the province.²³

Intravenous drug users also experienced a corresponding dramatic increase in the rate of infection for HIV and of other contagious diseases. Christensen and Cler-Cunningham note that the pervasive level of HIV/AIDS and Hepatitis C are at the heart of the health crisis.²⁴ For example, between 1994 and 1999, IDU was the predominant mode of HIV transmission in BC.²⁵ This has changed, however, and since

2000, men who have sex with men have been the predominant mode of transmission and IDU has fallen into second position. In 1997, the rate of HIV infection in Vancouver was 0.59 per 1,000 while the rest of the province was 0.06 per 1,000.²⁶ Some improvements have been made here, as the HIV infection rate in 2005 had dropped to 0.33 per 1,000 in Vancouver and remained the same across the province.²⁷

Historically, HIV infection rates have been much higher for aboriginal women than other groups in the DTES; as a result, aboriginal women have been more likely to die from HIV/AIDS than other segments of the female population.²⁸ Furthermore, in 1997, the infection rate for Hepatitis C was 343 per 100,000 in Vancouver, almost six times the national rate, with an estimated 70% of cases contracting the disease through IDU.²⁹ As of 2005, the Hepatitis C infection rate had dropped significantly to 88.9 per 100,000 in Vancouver and 66.5 per 100,000 in BC as a whole. While both HIV and Hepatitis C infection rates have improved in the last decade, they are still higher for Vancouver than they are for the rest of the province. These decreases may be related to the drop in the number of intravenous drug users overall, with use of heroin in particular decreasing, and an increase in crack smoking.³⁰ Outbreaks of

tuberculosis and syphilis are also disproportionately higher for the DTES than for the rest of the province.³¹

Case Study 3: Jeff

Jeff is originally from the East Coast, and slowly moved across Canada. He has several non-returnable warrants stemming from his time in other areas. He is addicted to cocaine and has entered recovery programs several times. Jeff has turned to committing petty crimes to support his addiction and thus has had several contacts with police. He has expressed a desire to return home as he believes he will die if he remains in the DTES. Collaboration between Income Assistance and Health to work on his drug addiction and need to commit crime to support his habit may assist Jeff in getting back to his home community a healthier and happier person.

POVERTY

The DTES is often described as “Canada’s poorest postal code” (V6A). While there are a few small, rural towns with lower average income levels than those observed in the DTES, this area is indisputably the poorest neighbourhood of any large urban centre in Canada. It is estimated that more than 50% of the population rely on income assistance. Benoit and Carroll cite a City of Vancouver report from 1998 stating that 75% of the population in the DTES live “at the edge of poverty, with an annual

income only one-third that of other Vancouver residents".³²

This is not a new problem for the DTES; a 1971 report by the City of Vancouver notes that at the time of the survey 86% of residents were unemployed and 57% were unemployed for at least the last year. Furthermore, they found that 30% of the population was living on a pension. A 2008 study found that 51% of those living in social housing and 12% of those in SROs were on a federal pension, while 25% of those living in social housing and 60% of those living in SROs were on social assistance.³³ For both groups, average monthly income was just over \$1,000 with almost 40% of their income typically going to rent payments.³⁴

For many in the DTES, earning an income is made more complicated by the challenges of having mental health issues, drug addiction, or developmental problems such as Fetal Alcohol Syndrome (FAS). Furthermore, a number of individuals in the DTES suffer from physical disabilities (such as missing limbs) or injuries that make physical labour impossible. Adding to the difficulties in finding employment, many have a low level of education, and few skills.

The low income issues faced by those in the DTES continue to be pervasive and the disparity between the income level of the residents of the DTES and the rest of Vancouver has grown. Specifically, the City of Vancouver noted in 2001 that while the median and average incomes of Vancouver residents were increasing, there was a decrease in the incomes of DTES residents (though this is not true for some of the neighbourhoods in the DTES, such as Gastown, which have seen a dramatic increase in income level).³⁵

HOUSING/HOMELESSNESS

Since the 1950s there has been a gradual concentration of low income singles in the SRO units that are found in the DTES. As a result, affordable and safe housing has long been a problem for the area. Historically, the demand for housing in the DTES also increased because of a concurrent reduction in affordable housing in other



areas of the region, including Kitsilano, Yaletown, North Vancouver and New Westminister and Fairview Slopes.³⁶ Though there were more affordable options available in the DTES compared to the rest of the Vancouver area, many of the housing options in the DTES were, and continue to be, dangerous and unhealthy. Rooming houses were noted to be providing the bulk of the housing options in the DTES by the 1970s.³⁷ Today, because of the low income of most of the residents, SRO housing can cost up to 65% of a person's income from social assistance.³⁸ Yet, the housing is typically a small single room, with a lack of security, privacy and few amenities. In addition, insect infestations (e.g., cockroaches and bed bugs) are not uncommon.

The City of Vancouver has taken several steps to improve the quality of low-income housing in the DTES and to address the growing issue of homelessness. Most of these plans and initiatives have been based on homeless counts from 2000. However, the number of homeless, though difficult to estimate, has increased both in the DTES and in the region as a whole at least in part due to changes in welfare policies, increased urban migration and the deinstitutionalization of the mentally ill. As such, it is more difficult for successes to be seen in eliminating homelessness.

Nonetheless, there have been significant changes to the housing stock available in the DTES and in the surrounding areas that have greatly influenced the area.

Specifically, since the 1970s, more than 5,000 non-market housing units have been built and the province is currently updating 17 hotels in the area to be run by non-profit operators in order to increase the low income housing stock. At the same time, the affordable housing resources have decreased in the surrounding areas, making the DTES one of few options for low income families.

Given the level of crime often found in SROs and lower income areas, the VPD has also been concerned with the quality of low-income housing in the DTES. To ensure that marginalized people are not being victimized, the VPD has conducted several undercover operations that targeted

My problem is cockroaches. The housing part, it's not adequate. There's a lot of slumlords out there, running these hotels and they don't put money into them and they just rent them as they are, and we have to try to fix them up when we move into them. [B]ut we can't live that way. We've been there for months and the cockroaches have been there. There's a lot of germs.

*-DTES Aboriginal Woman
cited in Benoit & Carroll (2001)*

predatory landlords to ensure that SRO's are a safe place for people to live. These buildings house people who are addicted to substances or are suffering from a mental illness or are attempting to recover from abusing drugs/alcohol.

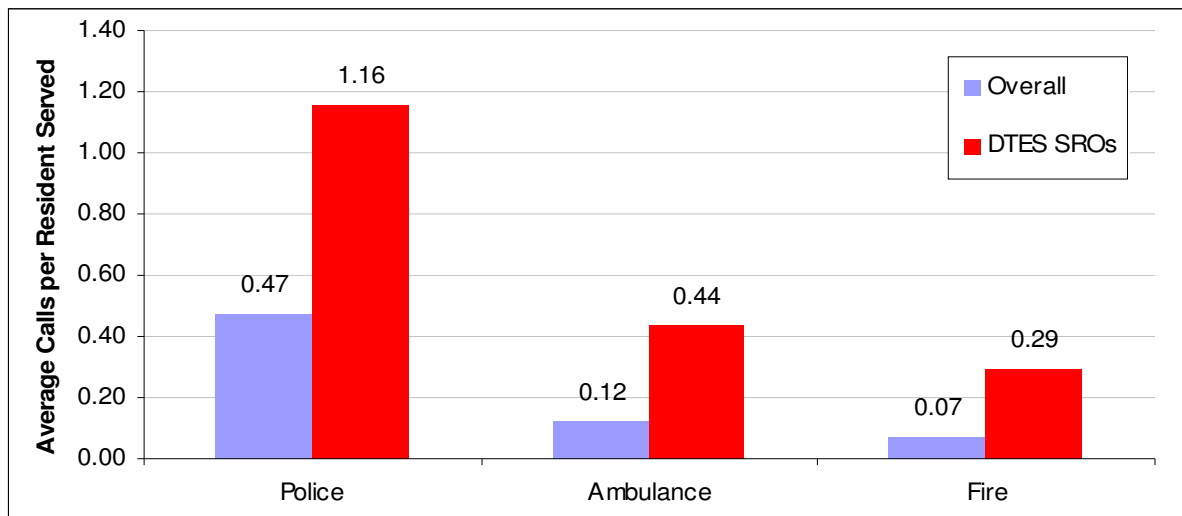
Hotels were targeted because of intelligence that there was criminal activity occurring, or to assess the level of compliance with bylaw and licensing regulations. The landlords that were charged as a result of these projects typically cashed an individual's social assistance cheque and gave them approximately half of the money back; the landlord then rented the room out to someone else, leaving the individual homeless and with little money. More than 35 charges involving 26 people resulted from these projects demonstrating that owners and landlords were often willing to turn a blind eye to drug dealing on or near their property and, in some cases, used drug dealing to increase their own profits.³⁹

Considering the rates of mental illness and substance addiction and the difficulties those suffering from these problems have with finding and maintaining steady employment, it is not surprising that so many in the DTES live in abhorrent conditions. A 2008 report prepared for the

City of Vancouver states that many who are mentally ill have difficulties obtaining adequate housing, and the lower cost options for housing are often in poor repair, neglected and/or dangerous, leaving many with little choice but to live on the streets.⁴⁰ Furthermore, this group of individuals utilizes the services of police, fire and health significantly more often than the remainder of the population, putting a strain on emergency resources.⁴¹

A 2007 report, prepared as part of the Vancouver Agreement, analyzed 54 SRO hotels in the DTES. An inspection of 3,100 rooms that was part of the study revealed that 80 percent of the buildings had bed bugs and 77 percent had rodents and/or cockroaches.⁴² In addition, this report documented the higher utilization of emergency services at these 54 SROs, (see Figure 2).

Recognizing the importance of having well managed SROs, the VPD in October 2008 partnered with the Provincial Government and the non-profit operators of 17 government-owned SROs in a project called Partners in Action. The program aims to ensure that SRO residents receive the safe, secure, and supportive housing that they deserve. To reach this goal, the project relies on increased communication between all three parties. The VPD assigns

Figure 2 - Utilization of Emergency Services at 54 SROs in the DTES

specific beat officers to work with the SROs to build a strong working relationship with staff. As a result of this cooperation, the VPD expects that the potential crime rate at these SROs will improve, thereby providing tenants with a safe environment that is free of predatory individuals.

ILLEGITIMATE BUSINESSES

The high poverty rate in the DTES has meant that legitimate businesses have a small consumer base to draw from, resulting in small profits (if any) and a negative perception of the neighbourhood that inhibits shopping in the area by other Vancouver residents.⁴³ The closure of Woodward's in 1993 was a serious economic hit for the DTES community.⁴⁴ By 2001, the storefront vacancy rate along Hastings Street between Main and Cambie

streets was 43%.⁴⁵ The Vancouver Agreement⁴⁶ noted that significant investments by other businesses or developers have been few. This decline in business in the DTES accelerated in large part with the closure of Woodward's and has continued ever since.

Though legitimate businesses have been decreasing since the Woodward's closure, illegitimate businesses have thrived. Beginning in the late 1980s, the use of crack cocaine impacted the levels of crime and illegitimate businesses. Users often turned to theft to support their addiction, selling the stolen products to second hand stores and pawnshops.⁴⁷ The 1990s brought an increase in the accessibility of gambling to the area, with many corner store owners placing video lottery terminals in their

After the 1993 closure of the Woodward's department store on this stretch – generally pegged as the beginning of the end for the Downtown Eastside – the entire block emptied, leaving behind a mess of boarded-up buildings and vacant storefronts.

*-The Eastside is Banking on Them
October 25, 2007
Maclean's*

businesses. It has been difficult for businesses remaining in the DTES to operate unless “they support, or at least do not interfere with, the illicit trade in property, drugs and prostitution”.⁴⁸

Business improvement associations (BIAs) in the DTES area are concerned enough about the security and crime levels around their businesses that they have put a substantial portion of their funds towards private security in order to reduce the disorder affecting their businesses. The VPD has also worked towards reducing illegitimate businesses and has carried out a number of undercover projects, named Raven, Lucille, Haven and Bodega, to identify and close down businesses that were supporting and involved in crime:

Business licenses were revoked and the some 47 pawn and second hand stores in the DTES were reduced to just over a dozen. Some public houses also lost their licenses, or even voluntarily shut down after being unable to sustain operating

costs once they were forced to operate legitimately.⁴⁹

Though there has been a significant decrease in the number of pawnshops in the area, an underground market for stolen goods has continued to thrive. As well, there has been an increase in the value of metals and recyclable goods that has resulted in many scavenging for these products on the street and in garbage bins in order to earn an income. Also, a rise in the value of metals has led to an increase in break & enters, mischief, and thefts in order to obtain metals to sell.

CRIME/PUBLIC DISORDER

The DTES is, unfortunately, infamous and has gained world-wide notoriety for its high crime rates. In the 1960s, 34% of all homicides and aggravated assaults, 10% of all rapes, 33% of all robberies and 66% of all “state of intoxication in a public place” arrests for the City of Vancouver occurred in the DTES (see Figure 1 for map of area included).⁵⁰ This picture has changed little, with much of the crime in Vancouver occurring in the DTES.

In particular, the DTES has a pervasive problem with violent crime. As of October 2008, the DTES accounted for 34.5% of reported serious assaults and 22.6% of robberies in the City of Vancouver (VPD

data, see Figure 3). This is particularly concerning given that many of the victims are more at risk because they are sick or elderly.

By the 1990s, there were increasing numbers of “chronic” offenders, individuals committing repeated offences primarily as a method of funding their drug addiction. A recent report by the VPD showed that Vancouver has an extensive problem with chronic offenders, particularly in the DTES (Figure 4), that appears to be unique among larger cities in the world.⁵¹

Though property crime has decreased in all areas of Vancouver since the late 1990s, the reduction of break and enters (B&Es) in the DTES has not been as significant as that in the rest of the city. The high number of

chronic offenders living in this area may explain, in part, the lack of reduction in Break and Enter occurrences in the DTES. This high rate of crime deters businesses from developing in the area and encourages legitimate businesses to leave.

The “Broken Windows” theory supports the view that the lack of social integration, the high number of vacant storefronts, the large-scale open-air drug market, and public disorder that continues to occur in the DTES creates an environment that emboldens criminal activity in the area.⁵² However, it should be noted that order is not only provided by the police. Ordinary citizens are also valuable assets to maintain law and order in their neighbourhoods. Jane Jacobs⁵³, a noted researcher on urban areas, states that informal social controls provided by the

Figure 3 - Crime in the DTES as a % of Total Crime in Vancouver 01/08 to 10/08

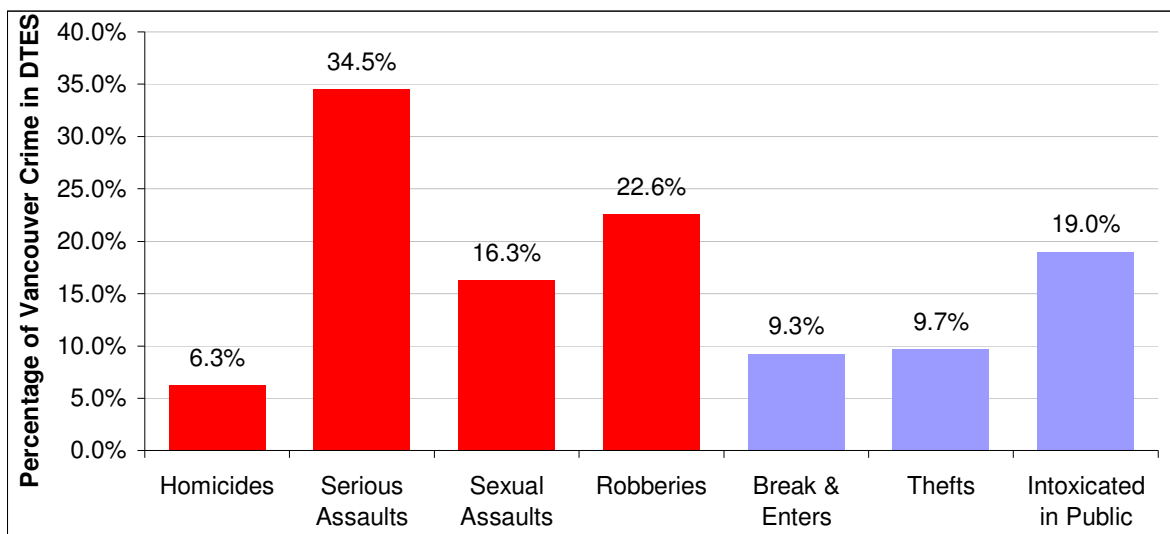
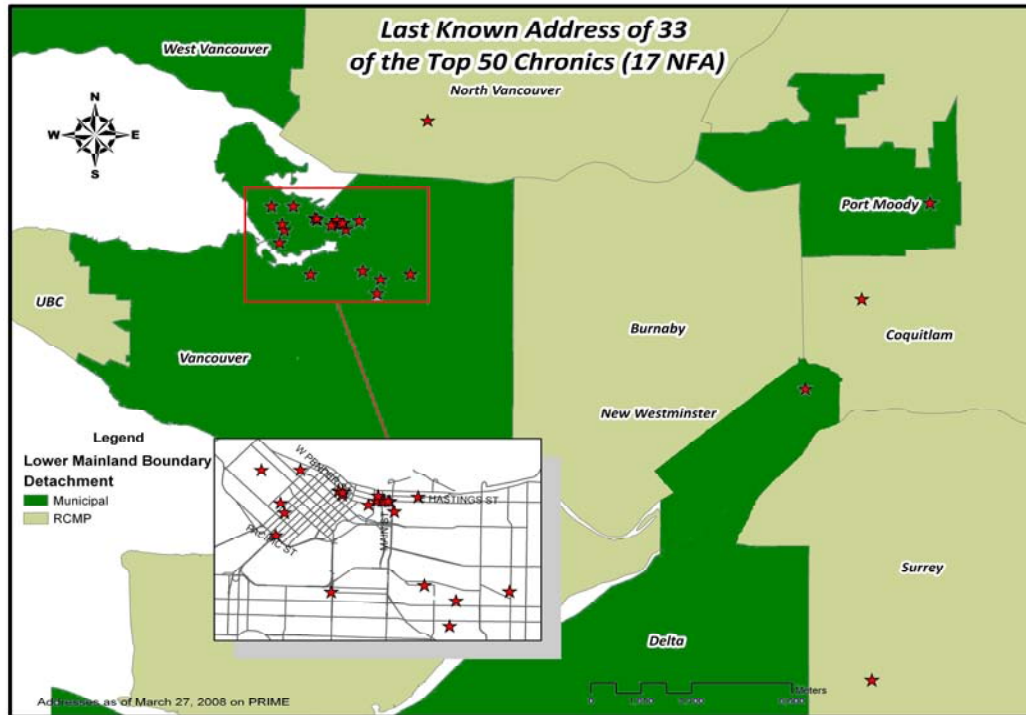


Figure 4 - Last Known Address of the Top 50 Chronic Offenders (17 have No Fixed Address)



people of the area are important and integral to the safety of an area. Increased police presence may lead to an increased civilian presence on the streets of the DTES, leading to greater feelings of security, safety, and increased use and “guardianship”, thereby reducing crime.

The extensive nature of the crime problem in the DTES can be demonstrated by the high levels of fear felt by those living, working or visiting the area. Tourism websites warn travellers to avoid the area, while the level of crime serves as a serious deterrent for businesses to develop.⁵⁴

SEX TRADE

The DTES has been the main area for prostitution and the sex trade since the late 1800s.⁵⁵ In fact, one of Canada’s first red-light districts could be found in parts of Chinatown in the early 1900s.⁵⁶ The size of the sex trade in the DTES grew in the mid-1980s when sex trade workers from Mount Pleasant relocated to the area due to police and community pressure and the subsequent creation of a special police task force. As well, an injunction forced sex trade workers from the West End of Vancouver. Together, the impact was that the DTES became the main location for the survival sex trade in Vancouver.

Current estimates suggest that there are between 1,000⁵⁷ and 1,500⁵⁸ sex trade workers in Vancouver and most work in the DTES. Many work on the streets though estimates of how many are difficult to establish. Primarily, these workers are women⁵⁹ and between 75%⁶⁰ and 80%⁶¹ of them are regular drug users. Up to 50% of workers are involved in the sex trade in order to support a drug addiction.⁶² This high level of drug use among sex trade workers has been a major driver in the high rates of HIV/AIDS and Hepatitis C infections in the DTES.⁶³

Aboriginal women are disproportionately represented as sex trade workers,⁶⁴ with estimates as high as 70%.⁶⁵ Benoit and Carroll note that the average sex trade worker is 26 years of age, has three or

more children and is lacking even a high school diploma.⁶⁶ Christensen and Cler-Cunningham found that more than half (62%) of the sex trade workers they interviewed had never completed high school.⁶⁷

Perhaps most concerning for sex trade workers is the exceptionally high rate of violence they experience. They are particularly vulnerable to attacks from predatory customers, but also from pimps, boyfriends, or violence occurring during drug-related incidents.⁶⁸ In the 1970s and 1980s, a STW occasionally went missing without explanation at a rate of about one every two years (some were located many years later), but between 1995 and 2001, the numbers of sex trade workers from the DTES going missing increased sharply and it eventually became clear they were likely the victims of a serial killer who was able to dispose of their bodies. In 2002, Robert Pickton was charged with the murders of 26 of the “Missing Women”. (He was also charged with the murder of a 27th unidentified “Jane Doe,” but the trial judge stayed the charge for technical reasons.) Pickton stands convicted in six of these deaths, with 20 murder counts still outstanding. Pickton is also the suspect in the deaths of six other Missing Women whose DNA was found on his property, but there is currently not enough evidence to



support charges. In other words, Pickton is convicted, charged, or suspected in the deaths of 33 women. Notably, Pickton claimed he had killed 49 women to an undercover police officer shortly after his arrest.

The Pivot Legal Society reports that most of the sex trade workers in the DTES earn between \$5-20 for a date, resulting in a need to work more frequently to cover living expenses and in workers accepting clients that they would otherwise refuse. The low income reported by the Pivot Legal Society is also consistent with that seen by the VPD's Vice Squad. Up to two-thirds of women working in the DTES have reported being the victims of physical or sexual assault while they were working, yet few report the victimization to the police for fear of both criminal prosecution and investigation by social assistance.⁶⁹

Many sex trade workers find it difficult to find appropriate housing as landlords refuse to rent to them and social assistance is inadequate to cover their needs, particularly when children are involved. In addition, many sex workers have complex medical needs, with multiple diagnoses for mental illness and physical health problems. Lastly, exiting from the sex trade is difficult as many workers have an addiction and/or a criminal record

which inhibits many legitimate businesses from hiring them, resulting in many workers remaining in the sex trade as a matter of necessity. The lives of DTES sex trade workers are difficult, to say the least, and are often tragically short, as a result of the effects of drugs, diseases such as HIV/AIDS, and violence.

REDUCTION OF POLICE PRESENCE

Since its inception in the late 1800s, the Vancouver Police Department has been a part of the DTES community in the Main and Hastings area. The building at 312/324 Main Street was built in 1953-1954 to house a growing police department. The location of the police building meant that there was a high level of police presence in the Main and Hastings area simply because of the number of police officers who were coming and going from headquarters (HQ) as part of their regular duties. In 1994, HQ moved from 312 Main Street to 2120 Cambie Street with the Patrol Division subsequently moving its base to the new facility. As a result, the number of patrol officers that routinely passed through the DTES en route to HQ has been reduced from more than 200 per day in 1994 to 20-25 per day currently. In addition, resource pressures and various policy decisions by management at the time of the move ultimately led to a reduction in the number of beat officers in the area. Though 312

Main Street is still an integral part of a patrol officer's duties in terms of report writing and the various support units that are housed there, police presence throughout the day has been reduced significantly in the DTES.

Recognizing the impact of the reduction in police presence in the DTES, the VPD has attempted to mitigate the effects of this shift of police presence by adding specialized teams to patrol the DTES. What began as the Citywide Enforcement Team (CET) pilot project in April 2003 has turned into a permanent, though relatively small (approximately 56 Police Constables, four Sergeants and two Staff Sergeants with nine to twelve officers patrolling at any given time), group of dedicated officers who patrol the Downtown Eastside, mostly on foot. This team was re-named the Beat Enforcement Team [BET] in 2006. The positive response from members of the DTES community and from residents of the City of Vancouver in general,⁷⁰ particularly in terms of the increases in perceived safety while in the DTES, has suggested that enhanced police presence in the DTES would be beneficial for the community. As well, given that a major deterrent to business development in the DTES is the fear of crime, increased police presence may also assist in encouraging more legitimate business to the area.

IMPACT ON ABORIGINAL POPULATION

As has been noted, the issues facing the DTES disproportionately affect the aboriginal community, who make up a significant proportion of the population of the DTES.⁷¹ The disproportionate impact on this population is particularly concerning and Benoit and Carroll note that up to 80% of aboriginal children in the DTES live in poverty. Dobell Advisory Services Inc and DCF Consulting Ltd note that aboriginals constitute 34% of the homeless population in Vancouver and most live in the DTES. Aboriginal women make up the majority of sex trade workers.⁷² Many are infected with HIV/AIDS and in fact have been displaced from their communities due to a lack of acceptance regarding the diagnosis.⁷³

Aboriginal women are at a higher risk of health consequences than others in the DTES due to "gender inequities in relationships"⁷⁴ and the fact that they are frequently involved in the sex trade. Benoit and Carroll note that "teenage births are 13 times higher in the DTES than in the general Vancouver Region... [and aboriginal women] ... are more likely than men to share needles, to be 'second on the needle', and to associate condom use or non-use with the important distinctions between work and relational sex".⁷⁵ However, it is important to note that the

health crisis facing the DTES affects the whole community, not only those of aboriginal descent.

CONVERGENCE

The unique challenges experienced by the DTES have been exacerbated by the concurrence of multiple problems. The rise in the use of crack cocaine in the early 1990s, the policy of deinstitutionalizing the mentally ill, the reduction of police presence in the 1990s, the closure of low income housing elsewhere, the de facto containment policy, the HIV epidemic, and the Federal Crown's lack of capacity to prosecute "minor" drug charges, all came together. Though any one of these factors would have impacted the DTES, the synchronicity of these events reinforced the negative impacts of each. These have been felt by some individuals more than others, and have highly affected the quality of life for those living in the DTES.

These changes in the area have made the DTES an efficient, though self-defeating, system where a synergistic underground economy fuels drug use and criminal behaviour and provides little incentive or encouragement for people to leave and improve their lives. Furthermore, for those seeking to escape, the consequences of the challenges facing them in the DTES (e.g., a criminal record, access to programs to

maintain treatment progress) can act as snares, pulling them back into the DTES, despite their attempts to leave.

DE FACTO CONCENTRATION

The problems of the DTES are large, both in number and in scale. The compounding of each issue has resulted in a neighbourhood in Vancouver with a significant number of people needing help. There has been a de facto concentration of the problems in the area because of various policies by both the public and private sector which directly or indirectly have led to a vicious cycle where people are forced to go to the DTES to access affordable housing or services. The accessibility and availability of lower income housing in the DTES has been a major draw to the area. However, the lack of affordable housing elsewhere has also pushed people into the area. As well, the

The DTES is an international embarrassment and has been for decades. Despite hundreds of studies, dozens of plans and the best efforts of thousands of people, the situation there remains horrible. It attracts people with addiction and mental-health problems from across the province and country, making it a cesspool that exacerbates the troubles of those living there.

*-Gary Mason, The Globe & Mail
October 23, 2008*

accessibility of drugs is indisputably a major reason that people end up in the DTES. Arguments have been made for accessibility to services and thus a preponderance of services has been established in the DTES. However, the presence of many services and lower income housing being predominantly located in one area has meant that people are drawn to the DTES and, in fact, add to the problems experienced by those living in the neighbourhood.

The historic concentration of problems for those in the DTES has meant that making the area a base for most services and low income housing has been logical since, certainly, services need to be accessible to those who require them, and there is no question that there is a need for services in the DTES. However, encouraging these services and affordable housing to locate predominantly in the DTES, and, the lack of the service and housing availability in other areas of Greater Vancouver and the province, has meant that individuals have to move to the DTES in order to access the services and affordable housing that they need. Once there, these individuals become effectively trapped in the DTES, as the scarce supply of these services and housing outside of this area act as a barrier that prevents the individual from being able to return to their home community.

If I go back [to Vancouver], I'm going to end up back in the downtown eastside and I'm going to kill myself. Maybe not physically, like, myself, but with the drug habit I will.

-Marc Sweet, ConAir offender returned to Winnipeg, media interview

In addition, the DTES has many conditions which facilitate criminal activities. Socio-economic issues and crime are inextricably linked and thus actions by the police and the criminal justice system are highly relevant to both the current state of the problems in the DTES as well as the improvement of it. Dandurand, Griffiths, Chin and Chan have noted that the police primarily took a reactive stance towards the DTES and the problems therein; however, this has changed with the development and continuation of the BET initiative to increase proactive policing in the area.⁷⁶

Furthermore, the concentration of a large number of people in a small geographic location has accelerated the spread of disease (such as HIV and Hepatitis C). Several researchers point out that, historically, disease has spread more virulently in poor communities because of the combined effects of close quarters and weakened immune systems due to

malnutrition.⁷⁷ This outcome forces individuals to accept services in an area where they are exposed to the numerous negative circumstances that exist in the DTES, perpetuating an already tragic situation and decreasing the likelihood for individuals to successfully deal with their addictions and other challenges. The next step is to tease apart which services are needed in the DTES because of gaps in services and which ones are not in order to help people live healthier lives.

PREVIOUS PLANS

The need to improve the quality of life in the DTES has been a longstanding policy objective for the City of Vancouver. City of Vancouver plans with goals of effecting change in this area can be found as early as the 1965 report entitled *Skid Road: A Plan for Action*, and the 1971 report *Downtown East Side: Social Planning/Community Development*. However, much continues to be done in response to the deterioration of the area.

In July 1998, Vancouver City Council formalized its commitment to provide guidance and planning for the DTES, Chinatown, Gastown, Strathcona and Victory Square.⁷⁸ The goals proposed by Council involved improving conditions at the street level, reducing crime, improving access to housing, reducing drug addiction,

and helping members of the community find allies. To guide efforts aimed at achieving these goals, Vancouver City Council adopted the following principles:⁷⁹

- Build from within and involve those who already live and work in the area;
- Preserve and enhance the sense of community felt by residents of the DTES and in surrounding communities;
- Listen to those most affected;
- Improve the livability and safety of the DTES for everyone; and
- Develop and implement a well understood plan that delivers results.

In the past seven years, the City of Vancouver has prepared numerous plans and undertaken several initiatives that address key issues and strive to improve conditions in the DTES. Overall, these plans largely focus on homelessness and housing, drug addiction, heritage and culture, and livability and the public realm.

The need for the three levels of government to work together to address the prevailing issues in the DTES has been well documented in many of the contemporary plans. To create a forum for this needed cooperation, the Vancouver Agreement was established between the

Government of Canada, the British Columbia Provincial Government, and the City of Vancouver in March of 2000. This agreement aimed to coordinate the efforts of all three levels of government. While the scope of this agreement covered the entire city, not just the DTES, several of its initiatives and programs specifically focussed on this community. The Vancouver Agreement is currently set to expire in March 2010. Despite the intent to bring about change through this agreement and the perception of its success by some, the DTES continues to be beset by the same issues.

THE NEED FOR CHANGE

Previous plans and initiatives, though extensive, have often been seen by some as “the” solution for the people of the



DTES. However, these previous plans have been perhaps too diverse in their goals by trying to address all issues present at once. As well, minor or lesser successes have unfortunately been overlooked because the overall initiative did not accomplish all of its goals.

It cannot be ignored, however, that despite these plans and the best efforts of government and private sector agencies to improve the DTES, the situation in this area has remained serious. The ability to significantly improve the quality of life in the DTES is limited by the number, scale, and interrelation of the current problems. Further exacerbating the problem is the fact that most of these issues have developed and grown in the community over several decades. As a result, many of these problems are now deeply entrenched. The multifaceted nature of the problems facing the DTES means that any solution, or improvement, to the situation must also, out of necessity, be multifaceted as well.

Though there has been widespread agreement regarding the need for collaborative action, coordinating and initiating change has been challenging. Political will and competing interests have made cooperative action more difficult to achieve. A lack of effective administrative

oversight or clear path of implementation has also been problematic. Despite agreement about the need for a coordinated effort to improve the lives of those in the DTES, a lack of consensus about the “solution”, multifaceted though it may be, has meant that there is no clear direction about how to move forward.

In addition to problems becoming entrenched, failing to improve the DTES creates an environment where the existing issues can multiply. Consider 24-year-old ‘Ann’, whose name has been changed to protect her privacy. Ann’s story began as a suburban Vancouver teenager who recreationally used drugs. At the age of 19, Ann gave birth to a young daughter. Within one year, Ann’s recreational drug use had grown into a full-scale addiction to hard drugs. At 20 years of age, Ann found herself living in an SRO in the DTES. In addition to battling a drug addiction, Ann also had to struggle with mental illness. On several occasions Ann was arrested by police, as she was believed to be an immediate threat to herself. Unfortunately, Ann’s dual diagnosis of a mental illness and drug addiction is not uncommon. The Canadian Mental Health Association found that over 50% of people with a mental illness have a dual diagnosis.⁸⁰ The reality that there is a disproportionately large population in the

DTES with a dual diagnosis was also noted in the VPD’s *Lost in Transition* report.⁸¹

Ann’s need to support her drug addiction led her to enter the sex trade. Tragically, Ann learned that she had contracted Hepatitis C. In addition to having health issues, Ann had several problems with the police. Even though she is just 24 years of age, police records show that Ann has already had 100 documented interactions with the police, including being charged 31 times. Currently, Ann lives in the DTES, is a sex trade worker, and has an unmanaged mental illness. Despite being exposed to a myriad of health, social and justice services in the DTES, Ann’s life has continued to decline. Unfortunately, the likelihood that Ann will be able to improve her future is limited by the reality that there is no integrated framework to deal with the concurrent issues that have resulted in her current dismal circumstances.

‘Cheryl’, whose name has also been changed to protect her privacy, also highlights the interrelated problems that currently prevail in the DTES. Cheryl is a 39-year-old Aboriginal female from Northern BC. Cheryl is the mother of five children, all of whom reside in her home community. In the spring of 2008, Cheryl came to the DTES to visit family. Being

exposed to a large open-air drug market led Cheryl to experiment with hard drugs. Unfortunately, Cheryl soon found herself addicted. Predatory drug bosses quickly recognized that Cheryl was addicted but was financially unable to support her addiction. As a result, these drug bosses soon paid Cheryl a small amount of drugs in exchange for conducting their open-air drug trafficking.

In June of 2008, Cheryl was arrested by police for trafficking. Cheryl was charged with trafficking and was released from jail. Cheryl was again exploited by drug bosses in the DTES because of her drug addiction. This led to Cheryl being arrested again for trafficking in September. Cheryl was released from jail, but now finds herself facing several serious drug charges. While Cheryl recognizes that her time in the DTES has badly harmed her and her family, Cheryl states that she cannot simply leave and return to her five children. When asked why, Cheryl cites a list of reasons including not wanting to potentially expose the children to her drug use, the need to remain in Vancouver to deal with her criminal charges, and being financially unable to pay for a return trip to her home community. Like Ann, the current environment and the lack of an integrated system to deal with multiple complex issues in the DTES have combined to trap

Cheryl in the area and quickly erode her quality of life.

These individual cases highlight the gaps in a system that fails to assist people with integrated and comprehensive treatment and recovery services. Instead the system focuses on dealing with the symptoms of the problem (e.g., mental and physical health, substance addiction, conflicts with the law) instead of dealing with the overarching issues facing the community (e.g., access to housing, employment, treatment services). The more extreme and tragic outcomes amongst these individual cases can include death by chronic illness, drug overdose, homicide, or suicide. Not everyone falls prey to these outcomes but the problems faced by these individuals and others are common in the DTES.



The situation in the DTES has reached critical status, requiring immediate action that is over and above all that is being done now. Without greater action, the issues in the DTES will further entrench themselves in the community and the people will continue to suffer. While it has been difficult to achieve a meaningful level of change in the DTES, the number of agreements and plans that have been developed, and the successes that have been seen, for the area indicate that there is a broad-based desire and the ability amongst different government and non-government agencies to make a positive impact on the lives of those that live and work in this community. The best chance for the success of these initiatives is to assist those who are most in need of help. This is a necessary condition of moving forward with other bigger picture initiatives. By starting with this high need group of people, the focus remains on improving the quality of life for those in the DTES.

ACHIEVING CHANGE

Despite all of the efforts that have occurred and the broad-based desire to see an improvement in this community, there is still no established body or forum with a specific mandate of ensuring that the lives of the most vulnerable in the DTES are improved. As a result, the issues facing the

vulnerable people of the DTES have become further entrenched, have had the opportunity to build, and the community continues to have a poor standard of living. This compounding of problems has led to a situation in which the problem is greater than the sum of its parts. The negative synergy in the DTES requires numerous interventions to disrupt the cycle of problems.

The multi-faceted and complex nature of the issues in the DTES requires a high level of inter-agency collaboration. In this unique environment, problems that were commonly held to be the responsibility of a single agency or small group of agencies cannot be impacted in a meaningful way without a significantly increased level of collaboration. The recommendations herein are based on the best and most effective pieces of the Vancouver Agreement and Project Civil City. Although this report proposes a particular governance structure, it is recognized that other models may be worthy of consideration (see Appendix B).

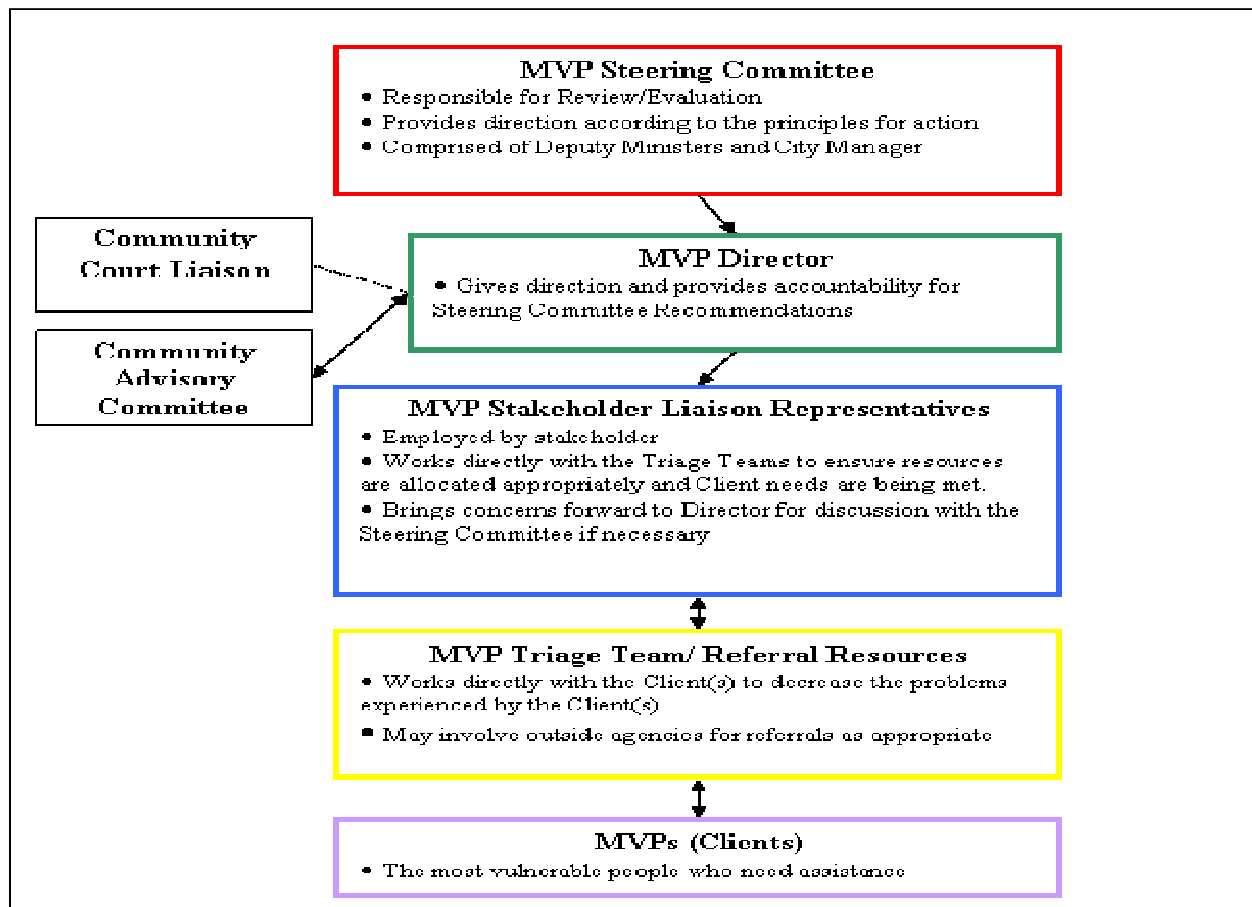
Given that the decisions of the other areas of the region and the province are highly relevant to the DTES, it is important that members of regional and provincial governments in particular are included on any initiatives to better make decisions

that benefit the people. This report recommends a client-centred approach where agencies and governments work together to support the most vulnerable.

To do this, a multi-level governance structure is proposed. This model suggests a process where funds and resources are funnelled or seconded to the initiative in order to devote them to improving the quality of life in the DTES. First, a most vulnerable population (MVP) steering committee made up of provincial and municipal government decision makers

(i.e., Deputy Ministers and City Managers for the region) of the relevant stakeholders (e.g., Health, Income Assistance) is needed for oversight and evaluation. Using the agreed upon principles for direction, they will provide recommendations where necessary to facilitate collaboration by the stakeholders (see Figure 5). As well, this committee may wish to consider what other governance structure would be best suited for the initiative. In particular, exploration of a public corporation model may be worthwhile.

Figure 5 - Organizational Chart of the Most Vulnerable Population (MVP) Initiative



An MVP Director will ensure implementation of the steering committee's recommendations to improve accountability. Knowing the importance of a passionate and committed individual in pushing things forward in a horizontal management structure such as the one proposed here, the Director will need to be a major driver in motivating and coordinating other stakeholders. As well, the Director will facilitate a team of stakeholder liaison representatives. The Director will assist them with a) collaboration between services and b) in problem solving issues that arise in managing the problems faced by the MVPs and those directly working with them.

The Representatives will remain employed by their home agency but will work together to implement protocol, resource and funding needs, priorities and vision for the initiative at both the agency and group levels. In addition, the representatives will also work with "triage" teams who work directly with the MVPs (the clients) to ensure that the teams have the resources necessary to assist their clients. The Triage teams, working with the client, will assess needs and assist that client in accessing services that are needed (e.g., housing, income assistance, treatment), either directly through the representative agencies or through referrals to other

appropriate agencies in the community. They will also report back to the Representatives to ensure that resources are being allocated appropriately at the client level.

Lastly, because of the local, regional and provincial consequences to making change in the DTES, the Director and Representatives will work with a Community Advisory Committee, made up of individuals from the Strathcona, Chinatown and Gastown neighbourhoods. These communities have already been very active in revitalization efforts and should be involved in any plans that would affect them as well. Also, there would be contact with the Liaison from the Community Court. These advisory groups would be used to facilitate community support and to address any concerns that arise in the community as a whole.

INFORMATION SHARING

One of the critical components of building a collaborative initiative is that of information sharing. To work with a client on his or her problem(s), it is far more effective for all relevant agencies/services to be working together. Moreover, addressing one issue may facilitate the effectiveness of another intervention; thus combining efforts and resources is as

beneficial to the service providers as it is to their clients.

In consideration of the collaborative initiatives proposed in this study, the *Freedom of Information and Protection of Privacy Act* (FIPPA) provides for four defined relationships pursuant to which personal information can be shared between agencies and services. First, if a client consents to the sharing of personal information between named agencies for a specified purpose, then the information can be shared according to that consent agreement. Second, information can be shared without consent if a public body determines that compelling circumstances exist that affect the health or safety of others. Though this process may apply for some of the most vulnerable people in the DTES, it is not considered to be an option that encourages personal accountability nor a positive relationship between the person and the service providing agencies. Third, personal information can be shared with consent under the protocol of a research trial or process. While a research project may provide valuable data to assist this initiative, anonymized research data alone is unlikely to meet the needs of this initiative for long term change. Lastly, public bodies, as defined by *FIPPA* (such as provincial government and municipal agencies), may share personal information



if the information is necessary for the delivery of a common or integrated program or activity [section 33.2(d), *FIPPA*].

In the program suggested here, it is argued that while clients can enter into the process in a number of ways, the most straightforward approach would be for clients to consent to the information being shared between agencies. Under this model, potential clients (i.e., the most vulnerable people identified by each agency using suitable criteria) would be referred to the integrated program and would voluntarily grant informed consent to the sharing of their personal information. The program itself would need to be developed in terms of protocol and procedure, but it could work similarly to a diversion program where the client foregoes the “traditional” route in favour

of this integrated, needs-based program. Clients would be free to enter the program from a referral by any participating agency or through self-selection. Once the client has consented, agencies would be free to share between them the information the client allowed and collaborative efforts could be made to coordinate their care. One program that has been proposed within the VPD is a “recovery car”. This car would involve a police officer and an addictions specialist (doctor/nurse) who would be available to attend police calls where a vulnerable victim/witness/other person was in contact with the police and in immediate need/ready at the time to go into recovery. This would require information sharing between the medical specialist as well as the police. This method would avoid many of the

legislative challenges and give clients full control over their own situation. Consideration will need to be given to a) the length of time the consent is valid for (unless revoked by the client, which can occur at any time), and b) what would be done with the file after the client has completed or withdrawn from the program.

As well, consideration will need to be given to those who are unable to give informed consent (e.g., those lacking the capacity to understand to what they are consenting). For these individuals, it may be beneficial to consider facilitating information sharing under Section 33.2(d) of the *FIPPA* or under the considerations for public health or safety. Moreover, where public bodies taking part in this proposed initiative are able to demonstrate a shared mandate resulting in a common or integrated program or activity, consent to share personal information is not required. Importantly, section 33.2(d) may only be relied upon for information sharing between public bodies, and requires that the program is not simply sharing information but rather that the information needs are integral to the running of the program. Regardless of the method chosen, ultimately, this process of information sharing is a requirement of a collaborative, client-centered approach and a key component of providing care to



those who are the most vulnerable in the DTES.

GUIDING PRINCIPLES

In order to achieve this vision of assisting the most vulnerable people in the DTES, the stakeholders must coordinate their efforts so that strategies complement each other and work towards common goals. Success should be measured not by activity but by outcomes. Specifically, the stakeholders should be working towards an

increase in the overall quality of life for the community as well as concrete improvement in the lives of the most vulnerable people.

To help in the formulation of these strategies to improve the lives of those in the DTES, guiding principles should be agreed upon, such as:

- Improve the lives of the people (sex trade workers, those with addictions and/or mental health problems, the homeless, the chronically sick, and the chronic offenders) who live in the DTES, and prevent more people from drifting into a life of despair.
- Information sharing is vital between agencies to facilitate collaboration
 - Agencies must be prepared to share information on their client base in order to achieve greater coordination of efforts and to record successes and failures.
- Strategies developed must support:
 - Lowering of crime rates
 - Diversity in terms of people, incomes, businesses, housing, recreational opportunities and so on in the DTES
 - Preservation and enhancement of the heritage and cultural legacy of the neighbourhoods
 - Ensuring that health, social service, and economic supports needed by low-income communities are provided (including expansion, development, or relocation of key health and social services needed

Some of the Advocates for the DTES:

Government	Private Sector
City of Vancouver	Downtown Eastside Residents Association
Business Improvement Areas	Downtown Eastside Women's Centre
Licenses & Inspections	Family Services of Greater Vancouver
Planning Department	First United Church
Social Planning Department	Franciscan Sisters Benevolent Society
Vancouver Fire & Rescue Services	Pivot Legal Society
Vancouver Police Department	Prostitution Alternatives Counseling and Education
Provincial Ministries & Agencies	Salvation Army
BC Ambulance Service	St. James Community Service Society
Liquor Control & Licensing Branch	Union Gospel Mission
Ministry of Children & Family Development	United We Can
Ministry of Community Services	Urban Native Youth Association
Vancouver Coastal Health Authority	Vancouver Area Network of Drug Users
Federal Departments & Agencies	Vancouver Economic Development Commission
Public Health Agency of Canada	Vancouver Foundation
Western Economic Diversification	WISH Drop-In Centre Society

while avoiding undue concentration of them in the DTES)

- Continuation of the Four Pillars approach on prevention, harm reduction, treatment and enforcement
 - Improving conditions on the street to provide amenities, safety and livability for all (e.g., street and lane cleaning, capital improvements on streets)
 - Business and employment development in the area
 - The availability of retail goods and services needed by all sectors of the community, including low-income residents
 - Access to civic facilities and services (e.g., parks, community centres, library, childcare) needed by all community residents is available
 - The City of Vancouver's housing policy of 1-for-1 replacement of SROs to ensure that lower income individuals are not displaced from the area
 - Involve all sectors of the community in planning and revitalization
 - Encourage tolerance and mutual respect in the diverse elements of the community
 - Affordable new market housing for moderate income households
 - Diffusion of services wherever possible to other areas of the region.
- Public and private agencies must be credited for their successes, and be

held accountable for performance inconsistent with the common goals for the DTES

These principles have been derived from the goals that have already been stated with regard to helping those living in the DTES, ensuring continuity in efforts to improve the DTES. However, the steering committee will need to add to this list with any other principles deemed necessary for the achievement of the common vision for the people of the DTES.

FRAMEWORK FOR MOVING FORWARD

The history of the DTES demonstrates that effecting substantial change in this community is a daunting challenge. When establishing a plan to move forward, it is useful to examine the past planning efforts to learn from what has succeeded and what has failed. One of the major challenges of past coordinated efforts was the attempt to simultaneously achieve a large number of goals without a concrete long term vision for the DTES. In addition, though agreement regarding the problem has been more easily attained, consensus regarding the strategies to solve it has been more difficult to find. More successful outcomes were seen when efforts were focused on a single or a very small number of outcomes that were

tangible. As a result, it is recommended that a phased approach be used.

Because of the far reaching consequences and potential for a “ripple effect”, it is recommended that the initiative first focus on the people who are most in need of assistance in the DTES. The most vulnerable people in the DTES often have concurrent problems and needs that require a coordinated approach (e.g., homeless and drug addicted and HIV positive). The group of people that are most in need should be identified through collaboration and information sharing between the relevant agencies (e.g., Health, Criminal Justice, Income Assistance). Once this group has been identified, a coordinated and proactive approach to service delivery can be undertaken.

This approach will ensure that these individuals receive the services that they require and will maximize the efficient use of existing resources as well as facilitate the development of new ones. The current approach to helping those in the DTES has primarily been agencies working in relative isolation from other agencies with similar goals. Establishing an integrated service delivery model for the most marginalized individuals ensures a people-centered approach that focuses on improving the

living conditions at the street level. Taking this action as the first step will increase the likelihood of other plans being successful, such as the economic revitalization of the area. By focusing first on improving the lives of those that are most in need, it is believed that positive momentum for change can be established and ultimately the community will follow, resulting in the development of a healthy and vibrant community.

After this initial phase, additional initiatives can be undertaken in the DTES focusing on the continuation and improvement of current revitalization initiatives (e.g., economic revitalization). Phase Two would continue to encourage collaboration between agencies, but would work at the community level rather than at the individual level. For example, the VPD is currently examining its facility needs. While the VPD could consider a multitude of potential sites across the city to be a base for its operations, the reduced crime and increased perception of public safety associated with such a facility suggest that the positive impact on the city would be maximized by having it located in the DTES. Initial estimates indicate that a public safety facility could increase the police presence in the area equivalent to adding up to 23 officers 24 hours a day, seven days a week. This increased

uniformed presence would have a positive impact on the detection of street level criminal activity, the reduction of street disorder, and the apprehension of criminals.

Previous efforts have been limited in success because of the challenges created by those who are high need as they are both the cause and victims of the circumstances found in the DTES. Resolution of their problems, and the prevention of new individuals from taking their place, will result in greater success in attempts to revitalize the DTES.

Moving forward with the initiative will require feedback regarding this proposal from Vancouver City Council. In particular, approval should be sought for the next steps that need to be taken to bring this project to fruition. Those steps include consulting with the public for feedback and comment, including agencies, residents of the DTES, and businesses so as to best evaluate the present situation and assess needs of the people in the area. Further, it will be necessary to request a commitment from the three levels of government to help fund the steering committee as well as the initiatives developed to improve lives of those in the DTES.

Once a group of top-level multi-government decision makers has been formed, the steering committee will need to systematically address the following tasks to ensure that change is achieved:

- Identify key issues and stakeholders;
- Reach agreement on strategies;
- Prioritize the actions that will be taken;
- Establish timelines for action;
- Determine the metrics that can be used to quantify progress; and
- Make decisions and take action.

COMMON VISION

While it is agreed that many of the people in the DTES are facing a large number of problems, and that the problems seem to be getting worse, discussion about what the DTES should look like if plans to improve quality of life were successful is important. For an initiative to assist those who are most in need to succeed, concurrent development of a broader scale vision is necessary. Though the committee will need to have a vision or mandate, this vision should be in line with the discussions already underway in the community. For example, a neighbourhood made up of people who are physically and mentally healthy, who can afford suitable housing, who are not forced to be a part of the

survival sex trade, who have diverse income levels and who are not exposed to drug traffickers and public drug use, and where people feel safe from violence and crime and businesses thrive would be a concrete vision for the Committee to work towards.

This report emphasizes that the vision should focus first on the lives of those who are the most vulnerable. At a macro level, the vision outlined above would be appropriate. However, it is important to also consider the micro level and to formulate a vision for how best to assist the most vulnerable in the DTES.

Whatever the decision about the vision, it is important that any plan for the DTES fully delineates how to achieve the ultimate vision for the community in tangible terms that can be seen and/or measured in some way. This vision, at its best and most useful, would have short and long term goals related to Phase One and Two of the initiative. Because of the urgency of the situation in the area, the timeline for the vision should focus on short term goals, such as the direction for the DTES in the next three to five years. The vision for the DTES, and the timeline for its fruition, will assist the committee in identifying areas of need, prioritizing strategies, and measuring success. Without

an end vision or goal, determining the best course of action will be fragmented and ineffective.

KEY ISSUES AND STAKEHOLDERS

When trying to determine how to best improve the quality of life for the people in the DTES, it is useful to first consider the key challenges that exist as well as the key stakeholders that can be engaged to facilitate change. A framework for potential collaboration can be obtained by constructing an issues-stakeholders matrix (see Figure 6).

Using a matrix to simultaneously consider the issues and stakeholders encourages the use of a collaborative approach. As a result, multiple organizations can demonstrate their role in bringing about change for the most vulnerable in the DTES. Adopting a coordinated approach amongst stakeholders is essential in achieving change in the DTES, as the most vulnerable people have problems that have become entrenched and are often found in combination. The matrix framework requires being progressive when considering the potential organizations that can be utilized to bring about change. As an example, the issue of criminal behaviour was historically often believed to be the sole responsibility of the police

Figure 6 - Issues-Stakeholders Matrix

		Stakeholders						
		VPD	City of Vancouver	Health	Justice	Other Provincial	Other Federal	Private and Non-Profit Sector
Challenges	Criminal Behaviour							
	Mental Illness							
	Alcohol and Drug Addiction							
	Street Disorder Involvement							
	Homelessness							
	Survival Sex Trade							
	Public Health Issues E.g. HIV/AIDS							

and the courts. However, the need to work with other partners is important due to the recognition that people involved in crime often have underlying issues of mental illness, homelessness, and drug addiction. As a result, strategies to reduce people's involvement in crime in the DTES have grown to include a wide range of stakeholders, many of whom were previously given little attention.

Creating an environment that encourages inter-agency collaboration can have significant positive impacts for the most vulnerable, even in areas where organizations may initially believe that they have a limited ability to be part of a solution. For example, the VPD and the City of Vancouver have recently been involved with the StreetoHome Foundation. This non-profit organization seeks to end homelessness in the City of Vancouver. Seeing an opportunity for collaboration and partnership, the parties involved in

StreetoHome recognized that police data could be used in conjunction with other data sources to identify the hardest to house individuals currently living in the City of Vancouver. This initiative is a great example of collaboration; multiple levels of government, private sector and non-profit agencies are all working together on this complex issue. It is hoped that this initiative will be able to achieve its goal of ending homelessness in Vancouver by 2015.

COOPERATIVE STRATEGIES

To address key issues facing the most vulnerable, relevant stakeholders should develop cooperative strategies that address the root causes of the problems. This will assist in reducing the potential for a "vacuum" effect to take place where the most in need people are continually replaced with new individuals.

The process of strategy development can begin by gathering together the existing

plans and strategies of each key stakeholder. This approach utilizes the work that has been done to date and leverages the expertise as well as the resources of each stakeholder. Collaboration between the stakeholders will allow information and ideas to be brought together; strategies can be progressively filled into the matrix by the relevant subject matter experts. An example of some of the current strategies being used at the community or individual level can be found in Appendix A. It should be noted that this matrix is by no means complete; it will take collaboration by all key stakeholders to effectively fill in this matrix (or one similar) and begin to develop collaborative person-centered strategies.

Once the existing information has been brought together, top-level decision makers will be in a position to formulate a common strategy or set of strategies to deal with each issue. It is important to note that simply populating the matrix with existing plans and strategies without ensuring that there is a forum for cooperation will not ensure success. The issue of how to address each problem facing the people of the DTES is a fundamental one and consensus here is critical to the success of the initiative. Failing to encourage greater cooperation

between stakeholders would only be an exercise in data aggregation. To ensure that the quality of life of the most vulnerable people is significantly improved, the steering committee will need to emphasize discussion and collaboration with regard to strategies to be used for the people of the DTES.

PRIORITIZE ACTIONS

With large projects, it is important to prioritize tasks and strategies. The urgent nature of the situation facing the people in the DTES requires immediate triaging in order to establish the extent of the current problems in the community and in individual lives. The number of people to be included in the initiative would need to be determined but a group of 2,500 people would provide an appropriate sample that could be followed to determine the success of strategies that are deployed. This should be the first task the stakeholders take on in order to ensure that resources are devoted to the most vulnerable people and the most prevalent issues affecting people in the DTES.

Because of the potential for a “ripple” effect to facilitate intervention in problems other than the targeted one, it is necessary to consider the consequences, both intended and unintended, of any strategy. Prioritization within the client’s



care should consider the level of need (i.e., how serious is the problem relative to others), the accessibility and availability of resources to effectively intervene in the problem, and the consequences of intervening with a given problem before another one. Appropriate ordering of the care strategies will increase the effectiveness of the interventions and strategies that are utilized. In addition, gaps in service delivery should become apparent and thus resources can be allocated towards developing services to fill those gaps. This should further assist the most vulnerable population in the DTES.

TIMELINES

As part of the action plan that the steering committee designs, it will be necessary to

develop timelines for each component. For the first phase of focused care to the most vulnerable people, the timeline for implementation will likely need to be within one to two years. Overall however, the process of determining timelines will help the steering committee to ensure that the identified goals for the community and the most vulnerable people are reached. Also, having agreed upon timelines will help guide stakeholders in their allocation of resources. In addition to helping guide year-over-year resource allocations, the establishment of common goals, strategies and timeline for the stakeholders will also enable each organization to consider how their non-reoccurring projects may be leveraged to improve the quality of life in the DTES. This is particularly true of identified service gaps where new services are developed and are the most resource intensive.

METRICS

In striving to reach a common goal or vision, it is important for the initiative to be able to quantify its successes and its areas for continued improvement. Global measures of the situation are needed, where assessments are made at the community level. Establishing “before” and “after” measures will allow direct comparisons of how the situation progresses over a given period of time.

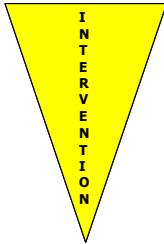
Using the measures at multiple time points (e.g., at the start, six months, one year, two years, etc.) rather than simply at the beginning and the end of a project is more realistic for any project with the people of the DTES due to the pervasive and multifaceted nature of the challenges in the area. The steering committee will need to carefully select parameters suited to the end goals and the strategies that are developed. As well, more in-depth research on the population of vulnerable people could be done to learn more about this group in a way that has not been previously done.

As well, it is necessary to assess change on a more individual level. As the first phase of the actions taken by the initiative will be directed towards improving the



standard of living for the most in need in the DTES, it is particularly important that the people are followed to ensure that the initiatives have resulted in beneficial outcomes. Consideration will have to be given to issues such as how to determine “success” for each individual. One way, shown in Figure 7, in which this could be assessed would be to determine the number of primary issues which impact the quality of life for each of the most vulnerable people. Intervening at an appropriate level based on the level of need, as defined by the number of concurrent issues, will ensure maximum benefit to the individual without overlooking those with fewer needs. This needs-based response is depicted by the inverted intervention triangle in the figure. Ultimately, this approach will reduce the size of the total population of the most vulnerable as well as the number of people at each level of need. By following this group, changes could be readily evaluated to determine what direct impact the interventions have had. In addition, the implementation of prevention strategies that have been shown to be effective in addressing the root causes of these problems will ensure that the influx of people coming into the DTES will be reduced.

Figure 7 - Possible Metrics to Assess Impact

Number of Issues	Current Situation		5 Years Later
6 +	150		50
5	250		150
4	350		300
3	450		400
2	600		500
1	700		600
Total	2,500		2,000

MAKE DECISIONS AND TAKE ACTION

This is one of the most important aspects for the team. Writing goal statements and outlining strategies will be meaningless if the group is unable to act and achieve results. Appropriate allocation of resources is an obvious place to help push the developing vision for the DTES to fruition; however, the steering committee will also need to work to inspire stakeholders and encourage them to come to the table in order to have discussions that can improve the quality of life for the most vulnerable.

Firm decision making does not mean dictating action to stakeholders; instead, it means that the committee enables the stakeholders to reach consensus about actions that need to be taken and facilitating the implementation of those actions.

CONCLUSION

- The lives of the most vulnerable people that reside in Vancouver's Downtown Eastside are increasingly negatively affected by mental health issues, illicit substance abuse, physical health issues like HIV and Hepatitis C infections, poor housing, illegitimate businesses, crime and public disorder, a thriving sex trade, a historical reduction in police presence and the impact on aboriginal people.
- Despite numerous previous attempts to coordinate efforts in order to take action on these serious issues, the quality of life in this community continues to be dismal for the most vulnerable. Immediate action is required to improve the lives of those most in need in the DTES.

- There is a need to establish an initiative including top-level government decision makers who can work with ground level teams to devise and implement strategies that can significantly improve the quality of life for the most vulnerable people in the DTES to ensure meaningful change; these individuals must have the ultimate decision making ability for their organization.
- The best chance for the success of any initiative is to assist those who are most in need of help. This is a necessary condition of moving forward with other bigger picture initiatives. Thus, one of the first tasks should be to work towards facilitating information sharing between agencies so that the most in need individuals can be identified. Then, a coordinated effort can be made to improve the lives of those individuals.
- The steering committee should be supported by adequate staffing including a director and support staff of agency representatives and a triage team.
- With appropriate prioritization and action, a positive “ripple effect” could be seen within the DTES community, whereby the improved quality of life for the most vulnerable would lead to improvements in surrounding communities.
- Civic investment is important to the area and should be encouraged as part of the efforts to improve the standard of living for the most vulnerable in the DTES. An example of a catalyst for change would be the relocation of VPD HQ back to the DTES.

Despite the efforts of numerous agencies and all levels of government, the most vulnerable people in the DTES are still facing a number of critical issues. However, it is recognized that the problems that degrade the quality of life for these individuals are larger than can be addressed by any single organization. Therefore, there is a need to work together at the highest levels, where top decision makers in each organization have the authority to take action and commit their resources to bring about change.

The goal should be to get people the help they need. Politics, or a desire to be treated in a certain way, should not be factored into any solution.

*-Michael Smythe,
Vancouver*

To guarantee success and facilitate the efficient use of resources, this report proposes the creation of a steering committee of top-level decision makers, support staff of agency representatives and a triage team. This essential collaboration will ensure that there is an improvement in the quality of life for the most vulnerable individuals and for the DTES community as a whole. By first focusing inter-agency efforts on identifying and assisting those who are the most in need and improving their quality of life, the health of the community will follow.

RECOMMENDATIONS

1. Establish a collaborative steering committee with top level decision makers with adequate support staff and community involvement as suggested in Figure 5.
2. The steering committee should facilitate an information sharing process between agencies to identify those individuals who are most in need and then work to improve the lives of those individuals.
3. The steering committee should further devise and implement strategies to significantly improve life in the DTES based on the guiding principles.
4. Evaluation and accountability must be an integral part of framework established by the steering committee. ■

APPENDIX A: Matrix of Some of the Existing Strategies

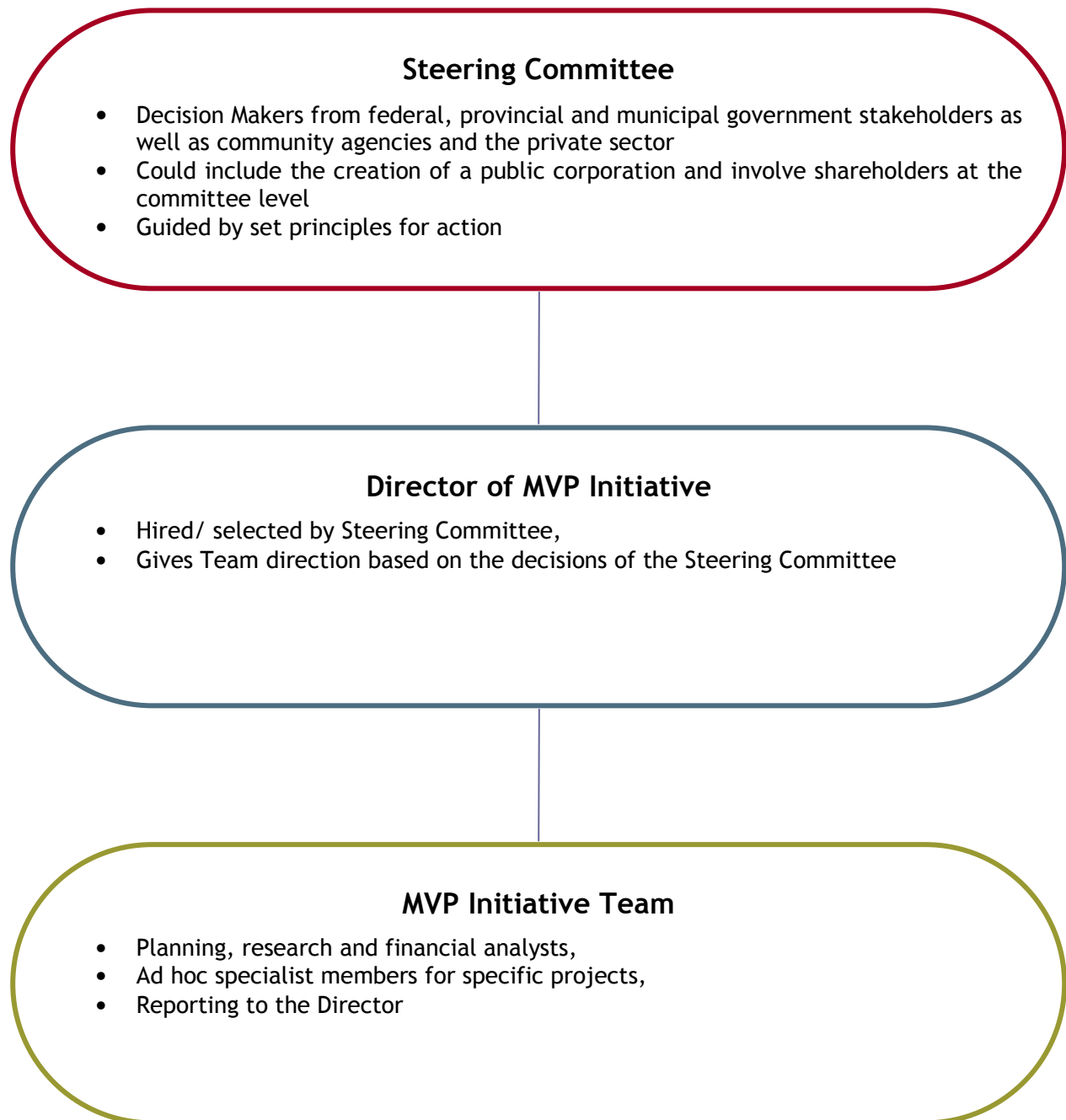
		Key Stakeholders						
		Police	City	Health	Justice	Other Provincial	Federal	Private and Non-Profit Sector
Challenges	Crime	Beat Enforcement Team (BET)			Downtown Community Court			ICBC Bait Car Program
		Crime Free Multi-Housing						
		Con-Air Program						
		Project Old Timer						
		Safer Parking Lot Program						
		Chronic Offender Unit						
Mental Illness	Mental Health Car (Car 87)	Supportive Housing Strategy	Vancouver Coastal Health's Mental Health & Addictions Supportive Housing Framework		Task Force on Homelessness, Mental Illness, and Addiction			
	Lost in Transition Report		New Vancouver Coastal Health Office at 2750 East Hastings Street					
Alcohol and Drug Addiction		Four-Pillar Approach	Centre for Concurrent Disorders	Vancouver Drug Court	Crystal Meth Secretariat		North American Opiate Medication Initiative (NAOMI)	
		Drug Policy Program	Assertive Community Treatment Program					
		Preventing Harm from Psychoactive Substance Abuse	Building on Strength Strategy Plan					
Street Disorder	Beat Enforcement Team (BET)	Project Civil City			Safe Streets Act		Private Security/ Ambassador Program	
	Police Facility at 312 Main Street	Neighbourhood Integrated Service Teams (NIST)						
Homelessness	StreetoHome	Downtown Eastside Housing Plan			Provincial Housing Strategy	Homelessness Partnership Initiative	StreetoHome Foundation	
		Homeless Action Plan						
Survival Sex Trade	Sex Trade Liaison Officer	Homeless Outreach Program					Women's Information Safe Haven (WISH)	
							Prostitution Alternatives Counselling and Education Society (PACE)	

APPENDIX B: Alternative Governance Model

Alternative governance structuring was considered during the development of this report. One suggestion of the many possible is included here. Based on the best and most effective pieces of the Vancouver Agreement and Project Civil City a high level multi-stakeholder steering committee could be formed to facilitate this alliance (see Figure 8). This committee could also include the creation of a public corporation whose shareholders are comprised of all relevant stakeholders, including the private sector. Given that decisions made in other areas of the region and the province are highly relevant to the DTES, it is important that high ranking members of regional and provincial governments in particular are included on the committee to better make decisions that benefit the people. Supporting this committee should be a Director and team, jointly funded by the three levels of government. To ensure success, the individuals that represent each stakeholder must have the ultimate decision making authority for their organizations, including the authority to commit resources.

Specifically, this committee will operate according to guiding principles about how to implement change in the DTES. To be most effective, the steering committee should be made up of cabinet ministers, deputy ministers or assistant deputy ministers, high level managers from the City of Vancouver and other agencies whose services impact the DTES, such as Health, Housing, Income Assistance, Justice, and the private sector, to name a few. This committee will then select a Director to supervise and manage a team of staff and resources in order to fulfill the direction of the steering committee. The Director will liaise with and report back to the Steering Committee while ensuring that the objectives of the committee are brought to fruition as well as facilitating the information sharing necessary between the agencies involved. This will assist in establishing accountability between the partners and in the coordination of public and private efforts to improve the DTES. The team of staff under the Director will be made up of planning, research and financial analysts who work to implement the strategies decided upon by the Committee. Other staff members may be brought on to work on specific projects. For example, experts or specialists in a field (such as health or crime) may be brought in to ensure that the implementation of the strategies at the ground level is as efficient and effective as possible.

Figure 8 - Alternative Model



ENDNOTES

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- ⁹ Smith, H. (2003). Planning, Policy and Polarization in Vancouver's Downtown Eastside. *Tijdschrift voor Economische en SocialGeografie*, 94, no. 4: 496-509.
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- ¹⁷ Wilson-Bates, 2008
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