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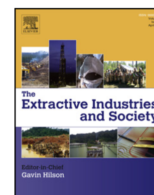

Original article

Help wanted: A call for the non-profit sector to increase services for hard-to-house persons with concurrent disorders in the Western Canadian Arctic

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ABSTRACT

Using a community-based research framework with mixed methods, this paper examines the experiences of homeless persons in Inuvik, NWT. Situated in a resource-rich region, the Beaufort Delta, Inuvik has been impacted by resource extraction and associated boom and bust economic cycles. In the wake of a downturn in oil and gas exploration in the Beaufort Sea, this paper examines the problem of housing for HtH persons with concurrent disorders. The experiences and observations of service providers and HtH persons are captured through focus groups, and HtH persons' quality of life is assessed through a questionnaire—Quality of Life for Homeless and Hard to House Individuals (QoLHHI). The paper concludes by recommending that governments and industry take responsibility and that the non-profit sector take a leadership role in service provision.

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1. Introduction

While the issue of homelessness and its relationship to concurrent disorders,[1] substance abuse and mental health problems, is well recognized and researched in urban contexts, less is known about these phenomena in rural settings. It was not until the late 1990s that public attention to the issues emerged in urbanizing communities in northern Canada. Indeed, a steady increase in visible homeless in Inuvik, NWT has resulted in an overbearing demand for shelter (IIC, 2003; YHC, 2007). This population is frequently referred to as chronic or long-term homeless, but this definition belies other elements of true homelessness. Hard-to-House (HtH) populations are comprised of persons whom may be temporarily homeless, cyclically homeless or simply in transition from being housed to HtH (Begin et al., 1999 in Echenberg and Jensen, 2008).

Situated on the Beaufort Delta and the urban center for several remote communities in the region, the Town of Inuvik has a population of roughly 3400 of whom 66% are aboriginal (NWT Bureau of Statistics, 2013). Inuvik is an interesting case study because it emerged, not as a resource extraction or industrial community, but as a strategic location for the Canadian Government. As a planned community, Inuvik was to be a beacon of Canadian sovereignty and was host to the largest military instillation in northern Canada (Deltor, 1989). The discovery of oil and gas, and the town's role in exploration and extraction did not occur until the early 1970s. The Mackenzie Valley Pipeline (MVP) Inquiry (1974–1977) lead by Justice Berger (1977) recommended that the pipeline not be constructed until land claims in the region had been settled. The complexity of relations between southern economic interests and northern inhabitants became known as the frontier/homeland divide (Ensign et al., 2014). In anticipation of exploration, a highway linking southern Canada to the arctic was completed in the mid-1970s, but the economic boom associated with exploration turned to bust as the shortage of petroleum linked to OPEC production eased (Coates, 1992). Yet, for almost two decades Inuvik prospered and quickly became a regional center for government and industry. Exploration continued until the early 1990s, but interest in oil exploration in the Beaufort Sea remained with activity waxing and waning depending on market conditions (Ensign et al., 2014; Dana et al., 2006).

Despite suspension of construction of the MVP, the frontier character associated with oil and gas exploration brought with it substantial social impacts, the effects of which are still present. While the causal linkages between homelessness and concurrent disorders are debated at many levels, a substantial body of research in northern Canada identifies the impact of colonization, resource extraction and economic development as key factors among

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[1] In this research, concurrent disorder refers to a combination of mental, emotional, and psychiatric problems combined with substance abuse (CAMH, 2013).

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aboriginal peoples (Abele, 2006; Asselin and Parkins, 2009; Dana et al., 2008; Ensign et al., 2014; Schmidt et al., 2014; Shandro et al., 2011). Justice Berger's (1977) recommendation represents a pivotal time in resource extraction history in that he literally halted the project out of concern for the people who called the Mackenzie Valley their home. Even at that time, the economic boom in Inuvik's early oil and gas years were associated with significant social problems including increases in crime, addictions, prostitution, housing shortages and welfare dependency (Berger, 1977).

Referring to the overall impact of exploration and resource extraction in the NWT, Abele (2006) observes that Inuvik and other communities in the Mackenzie Valley experienced accelerated, uneven development typically resulting in economic booms in larger communities and impoverishment in smaller ones. He writes:

> The wage centres swell with a migrant population, not all of whom actually find work. They become the urban poor. Rural areas and smaller centres lose skilled people and income generating opportunities to the boom centres. The countryside is depopulated and impoverished, leading people to leave it. This swells the wage centre populations further. In the end, two economies and two societies exist, differentiated by extreme inequalities in opportunities for business development and stable means of making a living. (Abele, 2006, p. 6)

Since the early 2000's, the population of Inuvik has remained relatively stable, at approximately 3400 between 2001 and 2012. An increase in the town's population occurred halfway through the decade reaching a peak of 3657 in 2005 (Inuvik-Statistical Profile, n.d.), which attests to the inward migration of workers and others seeking employment in businesses serving a growing population. Although their stay may be temporary, the impact of migrant workers on the community is felt at different levels. As in other resource extraction activities in the north, the majority of workers reside in work camps and visit the host community for social and personal purposes such as health care. Echoing Berger's (1977) comments, research on communities affected by resource extraction repeatedly shows that boom cycles are associated with: (a) increasing crime and addiction rates; (b) housing shortages and increased housing costs; and (c) strains on public services including health, social work and most levels of government infrastructure (Asselin and Parkins, 2009; Goldenberg et al., 2010; Shandro et al., 2011; Van Hinte et al., 2007).

Not surprisingly, in Inuvik and surrounding communities, not everyone experienced the economic booms of the last three decades positively. While there is minimal data available on earlier cycles, some of the effects of the early 2000's boom have been documented. While many of these effects are not quantified, the frontier mentality has significantly impacted those who call Inuvik home in terms of living conditions and overall lifestyles. During legislative debates, the issues related to exploration and migrant workers received scathing criticism. Speaking to a proposed increase on payroll tax, which would in effect penalize local residents, the member for Inuvik-Boot Lake, Robert McLeod said,

> I always hear about the NWT being rich in resources. I've also heard so many times, in almost every statement that comes out of this Assembly that we should be the major benefactors of our resources. In a lot of cases I don't see this happening, especially with the workforce that continues to be brought in from down South. I and my colleagues from Nunakput and Mackenzie Delta know that we have a skilled workforce in the Mackenzie Delta that should be utilized more, but there seems to be no effort to go up there and recruit them. They will gladly recruit workers from south of the border (2008 p. 1523).

In essence, McLeod (2008) argued that oil and gas exploration took much but contributed very little to local communities, and did so at the expense of local people. In an example, which was neither random nor unique, on one weekend over 50 migrant workers were jailed following a drunken spree in Inuvik. A spokesman for the Inuvik Alcohol Committee, Derek Lindsey, commented that history was repeating itself as similar events had occurred in the 1970s economic boom (CBC, 2011).

Yet, the biggest impact on the community came in terms of housing. Housing in the Arctic is precarious, which is reflected in Falvo's (2015) identification of housing issues in the north, including: higher construction costs, shorter life span, higher operating costs, declining government funding for construction, minimal supportive housing, inadequate conditions of homeless shelters, insufficient harm-reduction programs, aversion to housing first models,[2] minimal access to affordable housing and migration patterns of workers in resource exaction industries. With over 33% of housing being in core need – referring to suitability, adequacy or affordability (NWT Bureau of Statistics, 2010) – HtH persons face significant challenges finding housing.

If resource extraction, the frontier mentality associated with it, and social impacts can be considered the social foreground, then the legacy of colonization and the residential school experience clearly stand as a background to the challenges faced by HtH persons with concurrent disorders. The damage done to aboriginal peoples through colonization and resettlement into western-style communities is well documented in Canadian history. While it is beyond the scope of this paper to document the damage caused by colonization and economic development, the impact of these factors is achieving significant attention in the literature on community health (Abele, 2006; Asselin and Parkins, 2009; Christensen, 2012, 2013; Goldenberg et al., 2010; Shandro et al., 2011; Van Hinte et al., 2007). One specific example of these impacts by Christensen (2013) identifies the impact of collective experiences on homeless individuals in Inuvik. The upheaval of traditional culture resulting from the residential school experience, the child welfare system and physical displacement from the land to settlements severely challenged and undermined aboriginal understandings of home.

Unemployment and an inability to thrive in a western-style economy are problems for many survivors of colonization, and Inuvik is no different. While some survivors have managed adapt to dominant social structures, Christensen (2013) observes that the legacy of colonization and resettlement has resulted in physical and a type of spiritual homelessness experienced by many HtH persons. Not surprisingly, these people find it difficult to live and work in this context, and even if they can, adequate paying jobs are beyond their reach because they do not have the education or training to participate in the work force. Moreover, there is little appetite on behalf of industry to invest in local populations for employment (Abele, 2006; Van Hinte et al., 2007). And, while the government has some responsibility in this regard, the boom and bust economy makes long-term education and employment planning difficult resulting in the importation of migrant workers for most jobs requiring skilled workers.

Ironically, the influx of work groups from outside the community severely taxed available housing leaving many local residents at risk of becoming HtH (IIC, 2006a). One the one hand, Inuvik could have borrowed from the experience of other

[2] According to the Homeless Hub (2015), Housing First involves providing clients with assistance in finding and obtaining safe, secure and permanent housing as quickly as possible. Key to the Housing First philosophy is that individuals and families are not required to first demonstrate that they are 'ready' for housing. Housing is not conditional on sobriety or abstinence.

communities faced with boom cycles associated with oil and exploration and extraction. Asselin and Parkins (2009) posit that in anticipation of growth, Inuvik could have developed and implemented infrastructure to deal with the social impacts associated with development. On the other hand, it can be argued that sufficient parallel infrastructures did not develop to deal with the complexity and magnitude of social problems, particularly housing and health. Moreover, the Federal Government of Canada started cutting back social and affordable housing programs in the 1990s, which further exacerbated housing shortages (Caragata, 2006). Although renewed interest in oil and gas exploration emerged in the early 21st Century, commodity prices have stymied further extraction (Quenneville, 2009). Thus in the wake of exiting oil and gas companies and decline in industry investment in exploration and resource extraction, Inuvik was left with minimal resources to deal with significant social problems like homelessness, and concurrent disorders.

To be sure, the causes of homelessness are complex, and cannot be explained by structural conditions alone. Addictions and mental health problems are inextricably intertwined in the lives of HtH persons (CMHA, 2013 n.d.). And, while the causal relationship between these factors are elusive, homelessness and concurrent disorders are related to other structural conditions such as education, employment problems, physical abuse, marital breakdown, overall physical health to name a few (Echenberg and Jensen, 2008; Parkins and Angell, 2011), some of which are exacerbated by being aboriginal. Moreover, the legacy of damage caused by cultural assimilation policies carried out by the government, church and residential schools, remains ever present in many communities (Christensen, 2012; Quinn, 2007; Wenzel, 2008). Yet, as the preceding discussion shows, the link between exploration and extraction of oil and gas, and the resulting structural conditions affecting housing and the health of HtH persons, remains apparent.

At present, adult HtH persons in Inuvik primarily access four resources. All of these resources are based on a non-profit model and have their own governance structure. Funding for these resources comes from donations and fundraising activities such as bingo (IIC, 2006b). First, the emergency shelter can accommodate 16 men and women. Second, the transitional house can hold up to10 women and their children. Third, the Catholic Church supplies hot lunches and clothing to those in need, including HtH persons. (NWT Housing Corporation, 2014). Fourth, as noted below the Anglican Church has provided meals, clothing and toiletries for HtH persons, but it no longer provides overnight accommodation for persons not accepted at the emergency shelter (Thurton, 2015).

Other relevant resources available to HtH persons include family counseling, funded by the Canadian Mental Health Association, an “on the land camp” offered by the Gwich'in Tribal Council, and other culture based activities offered by both Gwich'in Tribal Council and the Inuvialuit Regional Corporation (IIC, 2006b). However, neither of these aboriginal organizations offers dedicated services for HtH aboriginal people. Health care and some social programs are provided by the Beaufort Delta Health and Social Services Authority (BDHSSA). In addition to one onsite medical detoxification bed, the BDHSSA provides psychiatric and psychological treatment; however, these services are offered by visiting professionals on a six week rotational basis (IIC, 2006b). Finally, during times of need (i.e., extreme cold) HtH persons have accessed the RCMP (Royal Canadian Mounted Police) cells for a warm place to stay.

With the exception of religious-based and aboriginal focused services, non-profit agencies serving HtH persons in Inuvik are virtually absent. Agencies such as the Salvation Army, well known for its expertise in working with homeless and addicted populations, are not established in Inuvik. Over the past two decades discussions about the need for services have preoccupied much of the Inuvik Interagency Committee’s (IIC) time, but the development of services has been minimal (IIC, 2003, 2006a,b). As non-profit organization, the IIC was formed as a committee to coordinate discussions and recommendations on community social issues. According to the former chairperson of the IIC, the Inuvik Alcohol committee, which operated the homeless shelter, was active in the early 2000’s but was dissolved due to financial difficulty. At that time, operation of the shelter was assumed by the Gwitch'in Tribal Council (Mero, personal communication). Outside of IIC discussions, provisions for housing and services are speculative and not well documented. Yet, given the impact of oil and gas exploration and extraction on the population, and the legacy of colonization and forced assimilation, the glaring need for services is obvious. For example, hosted by the local Anglican Church, an Emergency Warming Centre (EWC) has operated over the winter in 2013–14 and in 2014–15. The EWC was developed to provide a safe place for those not able to access the original homeless shelter due to intoxication. However, the church is no longer supporting the center due to budget problems and public perception that the EWC supports addictive lifestyles (Thurton, 2015).

2. Purpose

In recognition of the problems faced by HtH, many of whom experience concurrent disorders, this paper examines the gaps in mental health and addictions services, and the potential role that could be played by non-profit agencies in the delivery of service to HtH persons in Inuvik. Community groups such as the IIC have identified gaps in services and argue that concurrent disorders generate and perpetuate homelessness among many northern men and women (IIC, 2003, 2006a,b). This paper utilizes data collected for a project on rural migration and homelessness in northern Canada, concurrent disorders, and gaps in services (Young and Moses, 2013). Following the definition provided by Echenberg and Jensen (2008), being HtH includes chronic homelessness, cyclical homelessness and temporary homelessness. However, given the context of research HtH also refers to insecure housing and being homeless in the previous year. Concurrent disorders include, Axis 1; 2 disorders like psychosis, bipolar, and depression in the DSM IV and substance abuse involving stimulant, depressants (including alcohol) and hallucinogens but are not limited mental health problems (Skinner, 2005).

3. Methods

This research involved mixed methods within a community-based research (CBR) framework. In many ways CBR approaches mirror the tenets of Aboriginal methodology (Tuhiwai Smith, 1999), particularly in that the culture and context in which participants are situated are ever present in the research enterprise (Kelly et al., 2001). As such, local research needs can be used as drivers for social change (Pain, 2003). Through discussions with service providers and the IIC, it was determined that there were roughly 30 identifiable HtH persons in Inuvik. These same sources indicated that this estimate represented less than one half of the actual HtH population in the community because much of the HtH population remains invisible.

To capture a more complete picture of HtH participants, mixed methods were used in this research. The qualitative dimensions of HtH persons’ lives involved focus groups with service providers and HtH persons themselves. Service providers, all of whom were involved with the IIC, participated in discussions that ultimately resulted in the formation of two focus groups with service

providers. These focus groups included a set of questions to frame the discussions within those groups, which were then used to develop focus groups questions with HtH persons. The first group consisted of nine participants from community based agencies including local aboriginal groups, community counseling, family counseling, housing, justice services, and RCMP. The second focus group involved six participants from the BDHSSA. Appendix A provides the focus group questions for service providers. Using classical content analysis (Denzin et al., 2008), the results from a thematic assessment of the data gathered during the focus groups with service providers were used to construct a list of interview questions for discussions with HtH persons. The questions used in focus groups with HtH persons are provided in Appendix A. The role of service providers in the research stopped at this point.

Contact with the local emergency shelter resulted in the recruitment of 17HtH participants. HtH persons were each given a $50 honorarium for participating in the research. HtH persons attended one of three separate focus groups, the first with 10 participants, the second with three participants and the third with four participants. As with the focus groups with service providers, the data from focus groups with HtH persons were examined for themes relating to gaps in services, homelessness and concurrent disorders using classical content analysis (Denzin et al., 2008).

For the quantitative aspect of the research, HtH participants completed a questionnaire—the *Quality of Life for Homeless and Hard-to-House Inventory* (Hubley et al., 2009). The flexibility available for the administration of the questionnaire made it desirable to use in this research, particularly because of the research context and because the questionnaire has been used with other homeless populations in Canada. The questionnaire includes an MDT (multiple discrepancies theory) scale which is comprised of four domains. Three of the four domains in the survey were used in this research—housing, health and social support. The domains in the survey ask participants to

> . . . rate their level of satisfaction with a life area, describe the state of the life area, and to compare it to what they have to what they want, what others have, the best they have had in the past, what they expected to have by now, what they expected to have in the future, what would be ideal, what they deserve, and what they need. (Hubley et al., 2009, p.1)

Each MDT item was examined for statistical significance between present and future views of housing, health and social support using paired-samples *t*-tests. These tests indicate how participants rate their satisfaction regarding housing, health and social support using the aforementioned criteria established by Hubley et al. (2009). In particular, the paired sample *t*-tests allows for comparisons of how participants viewed their current and future situations in all three domains.

4. Results

The results presented here are confined to focus group data from 15 service providers and 17HtH persons in the town of Inuvik. The section begins with the presentation of HtH persons' demographic information. Using data from the focus groups, the breadth and scope of the HtH problem in Inuvik are identified from the perspectives of service providers in the IIC. This data is also used to identify the kinds of services that could assist HtH persons including how the non-profit sector could contribute to the provision of services. As well, focus group data with HtH persons are the source of information on the views of HtH persons regarding the need for services, including those that could be provided from the non-profit sector. The results conclude with the presentation of questionnaire data, which are provided in summary format.

4.1. Demographic characteristics of HtH participants

The majority of participants in the study (14) were male. The age ranged from 18 to 74 with a mean of 40.83. There were 15 aboriginal participants, 5 Gwich'in and 9 Inuvialuit and one metis. As well, there were one Caucasian and one participant who did not self-identify. Due to missing data for one participant, the following demographic characteristics are derived from 16 participants. For place of birth, 8 participants were born in Inuvik, 5 came from other communities in the NWT and 3 came from other provinces. Regarding education, 3 participants had achieved a grade 12 diploma and 3 indicated some college education. The remainder had not completed secondary education. Only 3 participants indicated that they were married or in a common law relationship. Although not primary caregivers, 12 participants indicated that they had one or more dependents. While 4 participants indicated no religion, the majority (12) indicated that they were Christian or Catholic. One half of participants (8) identified a physical or mental disability. Slightly less than one half of participants (7) indicated that they were employed or that they worked at odd jobs. Finally, one half or 8 participants were sleeping at the Inuvik shelter, 4 were staying with relatives, 2 were recently housed and 2 had no housing or place to sleep.

4.2. Focus group data

4.2.1. Breadth and scope of HtH persons

Given the estimate of 30HtH persons, and the apparent invisibility of other persons who may be experiencing housing problems, the lack of services is severe given the need. While the local shelter does hold 18 adults, it does not accept persons under the influence of alcohol or illicit substances. As well, because its mandate is to assist in domestic violence situations, the women's transition house is not considered a long-term suitable response to housing problems. According to service providers, the jail in the local RCMP detachment has become a *de facto* wet shelter with upwards of over 2500 annual admissions for public disturbance under the Criminal Code of Canada and offences against the territorial Liquor Act (personal communication, detachment superintendent). Very few of these admissions result in criminal charges which suggests that the RCMP are working outside of their official mandate to serve a need that should be met by other agencies in the community.

Several themes emerged from the focus groups for those living on the streets. Most HtH men and women suffer from severe addiction problems and cocurrent disorders including depression and schizophrenia. Significantly, many HtH men and women have experienced some kind of abuse in the residential school setting, or have lived in situations where family members, i.e. parents, have experienced the abuse. As such, generational trauma is highlighted as a contributor to the dysfunctional lives of HtH persons. These factors are complicated by a lack of education and social skills leaving HtH men and women with few coping skills. After losing their housing, assuming they had it to begin with, these men and women eventually “wear out their welcome” or “burn their bridges” with family and friends and end up staying at the homeless shelter.

Speaking to the issue of housing, several service providers noted that, not only was there a shortage of housing, but that there were no overall strategies for dealing with HtH persons. Moreover, the various agencies involved in service did not coordinate their efforts. In the words of one service provider,

. . . there’s no range of housing here, there's no supportive housing when you look at the homeless population there's more factors as to why they’re homeless. Poverty is a big issue here . . . I think the system as a whole as people have said, doesn't work together, it’s not integrated and often we're at odds in terms of even going after funding so there's no sort of overall strategy...

Another service provider observed that in addition to lack of coordination, some agencies did not know or understand the mandates of other agencies in the community. She said,

. . . I don’t know how many times people come to me and say I’m here for _____ and I say we don’t provide that and they say, well so and so over at Housing or Mental Health . . . say that you do. So it frustrates us as service providers and it frustrates our clients.

While not a current concern, one service provider commented that historically, industry has played a role in housing shortages. During economic booms associated with oil and gas exploration, money becomes available for some services as workers may require help with concurrent disorders. The downside, however, is the impact of industry on housing. This service provider notes,

. . . at the moment so we don’t have that money and government money is very limited and then when industry does come in we pick up a whole host of other problems because it gets really busy and companies coming and rent whole apartment buildings that sit empty for a year waiting for a pipeline . . .

One consistent theme emerging was the need for a continuum of housing service for HtH persons. Service providers noted that chronic HtH persons might obtain housing, but maintaining it is difficult. Referring to what she called the revolving door of housing, a service provider said,

. . . some of them might get out and get a housing unit and within months they’re back and why is that? No one at this table really questions why, there's no support for them because many of them have substance abuse and other mental health issues and we expect them to go from having been literally years at that shelter to full independent living so ideally we would have a continuum from an emergency shelter and that would be just that, an emergency shelter, and then there would be a sort of halfway house a supported independent living, onto living on your own with support of an outreach worker or a mental health, it could even be a nurse who is in mental health outreach but someone who does outreach to these folks.

HtH persons also provided insight on the issues of the lack of available supports. Referring to the emergency shelter that closes during the day, one HtH participant noted that, “ . . . there’s no funding for it. I mean what they’re saying is everybody get out at 10:00 in the morning and then do nothing but stay at the library or go drink but if you drink you’re not allowed back in.” Regarding services, this HtH participant went on to say that there are, “No kind of support groups or programs or things set up for anybody.”

Related to the dry shelter and use of the RCMP cells are a wet shelter is the lack of any real support services for homeless persons. Services such as community-based detoxification are not available. Those seeking such services must travel long distances to Hay River (now closed) and other communities. The same is true for those persons needing any kind of longer-term mental health treatment who travel to places such as Yellowknife, Edmonton and Vancouver. In addition, while members of the IIC share information on services and needs in the community, there is no funding to offer services. Supportive and/or transitional housing is considered an important step in helping homeless men and women with addiction and mental health problems regain the stability needed for self-sufficiency. These services would provide a safe environment where basic needs could be met, and the requisite social skills for healthy functioning could be acquired.

4.2.2. What might help?

Although very few comments from the focus groups identified specific non-profit agencies that could benefit the community, many themes on the kinds of services needed emerged in the discourse. This is not surprising given the level of frustration experienced by service providers tasked with helping HtH persons but not knowing what might be the best approach given the range of needs. Referring to the absence of what might be considered basic non-profit service provided by the Salvation Army, several service providers identified the need for holistic care delivered by continuum of service providers. At minimum, detoxification services were deemed essential as a starting point, but the cost was prohibitive. One service provider said,

We did this big presentation about a need for a detox facility at the hospital but all those solutions seemed to come with a fairly big price tags attached and that always feels like the barrier to actually coming up with the services that are required.

The lack of detoxification and related services led another service provider to note that short-term detoxification was not a solution to addiction, especially for those with mental health problems. This service provider said,

. . . we don’t have services for detox and for longer term care and so most of those chronic homeless people can't go without (substances) so they will find whatever they need to feed that addiction . . . personally, I see a strong correlation for many people who are homeless in terms of addiction and mental health, especially the chronic.

In addition to detoxification and longer-term follow up services, several service providers noted the need for outreach programs focused on HtH persons. For one service provider the need for support programs was glaring. She said, “No support groups or programs or things set up for anybody,” Referring to the time, energy and resources required for outreach, another service provider observed,

So outreach is an open door, in it for the long haul, ready for the ups and downs, and sticking with, it's that stick-to-it-ness that needs to be there. It has to be people who are committed to the community, who will be here long haul, it could be years down before you help somebody help themselves out of whatever situation they find themselves in.

The comments of HtH persons echoed those of service providers regarding availability of programs and outreach. Referring to what might help, one HtH person noted, “We need someone to sit down and say what is your problem . . . I would say like coaches is one of the solutions . . . ” Another HtH person said,

We all have our issues. But it would be nice if they (service providers) did have some kind of support for people. You know, like options . . . You know somebody coming and saying hey there's a group tonight from AA. You can have an AA meeting there of just a counselor to talk to if they have some issues they want to discuss. Like Whitehorse has Bloodties . . . but you know there's a big problem here with all kinds of stuff, not just the shelter . . .

4.2.3. Questionnaire results

The majority of items from the questionnaire did not reveal any significant differences between HtH persons' satisfaction or how they viewed their future prospects regarding the availability, quality and quantity of housing, health and social support (results

MDT housing
1. On the whole, how do you feel about the place where you currently live or stay?
10. Think about where you expect to be living or staying 5 years from now. How does that compare to the place where you currently live or stay?

MDT health
1. On the whole, how do you feel about your current health?
10. Think about how you expect your health to be 5 years from now. How does that compare to your current health?

MDT social support
1. On the whole, how do you feel about the practical and emotional support you currently get from others?
10. Think about the practical and emotional support you expect to be getting 5 years from now. How does that compare to the practical and emotional support you currently get?

Fig. 1. Domains and items.

Table 1
Data output.[a]

Variable pairs	Sample size	Mean	SD
Housing 1	15	4.0667	1.90738
Housing 10	15	5.6667	1.11270
Degrees Of freedom	14		
One-tailed distribution			
p-level	0.001		
VAR	Sample size	Mean	SD
Health 1	15	4.94118	4.6838
Health 10	15	5.11765	3.48528
Degrees Of freedom	14		
One-tailed distribution			
p-level	0.346		
VAR	Sample size	Mean	SD
Social support 1	15	5.17647	3.5294
Social support 10	15	5.11765	3.98529
Degrees Of freedom	14		
One-tailed distribution			
p-level	0.451		

[a] Cases with missing data excluded.

not shown). The items from three tests, the first and 10th variables in each domain, are noted below in Fig. 1 followed by the data output in Table 1. The results showed that only the data from housing was significant ($p = .001$)—HtH persons look forward to better housing in the future. One T-test for each of the other domains, while not statistically significant, suggest that HtH persons do not think their health or levels of social support will change much in five years.

5. Discussion

Using mixed methods, focus groups and questionnaire, the purpose of this research was to capture the experiences of HtH persons with concurrent disorders living in Inuvik, NWT and to determine if nonprofit agencies might play a role in providing services to this population. The results from the focus group data suggest that HtH persons experience problems accessing services needed to help them cope with addictions and mental health problems, and to find suitable housing. Indeed, based on the depictions of service providers and HtH persons themselves, being HtH house in a community located in the Arctic Circle possesses significant challenges for survival, let alone the ability to live a healthy and fulfilling life. Notwithstanding the need for more housing, generally, HtH persons and service providers identified significant gaps in terms of addictions and mental health treatment, counseling programs and supportive and/or transitional housing. As well, the absence of non-profit agencies was noted, despite the activities of two local churches. In the absence of alternative services, it may be argued that non-profit agencies could play a significant role in this context.

Suggestions for change speak to the need for services that, for the most part, are not coming anytime soon from the territorial government. The Town of Inuvik does not have the capacity or the mandate to provide services. Instead, BDHSSA and the Territory are responsible for the delivery of health care and social services. In addition, the role of industry in promoting and perpetuating the problems of housing shortages in Inuvik, and the nexus between housing and concurrent disorders, has not been examined in any systematic way. That said, the visible impact of resource exploration and extraction on the community and comments of service providers in this regard are telling in that industry can and does exact a toll on housing.

Interestingly, the results from questionnaire do not show significant differences in most items in the three domains analyzed here. To be sure, the data collected in this research can be used for comparative purposes in future research involving the participants or in other contexts. Yet, the results suggest that HtH persons in this research anticipate better housing conditions in the future and attest to the need for home. In the Arctic context this implies geographical, psychological and spiritual concepts of home.

6. Conclusion

This research used mixed methods to examine gaps in services to HtH persons and the potential role that non-profit agencies

could play in service delivery In Inuvik, Canada. Regarding housing and care for HtH persons, the focus group results indicate that Inuvik faces many challenges. Indeed the focus group results identify a lack of resources such as a detoxification facility, supportive/transitional housing and community outreach. Yet, the focus group results also demonstrate the resiliency of HtH persons to survive and the commitment of service providers to care for them. Indeed, despite the absence of resources, the concern expressed by service providers for HtH persons and the care they are able to provide given the circumstances is telling, and is reflected in broader community efforts to develop services such as the EWC. Although the operation was not sustainable, the EWC does provide evidence that the development and operation of such services is possible.[3]

The results from the questionnaire seem to suggest that HtH persons in Inuvik do not fair that badly. Yet, the results contradict the stark reality of being HtH in the Canadian Arctic. Given that the sample originated from the emergency shelter, living in a relatively safe and warm setting is likely considered more like home than living day-to-day couch surfing with friends or relatives, under buildings or in the RCMP cells. In this regard, the results from the questionnaire may be affected by the small sample size. Still, the data are instructive regarding the hope that many have in terms of improved living conditions, health and social support.

In a region that boasts one of the highest per capita incomes in Canada (Wilson, 2009) the HtH situation in Inuvik and communities like it is an embarrassment to the region and indeed Canada itself (Bell, 2013). Moreover, it may be argued that the situation represents an abuse of human rights.[4] Ironically, the current approach of doing nothing costs government and ultimately taxpayers over $6 billion annually for health care, justice and social services (Laird, 2007).

To be sure, the long-term impacts of colonialism and forced assimilation policies, combined with the effects of oil and gas exploration and extraction, are major contributing factors to homelessness and concurrent disorders in Inuvik. Christensen's (2013) research has documented the impact of intergenerational trauma on many HtH residents of Inuvik. As discussed, a significant body of research documents the negative impacts of resource extraction in northern Canadian communities, some of which includes Inuvik and the Beaufort Delta (Abele, 2006; Berger, 1977; Asselin and Parkins, 2009; Goldenberg et al., 2010; Shandro et al., 2011; Van Hinte et al., 2007). The experiences of other remote and northern communities underscores the claim that stakeholders, including government and resource extraction industries, have a role to play in the amelioration of the problems facing communities like Inuvik, and the development of prevention strategies (Webster, 2006).

Future research should examine the role that the non-profit sector plays in other regions and communities facing problems with HtH persons with concurrent disorders. How communities have mobilized to address the problem, what non-profit sectors appear more effective and why, and what role industry can play given the link between resource extraction and the state of HtH persons in those communities are places to start. Moreover, industry could play a role in research that could address the damages caused by past industrial activities, and in the development of strategies that could offset the potential damages of oil and gas exploration in the future. However, combined with the problems caused by colonization, resettlement and other forced relocation and socialization policies, it is crucial that industry, government and the non-profit sector work with the people most negatively affected, HtH persons, in the development of amelioration strategies.

Appendix A. : Focus groups questions

Focus group questions for community members

1. What is the scope of homelessness?
2. Who is the makeup of the homeless population?
3. What leads to homelessness?
4. Is there a relationship between homelessness, addictions and mental health?
5. What barriers to homeless persons face?
6. What services do they have?
7. What services do they use?
8. What barriers do homeless persons face accessing services?
9. What services are used most and why?
10. How does the broader community respond to homeless persons?

Focus group questions for hard-to-house participants

1. Where do you live?
   Probe: where else have you lived in the past year?
2. How did you end up living in these places?
   Probes: what happened to you? Why do you think they happened?
3. What problems do you have right now?
   Probes: housing, health, relationships?
4. What do you need to deal with these problems?
   Probes: medical help, help with housing, dealing with addiction...?
5. Have you tried or done anything to deal with your problems?
   Probes: seek advice? See medical help? See a counsellor? Ask a friend or relative...?
6. Have you been able to deal with any problems?
   Probes: how? Did things/people get in your way?

Appendix B. : MDT domains and items from QoLHHI

MDT housing situation

1. On the whole, how do you feel about the place where you currently live or stay?
2. On the whole, how would you describe the place where you currently live or stay?
3. How does the place where you currently live or stay compare to the average for most people?
4. How does the place where you currently live or stay compare to the best you have experienced in the past?
5. How does the place where you currently live or stay compare to what you expected to have at this point in your life?
6. How does the place where you currently live or stay compare to what you think you deserve?
7. How does the place where you currently live or stay compare to what you think you need?
8. How does the place where you currently live or stay compare to what you think would be ideal?
9. How does the place where you currently live or stay compare to what you want?

[3] Evaluation research on the effectiveness of the EWC in Inuvik is currently underway by the author.

[4] Although quashed by the Supreme Court of Ontario, the right to housing remains in Canadian courts. See Dirks (2015) for a review of the constitutional right to housing in Canada.

10. Think about where you expect to be living or staying 5 years from now. How does that compare to the place where you currently live or stay?

MDT health

1. On the whole, how do you feel about your current health?
2. On the whole, how would you describe your current health?
3. How does your current health compare to the average person's health?
4. How does your current health compare to the best you have experienced in the past?
5. How does your current health compare to what you expected to have at this point in your life?
6. How does your current health compare to what you think you deserve?
7. How does your current health compare to what you think you need?
8. How does your current health compare to what you think would be ideal?
9. How does your current health compare to what you want?
10. Think about how you expect your health to be 5 years from now. How does that compare to your current health?

MDT social support

1. On the whole, how do you feel about the practical and emotional support you currently get from others?
2. On the whole, how would you describe the practical and emotional support you currently get from others?
3. How does the practical and emotional support you currently get from others compare to the average for most people?
4. How does the practical and emotional support you currently get from others compare to the best you've experienced in the past?
5. How does the practical and emotional support you currently get from others compare to what you expected to have at this point in your life?
6. How does the practical and emotional support you currently get from others compare to what you think you deserve?
7. How does the practical and emotional support you currently get from others compare to what you think you need?
8. How does the practical and emotional support you currently get from others compare to what you think would be ideal?
9. How does the practical and emotional support you currently get from others compare to what you want?
10. Think about the practical and emotional support you expect to be getting 5 years from now. How does that compare to the practical and emotional support you currently get?

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