CITY OF VANCOUVER

# Appendices

PROJECT Civil City

Appendix I:

- Oversight Committee
- Expert Working Group

Appendix II:

Annotated Bibliography

Appendix III:

The Collaboration for Change Forum

Appendix IV:

Collaboration and Change:
Evidence Related to Reforming Housing,
Mental Health, and Addiction Care in Vancouver

# Appendix I:
## Oversight Committee

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|---|---|
| **Chair: Geoff Plant** | **Project Civil City Commissioner City of Vancouver** |
| Judy Rogers | City Manager, City of Vancouver |
| Ida Goodrean | President and CEO, Vancouver Coastal Health (VCH) |
| Catherine Lappe | Regional Director, Health Canada |
| Dianne Doyle | CEO, Providence Health Care |
| Jim Chu | Chief Constable, Vancouver Police Department |
| Stephen J. Toope | President and Vice-Chancellor, University of British Columbia |
| Michael Stevenson | President and Vice-Chancellor, Simon Fraser University |
| Edgar Kaiser | President, Kaiser Foundation |
| Virginia Greene | President and CEO, Business Council of British Columbia |
| Tom Cooper | President, City in Focus |
| Madeleine Dion Stout | BC Representative (Non-Government Director), Mental Health Commission of Canada |
| Ed John | Grand Chief Tl'azt'en Nation, First Nations Summit Task Group member, and member of First Nations Leadership Council |
| Perry Kendall | Provincial Health Officer |
| Lynda Cranston | CEO, Provincial Health Services Authority |
| Mary Freeman | Associate Deputy Minister, Office of Housing and Construction Standards, Ministry Responsible for Housing |
| Joy MacPhail | Former Minister of Health, Province of BC |
| Hugh Stansfield | Chief Judge, Provincial Court of BC |
| Faye Wightman | President and CEO, Vancouver Foundation |
| Michael McKnight | President and CEO, United Way of the Lower Mainland |
| Elizabeth Whynot | President, BC Women's Hospital and Health Centre |
| Christine Lattey | Executive Co-ordinator, Vancouver Agreement |
| Michael Krausz | UBC Department of Psychiatry and Co-Chair Expert Working Group |

# Appendix I:
## Expert Working Group

**Co-chair: Geoff Plant, Project Civil City**

**Co-chair: Michael Krausz, UBC Department of Psychiatry**

**Provincial Health Services Authority (PHSA)**

Patrick Smith, VP, Research Networks and Academic Development

David Brown, Research Scientist

Lorne Korman, Research Director, BC Provincial Youth Concurrent Disorders Program

**Vancouver Coastal Health (VCH)**

Trevor Young, Regional Medical Director, and Head, Psychiatry, UBC

Maureen Whyte, Chief Operating Officer, Vancouver Community

Heather Hay, Director, Addictions Services, HIVIAIDS and Aboriginal Health

Loma Howes, Director, Mental Health Services, Vancouver Community and Acute

Lynn Buhler, Director, Performance Management and Project Management, Medical Affairs

Val Munroe, Director, Community Health Services, Vancouver Community

Soma Ganeson, Psychiatric Medical Director

David Marsh, Physician Leader, Addictions Services, HIVIAIDS and Aboriginal Health

Linda Thomas, Director, Housing

John Carsley, Medical Health Officer, Communicable Disease Control

Heather Manson, Vice President, Population Continuums

**Providence Health Care**

Richard Pico, Chair of Psychiatry

Pamela Miller, Program Director, HIV/AIDS and Addiction

Bill MacEwan, Program Director, Mental Health Services

**City of Vancouver**

Jacquie Forbes-Roberts, General Manager of Community Services

Donald MacPherson, Drug Policy Coordinator

Cameron Gray, Director, Housing Centre

Jill Davidson, Senior Housing Planner, Housing Centre

Jessica Chen, Senior Planner, Planning Department (Lead on DTES)

MaryClare Zak, Director, Social Planning Department

**UBC**

Thomas Kerr, Research Scientist, Centre for Excellence

Tony Phillips, Professor, Department of Psychiatry

Aslam Anis, Professor of Health Economics

David Moore, Physician Epidemiologist, Centre for Excellence

**SFU**

Elliot Goldner, Professor, Faculty of Health Science (Mental Health Cornmission)

Julian Somers, Director, Centre for Applied Research in Mental Health and Addiction (CARMHA)

Michelle Patterson, Adjunct Professor, Centre for Applied Research in Mental Health and Addiction (CARMHA)

Neil Boyd, Professor, Criminology

Fiona Young, Dept. of Criminology

**Mental Health Commission of Canada**

Jayne Barker, Policy Director

**BC Housing**

Dominic Flanagan, Director Tenant Services

**Vancouver Foundation**

Catharine Hume, Program Director

**Vancouver Police Department**

Scott Thompson, Inspector, Youth Services Unit

**Provincial Health Officers Office**

Evan Adams, Director, Aboriginal Health Advisor

**BCCDC (BC Centre for Disease Control)**

Jane Buxton, Physician/Epidemiologist

Juanita Maginley, Director Street Nurse Program

**BCCEWH (BC Centre of Excellence for Women's Health)**

Nancy Poole, Research Network Development

Amy Salmon, Research Associate

**Ministry of Employment and Income Assistance (MEIA)**

Lynda Cavanaugh, Executive Director, Vancouver Coastal Regional Office

**Housing and Mental Health Action Group**

Nancy Hall, Mental Health Services Consultant

**City in Focus**

Jolmathan Bird, Director of Social Sustainability

Splats'in-Secwepeinc First Nation

Wayne Christian, Chief

**Covenant House**

Krista Thompson, Executive Director

**Coast Foundation**

Darrell Burnham, Executive Director

**Portland Hotel Society**

Dan Small, Director

**Triage**

Mark Smith, Executive Director

**Salvation Army Harbourlight**

Wayne Oster, Executive Director

**BC Persons with AIDS Society**

Terry Howard, Coordinator for the Prison Outreach Program

**Drug-user Representatives**

Ann Livingston, Coordinator, Vancouver Area Network of Drug Users (VANDU)

Chris Rempel, VANDU

Dean Wilson, VANDU

**Family Advocate(s)**

Rob Ruttan, From Grief to Action

Susie Ruttan, From Grief to Action

Joyce Locht, From Grief to Action

CITY OF VANCOUVER

# Appendix II:
## Annotated Bibliography

PROJECT Civil City

**British Columbia Assembly of First Nations, First Nations Summit, Union of British Columbia Indian Chiefs and The Government of British Columbia. (no date)** *The Transformative Change Accord, First Nations Health Plan.*

This report provides a series of recommendations to address key issues for First Nations social service provision and delivery, which are identified as: closing the gaps between First Nations and other British Columbians in the areas of education, health, housing and economic opportunities over the next 10 years; reconciling Aboriginal rights and title with those of the Crown, and; establishing a new relationship based on mutual respect and recognition. Each of the main sections has a specific set of action points and includes a series of measures to evaluate the effectiveness by 2015. The four action areas for change over the next 10 years are: the establishment of mental health programs to address substance abuse and youth suicide; the integration of the ActNow BC strategy with First Nations health programs to reduce incidences of preventable diseases like diabetes; the establishment of tripartite pilot programs in the Northern Health Authority and build the Lytton Health Centre to improve acute care and community health services utilizing an integrated approach to health and community programs as directed by the needs of First Nations; and to increase the number of trained First Nations health care professionals. Additional areas for future action include: governance, relationships and accountability; health promotion and disease and injury prevention; health services; performance tracking

**The four umbrella areas are also written into the:**

First Nations Health Plan Memorandum of Understanding Between The First Nations Leadership Council Representing the BC Assembly of First Nations, the First Nations Summit, the Union of BC Indian Chiefs, the Government of Canada, and the Government of British Columbia.

**BC Ministry of Health. (2005). Harm Reduction: A British Columbia Community Guide. Victoria: BC Ministry of Health.**

This guide has been written to assist municipalities in British Columbia in taking a leadership and a facilitative role in reducing the level of drug related harm in their communities. Principles of harm reduction include: pragmatism, human rights, focus on harms, maximize intervention options, priority of immediate goals, and drug user involvement. The Harm Reduction approach emphasizes education and outreach to teach drug users how to reduce risks associated with drug use; referrals to health and social services; low threshold service delivery; partnerships between law enforcement and health agencies to ensure complementary efforts that identify the root causes of community problems and the most effective actions for addressing them; needle exchange programs and gold standard methadone maintenance treatment; supervised consumption facilities; street drug testing and early warning systems; and heroin-assisted treatment. Recommendations for the development of a municipal harm reduction response includes bringing key stakeholders together, creating a leadership and organizational structure, identifying key community partners, conducting needs assessment and inventory of local services, developing a locally-driven harm reduction strategy guided by SMART Goals and Objectives, developing a strategic approach that minimizes the burden of harm with evidence-based intervention and strengthening existing services and infrastructure, focusing on prevention, treatment, community supports, and enforcement, mobilizing communities to implement the strategy, monitoring implementation and adjusting course if needed, and communicating results.

**Canadian Executive Council on Addictions. (2005). Canadian Addiction Survey (CAS). Ottawa: Health Canada.**

The objectives of the CAS is to determine the prevalence, incidence and patterns of drug use in the Canadian population aged 15 years and older; to measure the extent of harms associated with those individuals who use drugs; to assess the context of use and identify risk and protective factors related to drug use; to measure public opinions, views and knowledge about addiction policies; and to provide baseline data for future evaluation of the effectiveness of Canada's Drug Strategy. The results of the CAS suggest that alcohol problems are not uncommon and are differentially distributed among Canadians. If social policy directed at the prevention of alcohol-involved harm is to be evidence-based, it is important to identify target groups (heavy drinkers and younger people) that are vulnerable to these problems and that could benefit from prevention and intervention efforts. The increase in cannabis use from 15–17 year olds to 18–19 year olds is notable. The 15 to 17 year old group is an obvious target for prevention programming. Given some similarities in the harm of cannabis and tobacco smoke (Hall & MacPhee, 2002), cannabis interventions could explore cessation programming developed for cigarette use. Given that most who have used an illicit drug (excluding cannabis) in their lifetime no longer continue

# Appendix II:
## Annotated Bibliography

to use, the report suggests that more emphasis should be placed on recent use and current harms and consequences. There is a need to better understand the determinants of provincial and regional differences in alcohol and other drug use. Continuing efforts are warranted that focus on alcohol and drug-using populations with harm reduction and prevention measures, address evolving treatment needs, and reduce the social and economic costs of substance use. Finally, the report highlights the importance of developing a sustained and ongoing monitoring and surveillance strategy.

**Centre for Addiction and Mental Health. (2002). Best Practices: Concurrent Mental Health and Substance User Disorders. Ottawa: Health Canada.**

The report provides an updated synthesis of the latest research information for addiction and concurrent disorders and offers specific recommendations for the screening, assessment and treatment/ support of this underserved population. The report advocates thinking of mental health and substance use problems as a *plurality*, rather than a duality, as it is more consistent with the typical clinical presentation of the abuse of multiple drugs. It recommends a broader psychosocial rehabilitation perspective, which focuses on the critical role of acute treatment, medication management and symptom reduction in creating more long-term positive outcomes and further advocates for an integrated treatment program that supports housing, employment, recreation and social networks. It is recommended that all people seeking help for substance abuse be screened for co-occurring mental health disorders and co-occurring substance use disorders, and that based on a positive screen, a comprehensive diagnosis, assessment of psychosocial functioning and treatment and support plan be established. The report encourages a less prescriptive approach at the system level and promotes greater knowledge transfer, community and patient participation, inter-agency cooperation, improved data systems and access models, and more research, training and education in the field of addiction and co-occurring disorders.

**Community Directions. (2002). An Alcohol and Drug Plan for the Downtown Eastside Community. Vancouver.**

The Community Directions report was written by members of the Downtown Eastside community and is the result of extensive collaboration and consultation with community based groups and individuals. The plan uses the four pillars approach as a framework to provide a coordinated, holistic, and comprehensive way to address drug and alcohol issues. There are 27 separate actions outlined within the plan that range from general directives (ie increase the amount, available, variety and level of coordination in treatment) to more specific (ie establishment of a 24-hour sobering centre for people in immediate and acute alcohol and drug crisis). There are definitions and background for each action as well as a discussion of key implementation issues. Services are broken down into low threshold that targets drug users who are not ready or interested in treatment or rehabilitation, medium threshold that targets users who have some level of commitment to change, and high threshold that targets those who want to exit the drug scene. Eighteen principles guided both the development of the actions and the issues surrounding implementation. These include ideas such as: treatment must be normalized in that it should be made accessible and less threatening to those who want it, and that a continuum of services based on varying levels of need must be provided to alcohol and drug users.

**Goldberg, M. et al. (September, 2005). Homeless Count 2005. On our streets and in our shelters: Results of the 2005 Greater Vancouver Homeless Count. SPARC BC.**

This document presents the findings of the 2005 Greater Vancouver homeless count which provides an estimate of the number of homeless in the region, accompanying demographic information, and identifies trends in relation to the 2002 Homeless Count. Conducted on March 15th, interviewers approached people using services, such as drop-in centres, meal programs, certain social services, and shelters, to determine if they were homeless. For the purposes of the count, someone was defined as homeless if they did not have a place of their own where they could expect to stay for more than 30 days and if they did not pay rent. This includes both those individuals who have no physical shelter and those who stayed at a friend's place. Due to the methods used and limited time and space, the count is an under-representation of the number of homeless in Greater Vancouver. The results of the count indicated that there has been significant growth in the number of homeless counted region-wide, almost doubling from 1,121 persons in 2002 to 2,174 persons in 2005 and more homeless people were found on the street than in shelters. More than 800 people reported that they have an addiction problem and approximately one-third of homeless people with an addiction also reported having a mental illness. While the report does not provide specific recommendations, it does contribute to the evidence-base that is necessary for making informed policy decisions.

CONTINUED

# Appendix II:
## Annotated Bibliography

**Housing Centre, City of Vancouver. (June, 2005). Homeless Action Plan.**

Concern over the rise in the number of homeless in Vancouver as shown in the Homeless Count in 2005 prompted Vancouver City Council to ask City staff to prepare a Homeless Action Plan. The objectives of the plan are to identify actions that the City, other levels of government, the community and business can take to combat the issue. The plan identifies what changes are needed so that approximately 1,000 street homeless have stable housing and the number of people at risk of homelessness is reduced. The plan is modeled on the regional homelessness plan – *3 Ways to Home* – and focuses on three main strategic areas identified as essential to successfully deal with the complexities underlying homelessness: income, housing, and support services. Ultimately the action plan outlines a number of key goals that must be achieved within 10 years if it is to be considered successful: people who are capable of working have access to a job; people who need welfare are getting it and the amount of money received is sufficient; supportive housing and other forms of low-income housing has increased; the shelter system provides a safe place for those who require temporary accommodation; people can obtain mental health, addictions and other services which they need; and all sectors of the community are playing a role. Eighty-seven specific actions are outlined in the achievement of these goals and include steps required by the Federal, Provincial and Municipal Governments. Examples include having the Federal Government expand eligibility criteria for Employment Insurance (EI) benefits and having the City of Vancouver expand the network of organizations that might have the capacity to address the need for emergency accommodation in extreme weather.

**Kirby, Michael J., Chair and Keon, Wilbert J., Deputy Chair. (May, 2006). Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada. Final Report of The Standing Senate Committee on Social Affairs, Science and Technology. The Canadian Senate.**

This report, commissioned by the Canadian Senate as a follow up to the October, 2002 report on the state of the health care system in Canada, provides a thorough overview of the current situation of mental illness, mental health and addiction in the country. The report is divided into a number of parts that focus on various sectors of the population and on available resources and policies. These sections include focus on such groups as Aboriginal people, Seniors, Families and Youth, and concepts such as the role of Federal leadership, and strategic planning and inter-governmental coordination. Description and background information, as well as case studies, are offered in support of recommendations. Appendix A provides a list of the 118 recommendations that were either directly stated or implied in the body of the report. Most of these recommendations encourage inter-governmental and inter-organizational collaboration to reduce stigma and discrimination, and to improve knowledge translation and the continuum of care for those Canadians with mental illness. They include measures such as increasing supportive housing and expanding addiction services – both in general and, in some instances, more specific terms.

**MacPherson, Donald. (April 24, 2001). A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver. City of Vancouver.**

The four pillars approach provides a framework for action that incorporates municipal, provincial, and federal commitment in tackling the issues related to substance abuse in Vancouver. It is intended to show which levels of government should be responsible for which actions within the framework, to clarify the issues surrounding drug problems in the City of Vancouver, and to establish appropriate and achievable goals and actions to deal with those problems. The report calls for the Province and the Federal Government to take action and responsibility in dealing with the issues, to work towards restoring public order by reducing open drugs and the impact of illicit drugs on the community, to improve public health, and to coordinate, monitor and evaluate the implementation of these actions. The four pillars are: prevention, treatment, harm reduction, and enforcement. Prevention is achieved through promoting healthy communities, and it aims to improve the health of the general population and to reduce differences in health between groups of people. Treatment goals are to offer individuals access to services including peer-based counseling, methadone, day and residential treatment and housing support. Harm reduction involves reducing the spread of communicable diseases, preventing overdose deaths, and reducing consumption of drugs in the street. Enforcement targets organized crime, drug dealing, drug houses, etc in an effort to preserve public order and safety.

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# Appendix II:
## Annotated Bibliography

**Patterson, M., Somers, J., McIntosh, K., Shiell, A., Frankish, C.J., and Van der Leer, G. (2008). Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia. CARMHA.**

The focus of this report is the disproportionately high number of homeless and inadequately housed adults who have severe addictions and/or mental illness (SAMI). There is tremendous overlap between mental health, substance use, and homelessness ant this report attempts to provide up-to-date information with regard to the scope of the problem, recommended solutions, and associated costs. Published literature, academic experts, decision-makers and key informants were some of the sources utilized for information. The writers hoped that the report would provide the basis for constructive action to deal with the overlapping problems of homelessness and severe addictions and/or mental illness. It provides estimates of the number of BC residents with SAMI and then further breaks down those individuals by their housing situations. It also reviews the current models of housing and relateds upport for this population and estimates the costs associated with providing recommended models of housing and support to SAMI individuals in need of housing as well as the costs associated with maintaining the status quo. The report identifies the major challenges to providing housing and support as: a lack of integrated planning and communication; barriers to access of income assistance; shortage in the supply of low-cost rental housing; a crisis orientation to the issues; and insufficient community programs and supports for people with SAMI. Recommended key actions included: supported housing; housing first; multidisciplinary treatment teams; low-barrier housing; regional and provincial distribution of services; integrated mental health and addiction services; and fast-track to income assistance for homeless people. Ultimately, the cost of providing permanent supported housing for people with SAMI is more than offset by savings incurred by the health, corrections, and emergency shelter systems.

**SPARC BC. (November, 2003). 3 Ways to Home: Regional Homelessness Plan for Greater Vancouver.**

This plan was originally developed in March, 2001 by the Regional Steering Committee on Homelessness and has been updated in 2003 to provide a review of changes over the past few years. The objective is to provide a framework for the planning, coordination and development of housing, services, and facilities across Great Vancouver. Six principles were developed in the creation of the plan and outlines how the plan endeavours to be: comprehensive, accessible, inclusive, preventative, collaborative, and long term. Priorities, assets, gaps, policies and strategies to support each element of the plan, including housing, adequate income, and support services are discussed. Also acknowledged is the need for more research and data collection and an initial strategy for evaluating the work on the Plan. The report discusses current barriers to access of services and includes an abridged report out of the *2003 Aboriginal Homelessness Study*. Overall, the action plan focuses on three areas. 1) The need for a continuum of housing that ranges from Emergency shelter and safe houses, to transitional housing and supportive housing, to independent affordable housing; 2) The need for adequate income through access to employment and social assistance, and; 3) The need for support services that include those for mental health and addiction as well as preventative services.

**SPARC BC. (2007). In the Proper Hands: SPARC BC Research on Homelessness and Affordable Housing.**

This publication summarizes the knowledge accumulated in the course of SPARC BC's core and paid research on homelessness and affordable housing between 2003 and 2007. It includes information on the trends in and extent of homelessness as well as issues related to adequate income, support services, and the housing continuum. The work begins with a summary of trends affecting homelessness and housing that is basically an overview of government housing and social assistance policy and funding for the last twenty years. It goes on to describe the causes and effects of homelessness as a broad combination of systemic factors that include, among others, poverty, mental health issues, addictions, and unemployment. Finally, the report provides a framework for addressing homelessness that is based on the regional homelessness plan – *3 Ways to Home* – and focuses on three major elements linked to the root causes of homelessness: income, housing, and support services. While the report does not outline specific action points, it does outline the current situation and provides a form of gap analysis. According to the report, the provision of sustainable and flexible funding by government, and programs designed in consultation with homeless people and the community-based organizations who work with them are crucial. In addition, SPARC BC attempts to identify approaches that facilitate reaching populations in need, improve coordination of services, improve access, and obtain successful outcomes. The report also emphasizes the need for special attention to youth and seniors, Aboriginal people, single mothers, middle age women, and to the immigrant community of BC, in addressing homelessness and affordable housing issues.

CONTINUED

# Appendix II:
## Annotated Bibliography

**Victoria Cool Aid Society. Housing First – Plus Supports: Summarizing the results of the Homeless Needs Survey conducted from February 5 to 9, 2007 in the Capital Regional District of British Columbia, Canada. Homeless Needs Survey 2007 – A Pathway to Home.**

This publication reports the results of the 2007 Homeless Needs Survey conducted in and around the Capital Region from Sooke to Sidney and Salt Spring Island, but excluding the northwest Juan de Fuca area. It addresses the types of housing and supports people require when they are not housed or are in unstable housing. The survey identified 1,242 persons throughout the Capital Region who were homeless or unstably housed. Given the limitations of the survey methods, this is an undercount and a disproportionate number of those surveyed identified themselves as Aboriginal, First Nations, Metis, Inuit or Native. Information surrounding shelter use, income assistance provision, etc. is provided. Overall, the report expands upon six basic recommendations: 1) Create a range of affordable housing options; 2) Provide intensive community support for housing; 3) Provide a range of harm reduction and treatment services; 4) Provide income supports for people who are homeless or unstably Housed; 5) Provide short-term solutions during the transition to affordable Housing; and 6) Engage the broader community in solutions.

**Wilson-Bates, Fiona. (January, 2008). Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources. Vancouver: Special Investigation Section of the Vancouver Police Department for the Vancouver Police Board and Chief Constable Jim Chu.**

This report represents the official position of the Vancouver Police Department (VPD) and the Vancouver Police Board. It was commissioned to provide a quantitative analysis of the number of VPD calls that involve mentally ill clients, to identify factors that contribute to the frequency of these incidents, the potential consequences for a mentally ill person who comes into contact with police, and to identify the gaps in the mental health system's response to the mentally ill. The study found that during a 16-day period in September, 2007, 31 per cent of all calls involved at least one mentally ill person and that in certain areas of the city, specifically the downtown eastside, that figure rose to almost 50 per cent. The report utilizes case studies to illustrate gaps in the mental health system and the difficulties faced by mentally ill individuals and their families to obtain assistance and treatment. Deinstitutionalization and the current legislation is discussed as contributing factors to the current situation. The report outlines seven complementary recommendations to address the gap in mental health service and to decrease the percentage of VPD calls that involve mentally ill people. The recommendations include a continued increase in supportive housing and the creation of system that had readily accessible details of individual's mental health history.

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CITY OF VANCOUVER

# Appendix III:
## The Collaboration for Change Forum

PROJECT Civil City

### April 28

Geoff Plant opened the evening session, which took place at the Vancouver Playhouse, by outlining the purpose of the Collaboration for Change. He was followed by Aline LaFlamme and Daughters of the Drum, an Aboriginal group who provided the opening blessing. Mayor Sam Sullivan welcomed participants saying Vancouver's problems with addiction, mental health and homelessness issues must be addressed. He said that the Olympics are a good way to motivate the federal and provincial governments to help, adding that he has reminded senior governments that: "In 2010 Vancouver will represent us to the world." He said he continues to urge both levels of government to pay attention to Vancouver's struggles and help fund solutions.

Richard Utendale, President, Vancouver Area Network of Drug Users (VANDU) outlined his experiences with drug use. Saying he had a good childhood, he nevertheless started using drugs by 13 and was using cocaine heavily by 15. He failed his first year at university and then went on to work at a series of jobs. "The bottom line was, it was always about drugs." Utendale explained that VANDU, an association of current or former drug users, works to make people comfortable with themselves, and to advocate on their behalf.

Donna Whonnock of the Aboriginal Front Door Society described her life as a neglected and abused child who fell into alcoholism and addiction. "I didn't know how to live as a person, really." She said she eventually lost everything and wound up

in a hotel room in Vancouver's Downtown Eastside (DTES). A doctor's comment that he couldn't see the value in giving her an operation she needed, because he felt she was slowly killing herself anyway, struck a chord and Whonnock sought treatment. In a recovery house, Whonnock said she learned to look at herself as somebody who deserves to be alive.

Susie Ruttan, a founding member of the parent advocacy group From Grief to Action spoke about her son, the oldest of her three children, who has struggled with bipolar disorder and addictions since has was 15; he is now 26. He has been in and out of hospitals, psychiatric wards and jail and, after a good period, had relapsed three days before the Collaboration. Ruttan explained that the stress has led to her own and her husband's development of auto-immune diseases. Ruttan's daughter Tessa also spoke, describing how her brother's addiction took away the brother she knew. "I ask that you not pass judgement; families of drug users need your support."

Michael Kirby, who is Chair of the Mental Health Commission of Canada, said Canada lags behind other countries in its treatment of those who are mentally ill. "The whole purpose of today and tomorrow is to ask the question, how do we bring meaningful change in the lives of the people whose stories we heard this evening?" Despite statistics showing that Vancouver's DTES has the highest incidence of homelessness and mental illness in Canada, Kirby expressed optimism that change is imminent. He said the creation of his national commission, and its mandate to create a national mental health strategy, is positive. He said such a strategy must be both useful and practical: "It must be just inside the edge of political feasibility." Governments must jointly attack homelessness, mental health and addictions problems in order to be effective, he said. "You can't do these things sequentially." Underlining the size of the problem, Kirby pointed out that there are more people in Canada with mental health issues than with cancer and heart disease combined; further, there are more hospital days for people with mental illness than for those treated for cancer, heart disease and strokes combined. The cost of fixing the problem, he said, is $2.5 billion over the next 10 years, or $250 million per year. That will be cheaper than not dealing with the problem, which results in increased criminal justice, healthcare and other costs.

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# Appendix III:
## The Collaboration for Change Forum

### April 29

After welcoming people to the full-day session on April 29, held at the Wosk Centre, Geoff Plant introduced Sekyu Siyam Chief Ian Campbell of the Squamish First Nation, who offered an opening blessing. Vancouver Mayor Sam Sullivan also welcomed participants, saying the focus should remain on the population in need. Victoria Mayor Alan Lowe said he was pleased to participate in the event and to share Victoria's experiences. He said that homelessness and mental illness are a nation-wide issue and that he hoped the group could find collaborative solutions.

The program started with a personal story by Dr. Chris Richardson, Assistant Professor, Health Care and Epidemiology, Centre for health Evaluation and Outcome Sciences, UBC, who described a relative's tragic experience with mental illness and addiction.

Dr. Patrick Smith, Vice President, Research Networks and Academic Development, Provincial Health Services Authority of BC then outlined the national framework for action to reduce the harms associated with alcohol and drug use in Canada. One of the goals of this framework is to develop a national treatment strategy. He explained that substance use occurs along a continuum, as should treatment. He said that he has heard that there is no evidence base for treatment for addictions and mental health. In fact, he said, the evidence for treatment of these conditions is far better than for many diseases. He said there must be a focus on educating clinicians in the field and the policy makers, so that they understand the evidence base. When the strategy is released, he said, "We will need to take a harsh, critical look at what we have on the ground in BC."

Smith said there must be more opportunities to intervene earlier, and individually, or else the system will have to provide a higher level of care, as people's problems and health concerns deepen.

Each of the presentations was followed by open dialogue from invited participants. Throughout the dialogues, the issue of political will arose repeatedly. At one point, one participant asked what had changed in the 10 years since the Vancouver Agreement – a joint response by three levels of government to the public health disaster in the Downtown Eastside – was established. He asserted that significant political will and investment was required to effect change over the next decade, a view that was echoed repeatedly throughout the day.

After the first presentations a participant addressed the issue of addiction, saying that more chemical-dependency specialists are needed on the front lines. He questioned whether enough funding is directed to training doctors to intervene earlier in patients' drug use. Dr. Michael Krausz responded, saying that effective treatment is a question of capacity and approaches. He said the capacity in Vancouver is probably less then half of what's available in most European cities. A participant responded by saying that those working in the system on the front lines are so used to the very limited resources available they exhibit a kind of learned helplessness. He suggested that in order to fix this problem, the Collaboration must address systemic changes required in the healthcare system to change those attitudes. A number of people addressed the issue of poor funding as being a key part of the problem. One person described how the private system has strategies for helping those who can afford long-term counselling and medical solutions. He said the public sector has not moved forward as quickly.

A participant said one of the major obstacles to treatment is the fact that those who are mentally ill and addicted must become abstinent before they can get help for their mental illness. Another participant noted that drug use takes place on a continuum and therefore treatment must follow a similar path. Dr. Michael Krausz said it's a myth that people must delay interventions until the person is abstinent. He said physicians and service providers must work with people wherever they are in the drug-use continuum. Dr. Patrick Smith added that in 2003 the provincial government integrated mental health and addiction administratively.

One participant pointed out that one of the main issues the Collaboration is focused on is the chronically homeless. She cited Kelowna's success in focusing on two-three people at a time and Victoria's plan to work with 50 homeless people at a time.

CONTINUED

# Appendix III:
## The Collaboration for Change Forum

The second set of presentations started with an address by Dominic Flanagan, Director of Tenant Programs, BC Housing, who outlined a number of programs BC Housing offers to meet the needs of the vulnerable (such as the homeless, women who experience violence, people who have substance use and those with mental health problems). He said the province has also dedicated funds to opening emergency shelters 24 hours a day, seven days a week. Flanagan also explained that the 12 hotels the City purchased will undergo renovations and then offer housing for the homeless, in some cases specifically for women, Aboriginals and those still using drugs; some units will be for those who are alcohol and drug free.

Nancy Shewchuk, Director, Service Delivery, Ministry of Employment and Income Assistance (MEIA) explained that her ministry delivers services to 110,000 clients in BC providing temporary assistance, disability assistance and employment programs. Most of those clients are disabled and have significant barriers to employment. Shewchuk outlined the collaborations her ministry is involved in with other agencies and organizations: for example, the Homeless Outreach Program is a partnership with the City of Vancouver. Between January 2006 and January 2008, the program helped 740 people find housing; 500 of these remained housed in January of 2008.

Heather Hay, Director, Addictions services, HIV/AIDS, and Aboriginal Health, DTES, Vancouver Coastal Health Authority and Lorna Howes, Director, Mental Health Services, Vancouver Coastal Health Authority outlined the demographics of the situation in Vancouver's DTES and the continuum of care offered. They explained that there are about 2,100 people in crisis in the DTES, presenting complex health needs, high levels of concurrent disorders, and very high rates of HIV and Hepatitis C. There is some overlap between this population and the 277 chronic offenders identified by the Vancouver Police Department. They said that VCH is in the process of developing a comprehensive response that recognizes that addictions and mental illness are chronic conditions with relapse patterns. They pointed out that while there is a myth that most VCH funding goes towards harm reduction, in fact 73 per cent of the VCH dollars go into addictions treatment and 19 per cent funds harm reduction measures.

In the discussion that followed, one participant noted that housing providers are seeing more people with concurrent disorders and they require more training to support the front line staff. People raised questions about the proportion of housing to be dedicated to women with children or Aboriginal women. Dominic Flanagan said he hoped some of the projects in recently purchased hotels will offer small family units.

Dr. Michael Krausz said the first task is to agree on the size of the problem in Vancouver. He said that the current crisis took about 10-15 years to develop so a good understanding of the situation is critical. He encouraged health authorities to work with academics, scientists and experts to develop a culture of collaboration.

The afternoon presentation started with an address by BC's Provincial Health Officer, Dr. Perry Kendall. He said homelessness across BC is at record levels and yet there has never been such an array of resources, skills and talents available to tackle the problem. Kendall said addictions and mental health must be treated as health issues, not moral or justice issues. The failure to cope with them signals that the measures are being applied in inadequate doses, incorrectly or do not follow best practices. As a recent Simon Fraser University study showed, it would actually save taxpayer money if the homeless were provided with treatment, housing and supports. He said the three major changes that are needed are to: close the gap between planning and mental health and addictions; establish a centre for addictions and concurrent disorders that would offer training and support to front-line clinicians and serve as an academic and clinical centre; and then create measurable outcomes and timelines to deal with these issues. "I think Vancouver could be a beacon for the rest of Canada and it would actually save and improve lives here."

Victoria Mayor Alan Lowe described the process in Victoria's 2007 Mayor's Task Force on Mental Illness, Addictions and Homelessness. Three teams – the expert panel, the gap analysis team, and the steering committee – created a report that is now

# Appendix III:
## The Collaboration for Change Forum

being implemented. Lowe attributed the success of the project to the public's desire for change, the narrow focus on targeted initiatives to serve the population most in need, the relatively small teams that worked on the problems, the lack of blame and the focus on solutions. The model and action plan focus on supportive housing first and assertive community treatment. Abstinence is not a requirement for housing and the model has a client-centered approach.

Towards the end of the day, Geoff Plant said the forum was designed to be a place to hear ideas and thoughts about what to do next in Vancouver to achieve the change that needs to happen. He noted that while the homelessness issue has been on the City's radar for a few years, and has received some attention from the province, participants in the Collaboration have been clear that there is an urgent requirement for action, in terms of housing and supports for those who are homeless and suffering from concurrent disorders. Plant said participants know a lot about the problems and also know, in broad terms, what the solution should be. What's holding people back from implementing solutions is that while everybody likes the idea of collaboration, it's actually hard work to collaborate. He suggested that any point of entry into the system must be a valid point of entry to the whole system. There must be clear outcomes articulating needs and evaluating how closely the system is meeting those needs. The people who use the system must have a voice in it. "What holds us back? It is, I think, in large measure, political will." Plant called for an initial project to get the process started.

In the discussion that followed, one participant said she felt like she was hearing two solitudes: On the one hand there is good work being done, but she's also hearing that the proper outreach doesn't exist for those who are homeless, mentally ill and addicted. She said she feels a business-like approach to the problem – a plan with real outcomes and systems for measurement – is missing and required. Another participant commented that there are a number of lessons to be learned from the HIV/AIDS epidemic. Social networks, stigma, discrimination, local enforcement practices, and the physical context of injecting environments all must be considered. He said cities have a huge opportunity to address these issues by focusing on healthy environments, structural determinants and municipal policy development, for example.

A participant asked if Victoria involved the homeless in its process. Mayor Alan Lowe said that the homeless community was somewhat involved in the process through a community survey to determine what their needs were. He felt they should have been more involved, because it would have led to stronger buy-in to the plan.

Several participants said they thought that an awareness campaign was needed to combat stigma and clarify the social, personal and financial costs of ignoring the issue.

At the end of the forum, Michael Kirby offered a conference recap, restating his belief that coordination and collaboration requires change, which demands that people give up some of the power and prestige they think they have. Considering what he's learned from his visits to Vancouver, he referred to some of the information presented at the conference and mused that, "The truth on the ground might not be as rosy as the overheads might suggest." Kirby noted that during the conference there was little discussion about the role of family caregivers. Yet, he said, a very significant part of the service delivery for this population is by family members and they must be part of the solution. He also noted that the role of the private sector was not raised until late in the forum. "You're never going to deal with this issue if you don't get the private sector involved." Kirby also advised that there must be a reliable set of numbers that can ultimately be used as evidence. That helps with outlining social implications as well as the economics of the situation. This case, he said, is one of the rare instances in social policy where it truly is worthwhile to have public and private investments now because they will lead to tremendous savings later. In the past 10 years, Kirby said, the problems of homelessness, mental health and addictions have been magnified and are now hard to ignore. He envisions that a large social movement of concerned citizens, combined with the increased visibility of the problem, will make the difference.

CITY OF VANCOUVER

# Appendix IV:

PROJECT Civil City

## Collaboration and Change:
## Evidence Related to Reforming Housing, Mental Health, and Addiction Care in Vancouver


SIMON FRASER UNIVERSITY
FACULTY OF HEALTH SCIENCES

# Collaboration *and* Change: Evidence Related to Reforming Housing, Mental Health, and Addiction Care in Vancouver

Requested by: the City of Vancouver

Prepared by: Dr. Julian M Somers, Director, CARMHA

# Collaboration *and* Change: Evidence Related to Reforming Housing, Mental Health, and Addiction Care in Vancouver

## Introduction

In Vancouver, the overlap between substance use, mental disorders, and homelessness has become a civic crisis. The goals of this paper are to quantify and characterize the problems currently faced by Vancouver, and to recommend solutions that are founded on the best available evidence.

This paper is a product of an initiative led by the City of Vancouver titled "Collaboration for Change". This initiative was launched in January 2008, and over a period of six months has engaged a wide array of stakeholders in the areas of health, housing, and social services. In addition, several Provincial initiatives have stimulated discussion and planning on issues that overlap with the agenda launched by Collaboration for Change, including initiatives to reform public housing, the justice system, and mental health services. Further planning has been stimulated by the Mental Health Commission of Canada, which launched an initiative to reduce homelessness among persons with mental illness in five Canadian cities, including Vancouver. These initiatives include many of the same participants, and despite differing areas of focus have implications for overlapping sub-populations. In this paper we incorporate relevant information drawn from several recent and concurrent initiatives. The purpose of this paper is to provide evidence-based guidance to improve the clinical and public health response to people whose needs substantially involve housing and the treatment of severe addiction and/or another mental illness (SAMI) within Vancouver.

We begin with epidemiological research in order to estimate the number of adults with SAMI in Vancouver. We then describe the subset of this population who are also in need of housing. We define the evidence-based blend of health and housing

services that are required in order to provide care to Vancouver's homeless SAMI population, and highlight those areas of service that are most urgently in need of growth. Equally important, we address the need to ensure coordination and integration of services. We conclude by presenting a model for organizing services that balances the need for growth with the need for integration, and guided by relevant experiences in other jurisdictions.

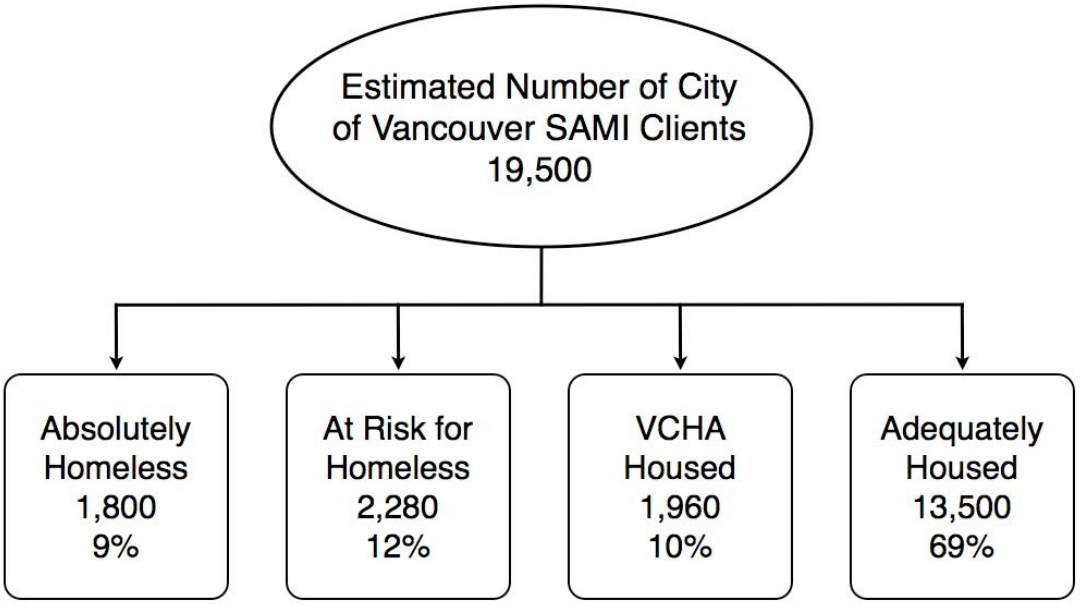
## The Population in Need

Not everyone who is homeless has a substance use or mental disorder. Conversely, not everyone with a substance use or mental disorder requires housing support (CIHI, 2007). Recent research in BC has estimated the number of individuals with SAMI across the Province as well as the proportion of this population that is homeless. Additional research has identified the overall service needs of people with SAMI, including the needs of those who are both homeless and have SAMI. The results of these complementary research initiatives serve as the basis for estimating the number of homeless SAMI individuals within the City of Vancouver, and the evidence-based services and supports required to meet their needs. We present major conclusions and directions in this paper, while the associated methodology and related details are available separately (see References).

A Provincial estimate of the SAMI population was prepared in 2007, based on the best available evidence from regional, Provincial, national and international sources. Estimates of the size of the SAMI population were calculated for each Health Authority (HA), adjusting for differences in the age of the population in different regions, as well as for co-morbidity. The estimated number of adults with SAMI in Vancouver Coastal HA was 33,000, with about sixty percent of those (19,500) living in the City of Vancouver. It must be emphasized that the available prevalence rates correspond to select clinical syndromes and severe levels of functional impairment. They do not take into account the prevalence of personality disorders, cognitive

disorders, or less severe forms of clinical syndromes (e.g., mild to moderate mood or anxiety disorders).

Figure 1. Housing Status of Vancouver's SAMI Population (2005)

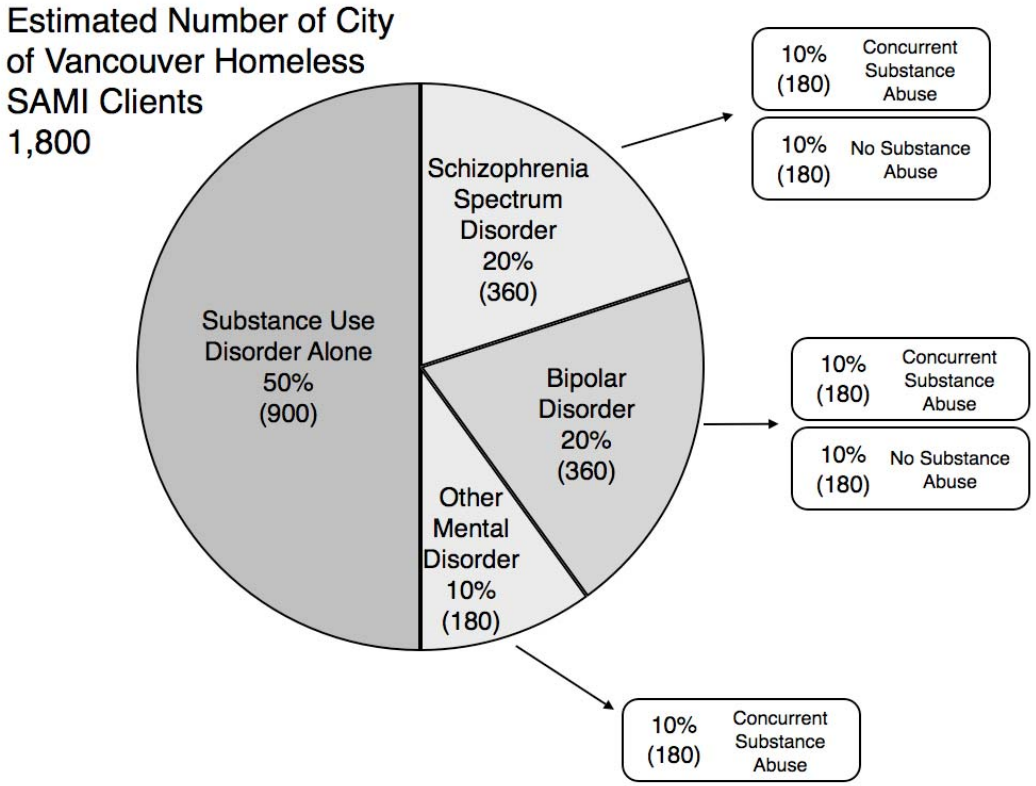



The housing status of the SAMI population varies widely, ranging from adequately housed to absolutely homeless. The condition of absolute homelessness is the focus of this paper. However, it must be emphasized that many people with SAMI are at risk of homelessness, due to the marked inadequacy of their current housing, deficiencies in the levels of support that they receive, and the severity of their individual symptoms. The distribution of Vancouver's SAMI population based on housing status is presented in Figure 1.

The homeless SAMI population in this model is comprised of individuals with diverse clinical syndromes and related health and social service needs. Epidemiological literature and other research suggests that approximately one half of Vancouver's

SAMI population has a primary substance use disorder that produces severe functional impairment. The other half of the SAMI population has other clinical syndromes (e.g., schizophrenia, bipolar disorder), often alongside a substance use disorder. The prevalence of major mental disorders resulting in severe functional impairment (including co-occurring disorders) among the SAMI population in Vancouver is presented in Figure 2

Figure 2. Prevalence of Substance Use and/or Mental Disorders Among Vancouver's SAMI Population




Clinical, social, and housing service needs vary within the homeless SAMI population. Diverse substance use services are required, ranging from withdrawal management to psychological treatment and drug substitution therapy. Public health measures (e.g., needle exchange, consumption facilities) require expansion in concert with the

advent of treatment. As noted above, substance use problems constitute the primary clinical need among one half of Vancouver's SAMI population. However, an additional 30% require substance use treatment *along with treatment for another major mental disorder*. An additional20% require treatment for a major mental disorder in the absence of a substance-related disorder. Additional medical and mental healthcare needs will vary on an individual basis.

Patient-centered care is an approach that matches particular services and interventions to the varying needs of individuals. Needs within the homeless SAMI population will vary among individuals at the initiation of treatment and over time, as patients progress from medical stabilization to the management of symptoms and recovery from illness. Healthcare as well as accommodation requirements must be assessed and modified in order to ensure that individuals are receiving adequate care, and also to ensure that they are not made dependent on levels of care or models of accommodation that compromise the continued achievement of physical, mental, and social independence and well-being.

Resource Gaps: Evidence-Based Services and Supports

Many high-quality services and supports have been developed in Vancouver and elsewhere in BC for people with severe addictions and/or mental illness. However, a number of significant gaps were highlighted when an evidence-based array of services was compared to existing resources (CARMHA Housing Report, SAMI Gap Analysis, VCHA Gap Analysis). When expressed in financial terms, current expenditures are approximately one-third of the amount required in order to sustain a complete, evidence-based complement of resources for the SAMI population in BC. However, the gap in care is much more complex than simply a lack of overall funding. Under an evidence-based system the majority of funding would be directed towards community-based (66%) versus institutional services (5%). Currently, approximately 53% of funds are directed towards community services, while 17% are allocated for institutional services. We focus below on the resource distributions within three

major service categories: the general health system; community mental health and addiction services; and institutional services.

General Health System

The general health system is the primary source of care for Canadians with substance use and mental disorders. Evidence-based care recommends a two-to-one ratio of funding between Physician/Specialist Services and Hospital-Based Services. Current allocations are approximately equal in each area of service. Greater emphasis is required on the expansion of general health services that are provided in the community (e.g., primary and shared care, and the provision of evidence-based psychological and psychosocial treatments). Further investments in this sector are needed for the SAMI population, but will also benefit other patients in Vancouver with less severe, but more common, substance use and mental disorders.

Community Mental Health & Addiction Services

Current investments represent about one quarter of the levels needed within the community mental health and addiction sector. The largest discrepancies were observed in relation to rehabilitation services, therapeutic/supervised residential services and substance-related services. Rehabilitation services include education and employment programs. Therapeutic/supervised residential services substantially consist of residential/high-support care. It is recommended that new residential/high-support care be in the form of independent supported housing rather than residential care facilities. Long-term residential treatment programs, concurrent disorder residential programs, community outpatient services, substitution therapies, and harm reduction services all need to be developed and/or enhanced to meet the needs of individuals with severe addictions. In addition, Assertive Community Treatment (ACT) needs to be implemented in Vancouver as elsewhere in BC. Development of ACT could reduce the need for tertiary, crisis-oriented, and institutionally based services (ACT Standards for BC, 2008).

Institutional Services

With the implementation of empirically supported community services, the need for institutional services is spared to a significant degree. Gaps in institutional care have been identified for specific sub-groups within the SAMI population, including long-term treatment for people with severe concurrent disorders. However, the greatest resource omissions for the SAMI population relate to those housing, health, and human services that enable people to achieve recovery and move forward with their lives in their neighborhoods and communities. The estimate budget to implement required services in Vancouver is $66,870,000 (Jones & Patterson, 2008).

The observed gaps in services and supports are a major reason for the current crisis in Vancouver. The lack of key components in an evidence-based continuum of care results in preventable harms to individuals, and preventable costs to society. It also compromises the effectiveness of current resources, ranging from police to emergency rooms, by continually challenging them to address needs that exceed the scope of their proficiency and primary mandate. Investments in adequate services are therefore associated with avoidance of costs due to the current burden on the courts, ambulance and emergency services, and police and other first responders. Based on available evidence, annual health and justice system costs for BC's homeless SAMI population are approximately $55,000 per person, which translates to nearly $100 million for the City of Vancouver. The implementation of evidence-based services and supports would mitigate current service volumes, reduce mortality and morbidity, improve quality of life, enhance public safety, and confer benefits to tourism, trade, and community businesses.

A major objective of evidence-based care for people with SAMI is to promote community integration and client recovery. Toward this goal, *how* services are delivered must be considered as carefully as *what* services are delivered. Unless services are effectively coordinated, the full value of even current resource

investments is unknown. Given that the needs of people with SAMI fluctuate over time, the intensity of support must vary accordingly.

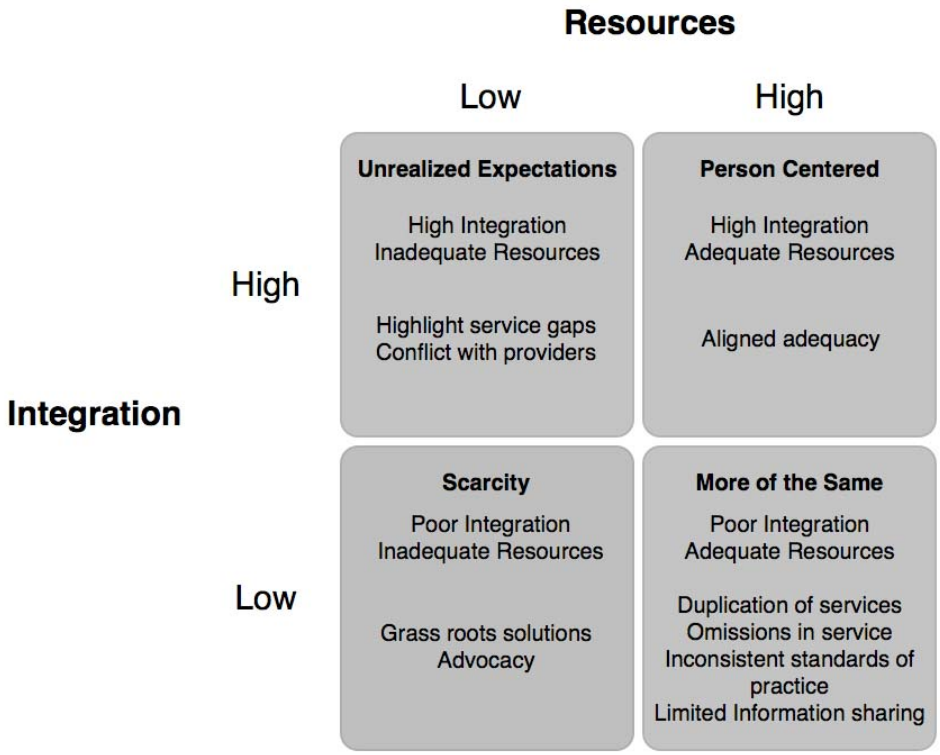
Integration: Coordinating Services and Supports for People

Vancouver's homeless SAMI population is not the sole responsibility of any single service provider. Over ninety agencies provide mental health or addiction services in Vancouver. Additional agencies address broader healthcare as well as housing and social service needs that include the SAMI population. Collectively, these services span across the administrative jurisdictions of several Provincial Ministries, the Provincial Health Services and Vancouver Coastal Health Authorities, numerous not-for-profit societies and foundations, peer support services, and other forms of care.

The need to coordinate services is underscored by the fact that the health and housing needs of each individual changes over time, requiring adjustments in various inter-dependent resources. It should be noted that there are examples of well-coordinated care within the array of services needed by the SAMI population, such as Assertive Community Treatment (ACT) and the Housing First model of supportive accommodation. However, coordination spanning the broader spectrum of resources is lacking.

The relationship between the expansion and coordination of diverse resources is illustrated in Figure 3. The lower left quadrant defines the circumstance where both resources and coordination are lacking. This is an environment of *scarcity*, and tends to precipitate grass roots solutions and a climate of advocacy on behalf of underserved constituencies. Meanwhile, preventable mortality and morbidity continue. This represents the least preferred environment.

Figure 3. Balancing Resource Expansion with Integration




A shift to the lower right quadrant is associated with the creation of more resources, but no enhancements to the processes that serve to integrate them. This quadrant signifies *more of the same*. Rather than solving complex problems, this approach tends to generate a climate of confusion among clients and service providers, based on the duplication of services, critical omissions in service, inconsistent standards of practice, and limited information sharing between providers. The *more of the same* approach is also confusing to the general public, who witness limited benefits despite significant public expenditures. This represents the second least preferred environment, because the amount invested in resources is not reflected in their performance.

The upper left quadrant represents enhanced integration, but with inadequate resources. This results in *unrealized expectations*, as illustrated in the early stages of Primary Care Trusts in the United Kingdom, where the cost of maintaining existing

required services (e.g., emergency rooms) precluded the development of expected innovations in care. Enhancements to integration, such as centralized referral or system-wide assessment, can serve to highlight service gaps. Other functions, such as a mandate for evaluation, or promoting evidence-based practice, lead to conflict with providers when service levels are inadequate. This approach can constitute a step toward balanced reform, and is therefore the second-best environment.

The upper right quadrant reflects a balance between resource expansion and integration across services. It corresponds to a *person-centered* environment, in which levels of care are matched to a patient's level of need. Relevant information and expertise is shared among diverse providers, avoiding fragmentation and helping to ensure that "every door is the right door".

The necessary introduction of services and integrative mechanisms must minimize disruption to existing resources and clinical services. We envision the implementation of essential but currently absent services alongside the creation of integrative mechanisms. We also emphasize the need for advanced educational positions that provide immediate and long-term support to the reform of British Columbia's health human workforce in the area of addiction. Educational reforms must include revisions to existing curricula, as well as the establishment of new programs. Accredited, high-quality training at the Masters level is urgently needed in order to foster the delivery of evidence-based psychosocial services. Building on experience in other jurisdictions, curricula should be designed to support new practitioners as well as existing professionals, and should be accessible through multiple BC campuses and with the active incorporation of e-learning strategies.

Other jurisdictions have developed organizational frameworks to coordinate resources and care for people with substance use, mental disorders, and other complex needs. This work serves as the basis for a recommended approach to reform in Vancouver. Specific coordinating functions include assessment and

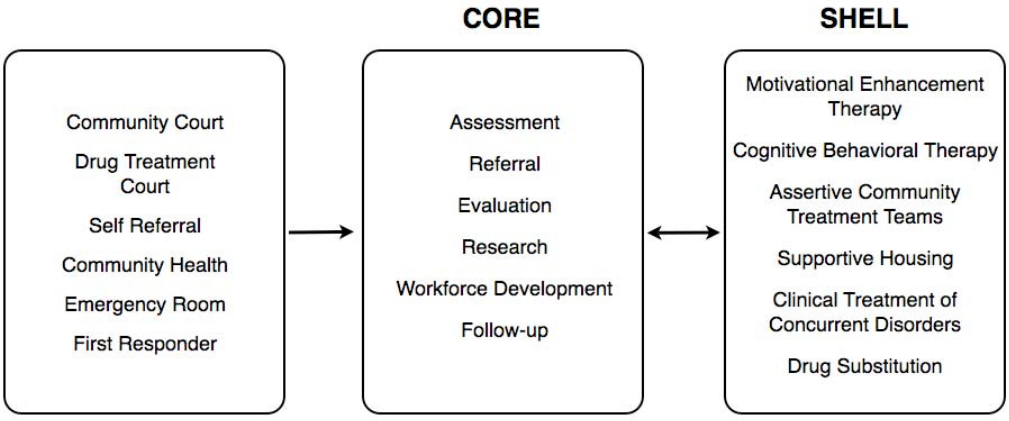
referral to services, promoting evidence-based practices, monitoring patient and client outcomes, systemic evaluation and accountability.

Organization and Governance

Authorities in the area of SAMI and homelessness have long recognized the inherent challenges posed by the traditional health and human service systems when trying to arrange care for people. The needs of SAMI individuals commonly transcend several areas simultaneously (e.g., concurrent mental and/or physical health problems, housing and employment needs, social service requirements). Moreover, services are often needed in a step-up (an initial intervention followed by more intensive treatment) or step-down manner (e.g., detoxification followed by outpatient treatment). These common features of client needs have stimulated the creation of organizational models that bring cohesion to diverse levels of care and resources (e.g., American Society of Addiction Medicine, Patient Placement Criteria).

One influential scheme for accomplishing these objectives is known as the Core-Shell Model (Glaser, 1974). Applied to the present context, the model (illustrated in Figure 4) identifies a "shell" of evidence-based community resources to serve the needs of Vancouver's homeless SAMI population. Services at the "shell" may or may not be deliberately integrated with one another, falling under different administrative authorities. The "core" operates at arms' length from service providers, and provides support to clients, service providers, and administrators by generating referrals, evaluating system performance, and providing educational support. In this model, referrals are person-centered, matching client needs to the broad environment of relevant clinical and social services. The use of evidence-based matching guidelines can strengthen the accuracy and efficiency of referrals (e.g., Merkx et al., 2006).

Figure 4. An Integrative Framework for Vancouver




The core-shell model was incorporated into a landmark report developed by the Institutes of Medicine, as part of a strategy to revitalize community based alcohol treatment services in the United States (IOM, 1990). Characteristics of the core-shell model are reflected in the operations of drug treatment courts (DTCs), which have grown in number from one court in 1989 to more than two thousand courts in 2007. DTCs are the most frequent single referral source to addiction treatment services in many parts of the US. Courts are also a common source of referrals in other countries, including Canada and the Netherlands. Vancouver's DTC is one of several potential sources of referral, alongside community court, primary healthcare providers, emergency rooms, housing service providers, and stabilization services for concurrent disorders.

The Dutch government instituted the core-shell model in 2002, in order to bring greater coherence and efficiency to a large number of scattered and diverse service

organizations (Schippers, 2008). In addition to the need for arms' length referral and evaluation, objectives of the Dutch government included the promotion of evidence based care and continuous quality assurance. These goals were addressed by instituting partnerships with academic centers, which drew upon their established expertise in order to address "core" functions such as evaluation, patient assessment, workforce development and professional training. A similar partnership model could provide much needed integrative and evaluative mechanism for persons in Vancouver. Significant longstanding collaborations are in place linking academic centers with service providers to address the needs of BC's SAMI population. Both SFU and UBC have established clinical and research units that are based in Vancouver, contributing expertise to civic, provincial, and national initiatives. The complementary strengths of UBC and SFU could be marshaled, and applied the development of professional development, evaluation, and person-centered referral processes. The operating principles of the core-shell model could be implemented, with assessment, client placement, evaluation, and clinical education taking place at arms' length from client services. In order to institute this vision, a governance coalition would need to be convened, with the authority to implement the following agenda:

a) Introduce patient placement criteria, matching patient needs to available resources in Vancouver
b) Fill the identified critical gaps in services
c) Implement clinical training programs for new practitioners in Vancouver and throughout BC
d) Conduct follow-up assessment of referred individuals
e) Implement continuing professional development programs for the existing health human workforce
f) Provide timely evaluations of services and supports of relevance to providers, funders, and clients, reflecting the highest level of research and accountability

Prior research, including papers cited in this document, has identified the critical gaps in services, as well as the need for person-centered, longitudinal coordination of resources. Significant investments are being made, and others will be required, in order to fill these gaps. The task of the proposed governance coalition would be to build on this established base of knowledge, and to manage the transformation of services for the SAMI population, ensuring that investments are coordinated, and balanced across a continuum of evidence-based care. To be successful, governance would need to represent the parties with major responsibility for SAMI services, professional education, evaluation, and policies in Vancouver, including: Community members, VCHA, PHSA, Provincial Ministries of Health, Housing and Social Development, Public Safety and Solicitor General, BC Housing, SFU and UBC. The governance coalition could be given a mandate to develop the business plan for major reforms related to the above tasks, followed by the implementation of the plan. Provincial support for the coalition's plan would be essential, subject to a full and regular reporting on results.

Important progress is being made to address the needs of Vancouver's SAMI homeless population. Additional reforms are urgently needed, which must be guided by a long-term vision of person-centered health. This vision requires the balanced cultivation of collaboration and change.

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