CITY OF VANCOUVER

JULY 28, 2008

Collaboration for Change:
A Progress Report

PROJECT Civil City

IN DECEMBER 2006, Vancouver City Council adopted Project Civil City goals which included eliminating homelessness with at least a 50 per cent reduction by 2010.

To move Vancouver closer to achieving this goal, the Civil City commissioner has focused on three broad themes, one of which is support to homeless and vulnerable populations. In support of this objective, Project Civil City has initiated and leads an innovative collaboration among a broad range of Vancouver's institutional and community stakeholders committed to addressing the urgent situation facing some of our most vulnerable citizens: those with mental health and addictions problems who are also homeless or living in acutely substandard conditions. This project is called the Collaboration for Change.

The purpose of this report is to summarize the work of the Collaboration to date, and in particular, to review the key elements required for continued progress towards solutions for those who are so critically in need.

The need

In Vancouver, the entanglement between substance use, mental disorders, and homelessness has become a civic crisis. According to research done using provincial estimates from 2007, approximately 19,500 adults with severe addiction and/or another mental illness (often referred to as SAMI) live within Vancouver's boundaries. Further work, relying on a 2008 study of Simon Fraser University's Centre for Applied Research in Mental Health and Addiction (CARMHA), indicates that approximately half of this population has a primary substance use disorder, while the other half has concurrent clinical conditions such as schizophrenia or bi-polar disorder.

In terms of treatment, half require substance use treatment, an additional 30 per cent need substance use treatment along with treatment for another major mental disorder, and 20 per cent more need just treatment for a major mental disorder.

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Homelessness has been growing. The March 2008 regional homeless count showed a 20 per cent increase in the number of street homeless and those staying in shelter in the Metro Vancouver

region – from about 2,200 homeless in 2005 to about 2,600 in 2008, with just under 1,600 people on the street and in shelters in Vancouver.

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From another perspective, taking a range of housing, health, income and other social indicators into account, the Vancouver Coastal Health Authority recently estimated that some 2,100 residents of the Downtown Eastside of Vancouver (DTES) constitute a "population in crisis", characterized by such circumstances as a lack of permanent housing, visibly erratic behaviour, significant addiction and mental illness, and high rates of HIV and hepatitis C. Moreover, as is well known, this population has significant interaction with the criminal justice system, as indicated in a report released by the Vancouver Police Department in February 2008 entitled Lost in Transition. More than one-third of all calls for Vancouver police involve people with mental health issues; in the DTES, this number increases to almost one in every two calls.

Among the other important elements of the crisis is the fact that aboriginals represent approximately 30 per cent of the homeless SAMI population and are over-represented in all critical areas.

Clinical experience and research also indicates that alternative approaches to service delivery to this population could avoid some or all of the costs incurred by the failure of the current system to meet the needs of homeless SAMI individuals. For example, the CARMHA study cited above concluded:

Excluding capital costs, the cost of providing supported housing and other health services to this population of adults with SAMI is lower than the cost incurred through use of emergency departments, the corrections system and emergency shelters when they are homeless.

The response

There has been significant progress in addressing these complex issues. The provincial government and the City of Vancouver have committed to building social and supportive housing on 12 building sites across Vancouver owned by the City. Over the past year, the Province has purchased 16 SRO hotels in the Vancouver's inner city for renovation and conversion to social and supportive housing. The Province is also developing a comprehensive 10-year Mental Health and Substance Use Plan for British Columbia which will underscore the need for a cross-government approach including health services, housing, income and support and other related areas. The Province has already announced one component of the plan: funding for the new Burnaby Centre for Mental Health and Addictions which is intended to be a provincial resource of 100 beds that will augment the current continuum of services and supports for this

population. Even more recently, the Province created a new ministry of Housing and Social Development that integrates responsibility for social housing with employment and income assistance and a stated responsibility for coordinating mental health and addictions services.

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These initiatives are significant and will make a real difference both in increasing the stock of available social and supportive housing, and in responding to the reality that the current system of housing and care does not adequately address the complex needs of those with concurrent disorders who are living on the streets of Vancouver. In particular, there is a lack of integration of planning, communication and knowledge exchange among the existing systems of care. Hospitals and mental health and addictions services, physical medicine and mental health services are not well connected. Observed gaps in services, as shown by the lack of key components in an evidence-based continuum of care, are a major reason for the current crisis.

The Collaboration for Change work to date

Against this evolving backdrop, last fall Vancouver's Civil City commissioner Geoff Plant, Dr. Michael Krausz, the LEEF Chair in Addiction Research at the University of BC, and Donald MacPherson, the City of Vancouver Drug Policy Coordinator, devised a process involving government, health, business, First Nations and non-profit groups. The intention was to explore ways to understand the status quo and the necessary ingredients of effective change. It was based on the belief that a critical component of a new approach in this area was collaboration among those affected by, and in a position to do something about, these issues – hence the title: Collaboration for Change.

In January, 2008 the Collaboration created a two-level structure: a group of experts to do the substantive work necessary to describe the problem and propose concrete policy responses; and an Oversight Committee of community leaders who would have the ability to both assist in the implementation of a new plan and to oversee, on behalf of the larger community, progress (see Appendix I for lists of participants). These two groups each met several times in early 2008. Draft documents were prepared to guide their work, and a record was made of the key insights at each meeting. One of the early conclusions of these discussions was that a great deal of work has already been done both to understand the scope of the problems and to propose actions to address them. For this purpose, an annotated bibliography of existing literature was prepared. It is attached as Appendix II to this report.

From the outset, it was intended to take the discussion about these issues into larger groups and to involve the public. Accordingly, a two day Forum on Mental Health, Addictions and Homelessness in Vancouver was organized

and took place at the end of April (see Appendix III for a detailed summary of the Forum). In brief, the public session on April 28 featured a presentation by the Chair of the Mental Health Commission of Canada, the Honourable Michael Kirby, and presentations by community members with direct experience of addictions, mental illness and homelessness. The invited dialogue session on April 29 included presentations that addressed the work being done to develop a national framework to reduce harms from drug use; outlined the work done in the City of Victoria by Mayor Alan Lowe's Task Force; summarized a wide range of provincial initiatives, and provided the perspective of Perry Kendall, the Provincial Health Officer. The Forum included opportunities for dialogue with all participants, including the public.

After the Forum, in recognition of the value in obtaining further expert assistance reflecting on the key issues, the Collaboration commissioned a paper from Dr. Julian Somers, the Director of CARMHA (which is attached as Appendix IV) on the scope of the problem, gaps in services and a potential model for service delivery in Vancouver which draws on successful experiences in other jurisdictions.

What we have learned

The Collaboration for Change process has helped build momentum among key government, community and business organizations, rooted in a shared consensus that addressing the issues of mental health, addiction and homelessness in Vancouver requires a sustained commitment to action and new approaches to service delivery.

Work has been done to improve our understanding of the scale of the problem, gather together the best research on effective programs and policies, and build consensus around the urgent need for a higher intensity of engagement and action.

There are significant initiatives already in place or underway which will make a major contribution to addressing the issues. This section of the report presents observations for the essential pre-requisites for the next stage work that is required to build on these initiatives, and transform the system of care and support so we can move from progress towards solution.

Addressing severe addiction and mental health problems at the community level is one of the biggest challenges for a caring society. The situation in Vancouver doesn't exist in isolation: it is connected to the same problems occurring in other municipalities. We can learn from best practices elsewhere, while at the same time build on our own expertise to create solutions which will best meet our unique circumstances.

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At each stage of the Collaboration consistent themes emerged. There is broad consensus that a truly effective, comprehensive response to the needs of the homeless who experience mental health and/or addiction problems should be client-centred, rather than "type of service" centred.

The implication of this re-orientation is that any point of entry to the system of care and support should be a point of entry to the entire system, or, to borrow a phrase repeatedly endorsed by participants, "every door is the right door," and should lead to an appropriate clinical pathway. For this to happen – that is, for services to reach a clientele that is, by definition, incapable of navigating complex, bureaucratically designed service frameworks – services should reach out to clients, not wait for clients to reach them.

While the discussion of these issues often uses labels and categories such as "homeless", "mentally disordered" or "chronically addicted", the reality is that we are speaking about – and trying to help – people whose circumstances and needs are complex, and who defy any one simple or easily predicted formula for assistance. Accordingly, clinical pathways should respect the unique circumstances and therapeutic needs of each client, while recognizing that connections between different parts of the system are crucial to assuring progress to stability and rehabilitation.

We heard a great deal about the concern that considerable resources are already expended in an effort to address these issues, without any apparent, or readily identifiable, success. In this regard, the observation of Philip Mangano, executive director of the U.S. Interagency Council on Homelessness, are apt:

*Our efforts are not to manage the crisis, or maintenance (sic) the effort, or to accommodate the wrong. Our work is to bring this disgrace to an end.**

* Testimony of Philip F. Mangano, Executive Director, Interagency Council on Homelessness, before the Committee on Veterans' Affairs, U.S. House of Representatives, September 12, 2002.

For this reason, participants consistently observed that every intervention should be driven by defined, measured and documented outcomes.

Everyone who participated in the Forum and in other parts of the Collaboration process was struck by the power and the passion of the stories we heard of the experience of clients and family members with existing services and programs. But more than just being moved by their histories, we learned from their insights into barriers and solutions. In any re-oriented system of care and service, those we are trying to help must have a voice in helping us understand and meet their needs.

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Initiatives which reflect these principles have the best chance of making a real difference on the streets of Vancouver. A model which exemplifies these principles, and has been shown to work in other jurisdictions, is set out in Dr. Somers' paper in Appendix IV.

The essential pre-requisites for transformative change

In an earlier section of this report we pointed out that there are many reports and proposals for programs and practices that could constitute elements of a comprehensive system of effective service and support. But a critical insight of the participants in the Collaboration is the need for something other than "more" services and support. The time is right to build on the good work that has been done and create momentum for truly transformative change. There is a high level of collective understanding and expertise available to bear down on these issues. When we look at where success has been achieved and try to draw the lessons for what is required to move from progress to solution, we think there are four critical components:

i) political leadership

Transformative change requires political leadership. All levels of government have undertaken significant initiatives to help address these issues. But with the recognition that movement from where we are to where we want to be will require new intensities of collaboration and integration, we believe a necessary element of a transformed system is publicly visible, political collaboration across and within the levels of government. This would serve both as a marker of the need for joint effort and as a platform to ensure substantive change is integrated into government agendas and implemented on the ground. Our objective here is not to be prescriptive about the precise form such leadership should take, and indeed, in the weeks since the Collaboration Forum at the end of April, the provincial government has taken a major step in acknowledging the importance of integrated service delivery by creating the new ministry of Housing and Social Development, bringing under one umbrella many of the provincial program responsibilities which are relevant to these issues. Further steps which established visible linkages between the province and the City would help build the necessary bridge between the different responsibilities of various levels of government.

ii) a role for the community

Achieving real success in addressing these complex issues requires the support and engagement of the whole community. There are important roles and responsibilities here for service providers, non-profits, interest groups, community agencies, philanthropists, concerned citizens, and the clients themselves. Everyone has a part to play in reaching across silos, and re-orienting the system of care and support to put the client at the centre, in place of the agendas of individual agencies and organizations.

The potential tasks here include:

- Reporting on the scale of the issue and the progress in addressing it.
- Acting as a forum for community-led discussion on challenges and solutions.
- Designing and implementing plans and actions.
- Sharing best practices and facilitating service integration among participants.

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Again, our role is not to define the precise shape of the community's engagement, but we observe that some building blocks are already in place. For example, the Oversight Committee made a critically important contribution to the work of the Collaboration for Change, and its membership includes the people and organizations who are community leaders.

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In addition, there has been work undertaken over the past few months to establish a Vancouver-based charitable foundation called StreetoHome as a catalyst for a community-based commitment to end homelessness. Once established, the board of this foundation will be a significant source of community support and engagement in these issues. The community itself will have to work over time to find the most effective vehicle for its role and responsibility in these issues, but the critical point is that government cannot do this work alone: the people, organizations and leaders of Vancouver are vitally important ingredients in the work of achieving transformative change.

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iii) initiating change with early action

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There are different perspectives on the scope of the problem, and a recognition that an approach which effectively reaches into the root causes of homelessness and related issues of mental health, addictions, HIV/AIDS, other health issues, and poverty needs to embrace a larger population than those who are, at present, most critically marginalized. But there is also a strong consensus around the urgent need to help those who most need help.

It is not necessary or desirable to wait for the perfect approach to be developed before taking action that will make a difference by providing support and services within an integrated, evidence-based system of care. Canada's Mental Health Commission has $110 million available to fund projects in five Canadian cities, including Vancouver, over the next five years on a basis which offers an opportunity both to enhance service integration and evaluate outcomes.

The work done by Ken Dobell and Don Fairbairn in preparing their report for the City of Vancouver in 2007 entitled More than Just a Warm Bed strongly suggests that there are untapped philanthropic resources available in Vancouver that could be called upon to support initiatives in this area. The provincial government and its health authorities have undertaken significant new initiatives recently, and there may be opportunities for more.

The paper prepared by Dr. Somers offers a tested proposal which would transform the delivery of services in keeping with the key lessons of the Collaboration. All of this is to say that there is an opportunity for early action. And a consistent message throughout the work of the Collaboration is that action is needed. Thinking about what next steps could and should be leads us to our fourth observation.

iv) everyone must be in the room

It is trite to say that these are complex issues. The existing array of services and programs – it may be too much to call it a system – is inevitably complex, given that the

range of needs and appropriate interventions is so diverse. But the proliferation of agencies, departments and ministries, each with some measure of responsibility for a particular program or service, cannot help but challenge the objectives of coordination and integration. Agencies, departments and ministries are all forced to compete for scarce public and private funds, and they have different areas of interest and perspective.

There is evidence of conflict, overlap, duplication, rivalry, and continuing uncertainty about who really has responsibility for what.

To give just one set of examples, there are some addiction treatment service providers who require abstinence as a pre-condition for acceptance into their programs, while others do not. Rather than argue about which approach is correct, the likelihood is that each has its role to play for the different therapeutic needs of its own client base. But at the same time, when the sector is viewed as a whole, there is evidence of conflict, overlap, duplication, rivalry, and continuing uncertainty about who really has responsibility for what.

Some competition among service providers is healthy; properly overseen, and where linked to performance outcome measurement, it can encourage an environment in which success is rewarded. And, given the essential complexity of the client needs it is at least impractical, and perhaps wrong in principle, to seek to strive for one, simple, over-arching structure. But the work of the Collaboration has made it clear that the best chance for a real transformation of the system is when the process of system review and reform is inclusive, rather than when those who have a part to play are excluded.

Inclusive processes are unwieldy and require hard work and patience. But our experience tells us that when people come together to seek a measure of consensus, informed by evidence, the result is that it becomes easier to find and agree upon new approaches. We have learned that the most effective way to make a difference for the people we are trying to help is to ensure that they have access to the widest range of useful interventions – from safe and secure housing, to treatment for addictions and other mental and physical health issues, to social assistance and skills training and more, within a framework that is evidence and outcome-based, and coordinated and integrative. The only way to achieve a truly transformed system of support and care is if everyone with a stake in the outcome is in the room to do the work of transformative change.

Conclusion

The next steps in the Collaboration for Change process will be guided by the insights obtained in the work to date and focused on the key elements needed to achieve transformative systems change:

- political leadership
- a role for the community
- early action
- inclusiveness

The Collaboration for Change will continue to bring together a diverse array of people from across the community to lead the necessary public discussion. We conclude with a reminder that people living with mental health and addictions problems have a lot to teach us as we move forward.

The Collaboration for Change will continue to bring together a diverse array of people from across the community to lead the necessary public discussion.

We must work with them in order to benefit from the extensive experience individuals have in navigating the system. With their help, we can create a truly person-centred, inclusive, integrated and responsive system of care that includes all residents of Vancouver, which can, in turn, become a model for the rest of the country.

More information on Collaboration for Change:

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