Edmonton Homeless Commission

Final Report:

Study of the Homeless in Edmonton with Intensive Needs

By: KPMG and OrgCode Consulting

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1. Executive Summary

Since 2009, the Edmonton Homeless Commission (EHC) has overseen numerous partners working to implement *A Place to Call Home – Edmonton's 10 Year Plan to End Homelessness* (The 10 Year Plan). In alignment with The 10 Year Plan, the EHC recently identified the need to explore better ways to house and support a segment of the homeless population whose intensive needs have not been addressed effectively to date by the housing and support options available in Edmonton. In July 2011, the Edmonton Homeless Commission engaged KPMG and OrgCode Consulting to conduct a study with the following objectives:

1. Describe the profile of the target population and their needs;
2. Outline the current state of housing and supports available to meet the needs of this population, and analyze the gaps in what is currently available;
3. Identify local promising practices and opportunities for improvement, as well as best practices elsewhere; and
4. Make recommendations about how best to support the homeless who have very intensive support needs.

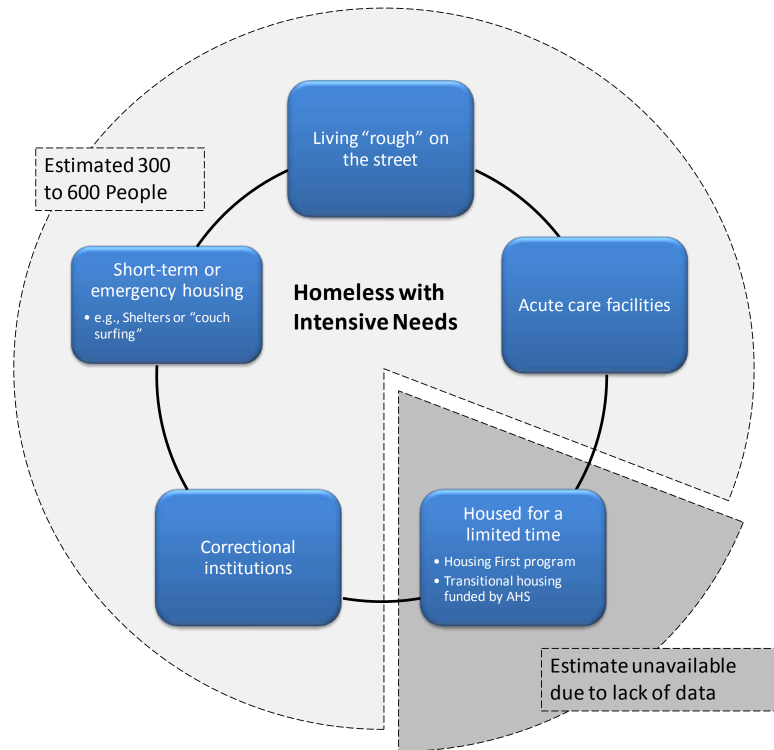
Population Profile

Members of the homeless population with intensive needs are challenging to characterize. In the broadest sense, their functional abilities are severely limited by the intensity and interaction of the challenges they face, which include more than one of the following:

- Severe mental illness;
- An acquired brain injury;
- An intellectual disability;
- A significant substance abuse problem;
- Pose a significant risk of harm to self or others;
- Require intensive support and would benefit from receiving coordinated services; and/or
- For whom the existing service system is not working.

These individuals are known to be highly vulnerable to abuse and exploitation, and are known to frequently engage with multiple service systems (such as health, police, emergency,

corrections, justice, etc.). Edmonton stakeholders emphasize that multiple service systems are – and need to be – involved in meeting the needs of this population.



It is estimated there are between 300 and 600 individuals in Edmonton who fit this population profile, not including those currently housed on an interim basis who are likely to become homeless again. This is not a scientific or precise estimate, owing to the limited availability of reliable data, but it serves as a reasonable illustration of the order of magnitude of the challenge.

Homeless individuals with intensive needs require a costly blend of services from different organizations and sectors, including health, police and corrections, emergency services and community services. Their cycle of homelessness and need has a large impact on service capacity and prevents efficient use of resources within each sector, at tremendous cumulative cost. Stakeholders expressed that individuals in this segment of the homeless population are extremely high users of services in all of the sectors being examined. It is well established that intervention is required to stabilize and house these individuals so that overall costs can be reduced.

The Case for Action

Given what is known about the homeless population with the most intensive needs, the case for ending their homelessness is clear:

- *For the target population*, there is potential to break the cycle of homelessness, deal with some of the challenges that they face, and improve quality of life.
- *For service providers*, dramatic cost savings are possible, together with increased efficiency and capacity of service delivery.

- *For government and taxpayers*, investing in ending homelessness for these individuals will save money over the long term.
- *For communities*, ending homelessness means fewer people living on the street, in shelters, or in inadequate housing, which translates to less crime, victimization and social disorder.

Assessment of Current Housing and Supports

No ready inventory of available services exists in Edmonton for the target population. However, stakeholders identified a number of strong themes about how this population is currently served in Edmonton, and what the gaps in service are:

- Housing supply and support capacity is not sufficient to meet demand.
- There are a number of barriers to accessing existing services that are unique to this population.
- Coordination of services and service sectors is not sufficient to address the presenting intensity and combination of needs.
- No single solution currently exists in Edmonton to address the needs of the target population.
- A continuum of supports from multiple sectors is required. There is no “one size fits all” solution to meet the range of needs that present; multiple options with different blends of support services are needed.
- There is a need for better integration of housing and health services.

Local Promising Practices

Several promising practices in Edmonton could be expanded, replicated and/or augmented to better serve the homeless who have intensive needs, including:

- There are long-term, supportive housing programs currently operating in the city that have experienced success serving the target population for this study (e.g., Grand Manor, Urban Manor and People in Need Shelter Society).
- There is considerable expertise within Edmonton’s housing sector in providing supportive housing in alignment with a Housing First philosophy.

- Several programs/facilities offer harm reduction programming, including Urban Manor, Grand Manor and the George Spady Centre.
- The Edmonton Police Service is making changes to enhance their traditional approaches to enforcement, and to work more effectively in addressing intoxication, social disorder and crisis situations that frequently present among the population of homeless with intensive needs.
- The release of *Creating Connections: Alberta's Addiction and Mental Health Strategy* in September of 2011 is an extremely promising step toward closer collaboration with the housing sector. In this strategy, AHS commits to improving supports for the homeless, as well as individuals with complex needs, and singles out both of these populations as priorities for action. In fact, the strategy explicitly sets the stage for greater AHS participation in a Housing First approach. This represents a critical shift in serving the homeless with complex, intensive needs and suggests tremendous future opportunity for partnerships between health and housing stakeholders to address the intensive mental health and addiction challenges of this population with stable housing as a foundation.

Each of these promising practices aligns with the Housing First philosophy embraced in Edmonton under The 10 Year Plan. Not only has this philosophy been endorsed by the community and multiple levels of government, but it is showing success in our city and in jurisdictions across North America.

Permanent Supportive Housing as a Leading Practice

Research and the experience of other jurisdictions suggest Permanent Supportive Housing (PSH) as a leading practice for the target population. No single model of PSH exists that can simply be transplanted from city to city. PSH models vary greatly across dimensions including affordability, access, concentration, building design and density, community relationships, and specializations. Furthermore, a need for multiple types of PSH in Edmonton was revealed through this study. Key considerations that were strongly agreed upon include an emphasis on safety, the desire for 24-hour staff support, on-site supports, and anonymity of the housing among other buildings.

It is difficult to accurately estimate the costs of implementing new PSH in Edmonton. However, costs increase as the needs of the people served increase and become more complex. Three options for PSH to support individuals with high intensity needs are identified, characterized as

single detached, four-plex, and 20-unit housing models. Cost estimates for these options range from $135,000 to $180,000 per person, per year, plus capital investment.

Conclusions

Analysis of the current state of the housing and support sectors in Edmonton, combined with relevant research, suggests that:

1. At least 300-600 individuals with intensive needs are currently homeless in Edmonton. This is a conservative estimate as it excludes those currently in transitional housing who are at risk of becoming homeless.
2. More supportive housing is required. Current supply is not adequate to meet the needs of homeless individuals with intensive needs.
3. The costs of homelessness exceed those to appropriately and permanently support individuals with high needs.
4. Permanent Supportive Housing is a leading practice for serving the homeless who have intensive needs.
5. Additional supportive housing approaches are required to address the range and intensity of needs that present among this population, although there are promising practices in Edmonton that can be built upon. It will therefore be necessary both to enhance current programs and to develop new supportive housing options.
6. Supportive housing requires coordinated service delivery from multiple service systems and, in particular, requires strong integration with mental health and addiction supports.

Recommendations

This analysis indicates that while supportive housing is required, there are also several more foundational pieces required to ensure successful, long-term housing and supports for individuals with intensive needs. Accordingly, several actions are recommended to end homelessness among the target population, including but not limited to discussion of number, size and location of PSH. Readers should note that the recommendations are not directed at any one audience; rather they represent important steps that should be embraced by the wide range of stakeholders involved in this important work. Key recommendations include:

Design actions to specifically support homeless individuals with intensive needs.

As anticipated by The 10 Year Plan, some of Edmonton's homeless require long-term, supportive housing to end the cycle of homelessness. Given the complexity of their situations, it is imperative that actions be specifically designed for homeless individuals with intensive needs. There is a clear case for investment from multiple sectors to address the needs of this population in particular, based on the tremendous potential for cost savings, as well as the need for coordinated action in order to stabilize this population and reduce usage of multiple service systems.

Increase the availability of Permanent Supportive Housing in Edmonton.

Edmonton's housing sector does not currently have adequate capacity to appropriately house and support those homeless who have the most intensive needs. **Permanent Supportive Housing (PSH) presents an opportunity to end homelessness for those homeless with the most intensive needs**. Not only does PSH align with the philosophy and vision for Edmonton's housing efforts under The 10 Year Plan, but it has also proved to be successful in jurisdictions across North America. In fact, the National Alliance to End Homelessness (USA) recently stated the following:[1]

> *One policy alternative that is proven effective in reducing chronic homelessness, as well as public health care costs, is permanent supportive housing. Permanent supportive housing programs provide affordable housing accompanied by supportive on-site or community-based services such as mental health and substance abuse treatment, health care, and other ongoing supports…A mounting number of studies and documented success stories definitively find not only the cost effectiveness of permanent housing interventions in reducing emergency room costs, but marked success in reducing chronic homelessness.*

Some PSH exists in Edmonton, but additional capacity for a minimum of 300-600 individuals is required to meet current unmet demand for PSH. Recognizing that it may take time to establish adequate PSH capacity, it may be possible to expand or enhance existing programming.

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[1] National Alliance to End Homelessness. Federal policy brief released August 4, 2011. Available online at http://www.endhomelessness.org/content/article/detail/4148. Accessed August 25, 2011.

Improve coordination among partners who have a stake in ending homelessness for this population.

This particular segment of the homeless population not only presents complex needs, but also demonstrates complex interactions with multiple service systems, including but not limited to health and housing services. Systemic gaps must be closed; health, housing, emergency, police and corrections service systems have proven ineffective in isolation in meeting the full scope of needs that present among this population. A more holistic approach that integrates different services with stable housing is required to end their homelessness, improve quality of life, and reduce the need for costly support services.

It is clear that no one program or model will address the entire range of needs faced by the target population. A continuum of supports is required to end homelessness for the most challenging subset of homeless in our city – meaning that multiple supportive housing options are required to address the quantity, variety and combination of needs that present among this population. To achieve this, coordination among government, community and agency partners should be enhanced in a number of ways, leading to:

- A broader, more strategic approach across the housing sector to address gaps in service, resolve duplication of service offerings by different agencies, and explore opportunities to share administrative and specialized resources.
- Efforts by police, AHS (including emergency and specialized service areas), and agencies to together define the protocols, partnerships and resources required to address acute and crisis situations. Stakeholders have suggested that there are gaps in shorter-term, reactive services to address day-to-day situations that occur in part because of the fact that these people are homeless, including health and mental health crises, social disorder and public intoxication.
- Attachment of health services resources to the capital and operating funding for PSH projects.
- Stronger partnerships between supportive housing projects and institutions from which individuals may be discharged without stable housing (i.e., both correctional and health facilities).

Implement PSH in a manner that is customized for Edmonton.

More than one model of Permanent Supportive Housing is required in Edmonton, and the delivery of these models should happen concurrently so that people can choose the option best suited to their needs. Key considerations for how best to address gaps in service for the homeless with intensive needs in Edmonton include:

- PSH should align with the philosophy and practice of Housing First in Edmonton.
- More harm reduction-focused housing is required that is tolerant of substance use and related behaviours.
- Services that resonate with the cultural perspective of Aboriginal people in Edmonton are important in working with many of Edmonton's homeless who have the greatest needs for support.
- Those with the most complex challenges should be served first. This includes, but is not limited to, persons with cognitive functioning challenges.
- Assertive outreach is necessary to overcome barriers to access, and in particular to reach those individuals "living rough" on the street, and those who have not been willing or able to access existing programs.
- Housing models on a small scale – less than 30 (or even 20) units – are likely to be more successful at integrating within communities in Edmonton.
- Ghettoization should be avoided, and community resources should be engaged appropriately. PSH projects should ideally be located in well-developed communities to enable integration, a broad network of support, and opportunities for healthy participation in community life. However, it may continue to prove difficult to locate PSH projects, which can be controversial, within established communities do to opposition from residents. Innovative solutions, political will and/or different locations may be necessary to establish adequate PSH in Edmonton.
- Transparent access criteria are important to ensure that PSH is not used as a "dumping ground" for people deemed hard to serve by a given agency or institution.
- Community-based operators can help make PSH successful since they have established trust in the community and they have experience with potential clients.
- To ensure sustainability, there is need for a long-term commitment of resources (i.e. in the order of 25 years).

2. Introduction

This report concludes a study completed for the Edmonton Homeless Commission by KPMG and OrgCode Consulting. **The study is intended to provide insight to the Homeless Commission, policy makers and partners in ending homelessness about how a particular subset of Edmonton's homeless population who have intensive needs could be better served in our city.** The specific objectives of the report are to:

1. Describe the profile of the target population and their needs;
2. Outline the current state of housing and supports available to meet the needs of this population, and analyze the gaps in what is currently available;
3. Identify local promising practices, best practices from other jurisdictions and future avenues to address the needs of this population; and
4. Recommend how best to end homelessness for this subset of the homeless population.

Project Background

This project is intended to explore better ways to house and support a segment of the homeless population whose intensive needs have not been fully addressed to date by the housing and support options available in Edmonton. This work builds on the efforts of the Edmonton Homeless Commission (EHC) since early 2009 to oversee *A Place to Call Home – Edmonton's 10 Year Plan to End Homelessness* (The 10 Year Plan). The primary goal of the plan is to find a permanent home for people who have no place to live, to give them a chance to live again, regardless of their past or present issues. This approach is founded on a strong base of evidence that proactively housing the homeless has tremendous economic, social and community benefits. In addition, the plan embraces a **Housing First philosophy** that people must first be securely housed in order to successfully address the range of issues responsible for their homelessness. Already, the tide of change in our community is being felt; more than 1,350 people have been housed under this initiative in just 2 years, and homeless numbers have declined.

The 10 Year Plan is founded on a Housing First approach. Housing First can take different forms in its implementation, and so it is important to distinguish philosophy and methods. **The 10 Year Plan describes the Housing First philosophy as follows**:[2]

> *The 10 Year Plan developed by the Committee focuses on the Housing First principle. Shelters and drop-in centers and other emergency supports, do not solve the problem of homelessness, they simply manage the crisis. The Housing First approach says the first step in solving the problem is to find people permanent homes and give them the support they need to be successful in those homes. This philosophy represents a shift away from the theory that people have to be 'prepared' or 'transitioned' into housing by first dealing with mental health and addiction issues or finding a job. It recognizes that the best place to deal with those issues is not living on the street but in safe, secure housing.*

In recent years, jurisdictions across North America have taken steps to refine and augment their Housing First efforts in collaboration with health systems and other partners in order to target a more complex, challenging population of homeless with very intensive needs. In line with this trend, **taking a deliberate approach in Edmonton to housing and supporting this population is a natural and predictable next step to build on the progress to date under The 10 Year Plan.** In fact, The 10 Year Plan anticipates the need for more long-term supportive housing, understanding that a variety of supports and service systems are required to address the range of needs for those who find themselves homeless. The Edmonton Homeless Commission has initiated this study to determine how best to support the population with very intensive needs going forward, in alignment with the Housing First philosophy of The 10 Year Plan.

Methods

This study combines findings from research and stakeholder consultation. Data collection activities included:

- Reviewing research on Permanent Supportive Housing over the past decade.
- Reviewing a wide range of Permanent Supportive Housing models.

[2] Edmonton Committee to End Homelessness. (2009). *A Place to Call Home: Edmonton's 10 Year Plan to End Homelessness*.

- Working with staff from Homeward Trust Edmonton to review existing Housing First information within the Efforts to Outcomes database.
- Conducting semi-structured interviews with Housing First stakeholders in Edmonton, including various Team Leads, Executive Directors and Senior Program Officers from non-profit agencies and staff from Homeward Trust Edmonton.
- Conducting interviews with Persons with Lived Experience who were currently longer-term homeless with one or more barriers to housing, and who self-identified as a likely candidate for Permanent Supportive Housing.
- Consulting with various Permanent Supportive Housing operators and practitioners throughout North America.
- Engaging in discussions with subject matter experts from the Corporation for Supportive Housing, Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Alliance to End Homelessness.
- Select organizations in the housing sector were invited to participate in key informant interviews. In addition, all Housing First organizations were invited to attend and participate in a focus group discussion. Altogether, the following housing organizations from Edmonton and elsewhere contributed to this report:
    - Boyle Street Community Services
    - Boyle McCauley Health Center
    - Jasper Place Health and Wellness Centre
    - YMCA
    - DiverseCity
    - George Spady Centre
    - E4C
    - Homeward Trust
    - Common Ground
    - Houselink
    - Homes First Society
    - Fred Victor Centre
    - Mainstay Housing
    - Ecuhomes
    - Portland Hotel
    - Bosman Hotel
    - Corporation for Supportive Housing
    - National Alliance to End Homelessness
    - Canadian Mental Health Association
    - South Loop

- DESC – 811 Eastlake
- City of Portland
- Pathways to Housing (USA)
- City of Toronto
- SAMHSA

- Stakeholder interviews were also completed with the following individuals, many of whom were also able to provide relevant data and/or research:
  - Nancy Fraser, Alberta Health Services
  - Marni Bercov, Alberta Health Services (Justice Services)
  - The Edmonton Police Commission – Vulnerable Persons Subcommittee and Executive Director
  - Edmonton Police Service Inner City Police and Crisis Team
  - Inspector Ed Keller, Edmonton Police Service
  - Susan McGee, Executive Director of Homeward Trust Edmonton
  - Dr. Daniel Li (President, Medical Staff Association, Alberta Hospital Edmonton) and physician colleagues from AHE
  - Dr. Balachandra, AHE and Pathways to Housing (provided written submission)
  - Dr. Peter Silverstone, University of Alberta Hospital
  - Daryl Procinsky, ONPA Architects
- An Advisory Group was convened by the EHC to provide input based on the project's Interim Report. This group included:
  - Nancy Fraser, Alberta Health Services
  - Susan McGee, Homeward Trust
  - Inspector Ed Keller, Edmonton Police Service
  - Bob Haubrich, Pathways to Housing
  - Lorette Garrick, George Spady Center

A note regarding cost analysis: This study recognizes that the case for reduced government and service system costs – particularly health care costs – through Housing First and Permanent

Supportive Housing is well-established, and supported by considerable evidence from multiple jurisdictions. No attempt has been made here to recreate this case here. Further, local data is not sufficient to project or interpolate specific cost savings in Edmonton as a result of successfully housing the particular subset of the homeless that is the focus of this study.

3. The Case for Action

The Edmonton Homeless Commission is seeking to determine the best way(s) to end homelessness for those homeless in our city with the most intensive, complex needs. This task is complicated because **the population itself is difficult to define and to count, making it challenging to illustrate the magnitude of need**. **It is clear, however, that this subset of the homeless consumes a high-cost blend of services, and that better meeting their needs therefore has strong potential to benefit these individuals, the community, and service systems.**

Population Profile

The subset of the homeless population who have the most intensive needs are a challenging group to define in a narrow way because they:

- Do not all necessarily share the same needs or challenges;
- Have not been accurately counted, and are difficult to count because of their homelessness, and because different organizations do not identify them in the same way;
- Are not all living on the streets – many are living in institutions with no appropriate home to go back to in the community;
- Tend to interact with multiple service "systems" (such as health, police, emergency, corrections, justice, etc.) but do not necessarily share a consistent pattern of service use; and
- Are identified and understood differently by different stakeholders in the Edmonton region.

Stakeholders from the health, justice and housing sectors in our city describe a similar population of homeless with extremely high needs that frequently come into contact with the services within their respective sectors – but each stakeholder group understands and identifies the population somewhat differently. On the other hand, analysis of input from these multiple

perspectives does reveal several unifying factors that help to clarify a shared understanding of who the target population includes. [3,4]

Population Profile: Homeless with Intensive Needs

Homeless people (including those inappropriately institutionalized because appropriate housing and supports are not available in the community) who experience **more than one of the following challenges, which together compound their difficulties in sustaining housing and maintaining a high quality of life**:

- Severe mental illness;
- An acquired brain injury;
- An intellectual disability;
- A significant substance abuse problem;
- Pose a significant risk and/or are destructive to themselves, others or property;
- Require intensive support and would benefit from receiving coordinated services; and/or
- For whom the existing service system is not working.

In addition, stakeholders suggest a range of related factors that may overlap with these factors for some – developmental delays, entrenchment in street culture and a history of criminal behavior, for instance. In any case, functional abilities are severely limited in all cases by the intensity and interaction of these challenges.

This population can also be described succinctly as follows:

> *[They] are well known to the service system. They experience a combination of long-term problems that are spread across most areas of their lives such as mental illness, intellectual disability, an acquired brain injury, substance abuse, a history of childhood problems, family dysfunction, social isolation, unstable housing, poverty and dependence on welfare agencies. They may be highly vulnerable to abuse and exploitation and/or display anti-social or challenging behaviours, which put them and others at risk. These individuals often engage with the service system when in crisis or when they come to the attention of the criminal justice system.*

In Edmonton, there are also significant geographical and cultural considerations – the homeless population in question **tends to be concentrated heavily in the downtown core and in health or correctional facilities**, and **includes a significant proportion of Aboriginal people**. Further, Edmonton stakeholders emphasize that multiple service systems are – and need to be – involved in meeting the needs of this population, but that individuals must choose to access intensive, community-based supports (i.e. they cannot be forced to change their lives).

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[3] The following list of challenges reflects input from multiple Edmonton stakeholders, however the list itself is adapted from: Government of Western Australia. (2007). *People with Exceptionally Complex Needs Project: Phase 1 Report.* Department of the Premier and Cabinet, Social Policy Unit.

[4] The descriptive paragraph quoted here, which mirrors input from Edmonton stakeholders, appears in: Department of Human Services Victoria (2003). *Responding to People with Multiple and Complex Needs: Phase One Report*.

How many individuals are there in the target population?

Available data does not allow a precise estimate of the number of homeless (including institutionalized) individuals who fit this population profile, primarily because they are difficult to isolate and they are understood differently within each service system with which they interact. Moreover, housing sector stakeholders point out that this ambiguity is to be expected; part of the work of implementing Housing First in Edmonton involves gaining a greater understanding of the range of needs to be addressed and adapting approaches accordingly. Despite these challenges, those consulted have provided some qualitative information that permits a rough "order of magnitude" estimate:

- A point-in-time analysis by Alberta Health Services (AHS) in December of 2010 determined that 18% of acute care mental health beds in the Edmonton region were occupied by individuals who fit this profile. This translates to 113 people that the health system was unable to discharge to the community due to a lack of appropriate housing and supports to meet their intensive needs.
- Since January, the Edmonton Police Service's Inner City Police and Crisis Team has received referrals for 172 individuals. They have further estimated that up to ¼ of the homeless population (approximately 600 people, based on the most recent homeless count) demonstrate severe mental illness and addictions challenges.
- Approximately 277 people (17%) were unsuccessful in sustaining their housing within Housing First programs during the first two years of operation, some of whom belong to this population. If one were to extrapolate the 17% rate to the entire homeless population of 2,421 (counted) individuals, over 400 people would be unlikely to succeed within current housing programming. We know, however, that people have not succeeded in Housing First for multiple reasons (thereby decreasing the estimate), and

EPS Inner City Police and Crisis Team

- *A partnership with AHS; also some Safe Communities Innovation Fund support*
- *Combines 2 officers with a social worker and psychologist*
- *Works with those experiencing mental health or "social" crises; aggressive outreach combined with referrals from shelters and police*
- *Conduct assessments and try to connect individuals with needed supports*
- *Proactive, team-based outreach and follow-up*
- *Downtown focus*
- *Weekday service*

that some of the target population who are unlikely to succeed have not been able to access Housing First (which would increase the estimate). Thus, this figure serves only as a rough approximation and not a reliable estimate. It is also worth reiterating that the Housing First teams operating in Edmonton have not necessarily been designed or staffed to serve homeless people with the most complex, intensive needs – this is not a failure of current efforts, in other words.

- Police and health system stakeholders report that some of those fitting the population profile are incarcerated in correctional facilities. Although it is not possible at this time to estimate how many, findings from several research studies suggest that incarceration for this population occurs often, and perpetuates the cycle of homelessness:
  - The 2002 Calgary homelessness study found that 77% of the homeless persons in Calgary had been jailed at some point in their lives.[5]
  - Among the homeless population, those who report psychiatric illness or hospitalization are most likely to have a history of arrest or incarceration.[6]
  - A Vancouver study of 790 men admitted to a pre-trial facility over a 12 month period found that 36% of the homeless people detained were severely mentally disordered in contrast with 17% of the housed.[7]
  - Offenders serving lengthy sentences are especially likely to become isolated from family and community, and lose social connections that may be beneficial in terms of securing employment or housing.[8]

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[5] Gardiner, H., & Cairns, K.V. 2002. *Calgary Homelessness Study: Final Report*. Calgary: Research Report to the Calgary Homeless Foundation.

[6] Eberle, M., Kraus, D., Serge, L., & Hulchanski, D. 2001. *Homelessness - causes & effects: The relationship between homelessness and the health*. Social Services and Criminal Justice Systems: A Review of the Literature, 1.

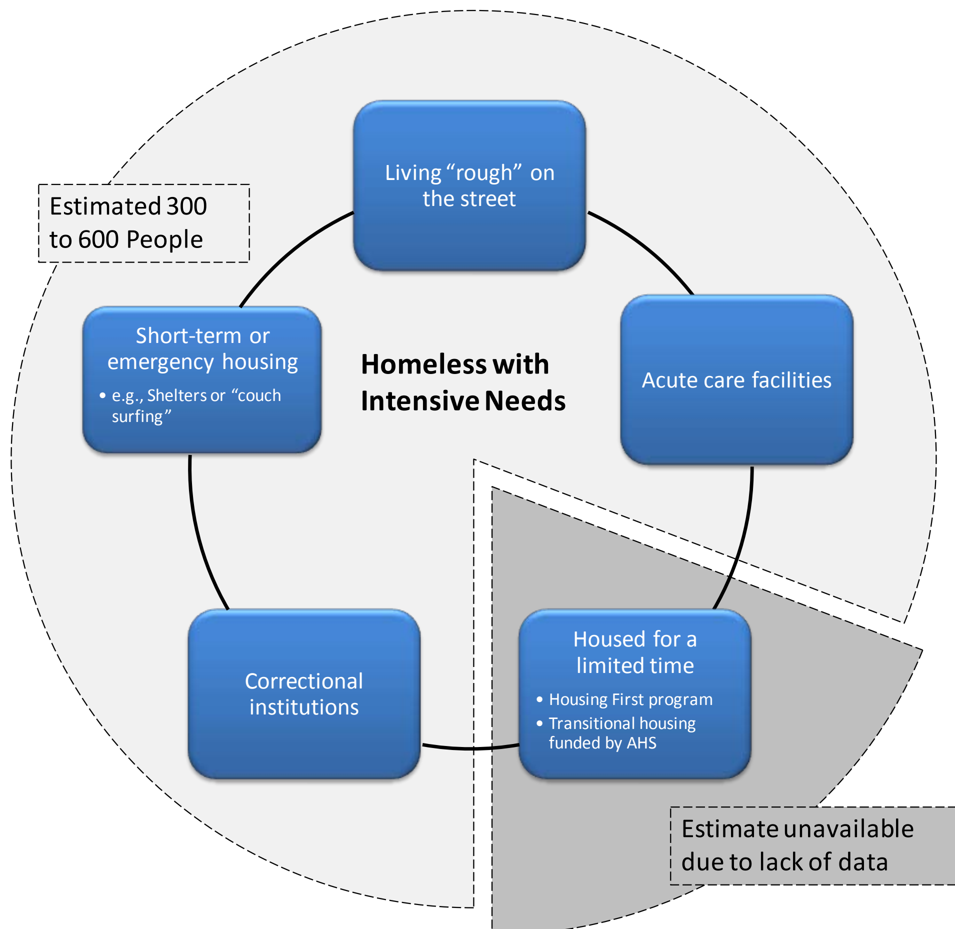
[7] Zaph, P., Roesch, R., & Hart, S. 1996. *An examination of the relationship of homelessness to mental disorder, criminal behaviour, and health care in a pretrial jail population*. Canadian Journal of Psychiatry, 41(7), 435-440.

[8] Zorzi, R., Scott, S., Doherty, D., Engman, A., Lauzon, C., Mc Guire, M. et al. 2006. *Housing Options Upon Discharge from Correctional Facilities*. Prepared for the Canada Mortgage and Housing Corporation. Toronto: Cathexis Consulting Inc.

Based on this information and the opinions of those individuals consulted, an estimate of the scale of the population has been compiled.

It is estimated that there are **between 300 and 600 individuals in Edmonton who fit this population profile**. This is not a scientific or precise estimate, owing to the limited availability of reliable data, but it serves as a reasonable illustration of the order of magnitude of the challenge. In addition, it is important to emphasize that **this estimate does not include those individuals who are currently housed** within an existing program in Edmonton, as illustrated in the figure below. This means that Edmonton requires housing and supports to serve at least 300-600 high-needs homeless **over and above the current capacity in the city**.

Figure 1: *Where and How Many?*



Current Costs to Support Homeless Individuals with Intensive Needs

Homeless individuals with intensive needs tend to require a costly blend of services from different organizations and sectors, as noted above. Their cycle of homelessness and need has a **large impact on service capacity** and **prevents efficient use of resources within each sector, at tremendous cumulative cost**. For example:

- These individuals often spend much of their time moving from agency to agency downtown to access meals and services that are offered on a time-limited basis.
- Police respond to frequent calls related to criminal behavior, public intoxication and disorderly behavior among this population. EPS officers have few options when responding to these calls, and many individuals are ticketed, arrested, or taken to Emergency Departments as a result – yet none of these responses are perceived to be effective in preventing future incidents. The length of time required for officers to address these calls is increased by limited access to facilities in which individuals can safely sober up. Risk, meanwhile, is high when dealing with intoxicated persons.
- Frequent use of police resources to address repeat clients among this population diverts efforts of the police from other enforcement and community priorities.
- These individuals are extremely vulnerable to victimization, and are much more likely than average to be the victim of violence or other crime. This frequent victimization contributes to higher use of both police and health system resources.
- Delayed discharge from health facilities results in inappropriate use of short-term inpatient facilities for long-term stays when that level of care is no longer required. This contributes to capacity pressures in acute care and emergency room settings across the province.
- Relapse of addiction and/or mental health crises frequently result in housing placements breaking down, readmission to the health system and a cycle of institutionalization at health facilities.
- A significant proportion of resources in the police and health systems are devoted to a relatively small proportion of clients. The high-needs homeless figure prominently among these resource-intensive populations within both systems.

Not only do these individuals demonstrate multiple, intensive support needs, but their interactions with various service systems can be equally complex. The types of service usage patterns that are typical for this subset of the homeless population include: [9]

- Offending behaviours which have resulted in frequent contact with the police and criminal justice system, often with multiple periods of imprisonment;
- High use of emergency services (including hospital emergency departments, ambulance and police);
- Repeated hospital admissions (including psychiatric or general; often characterized by difficulties finding suitable accommodation and support for discharge);
- Numerous placements in accommodation and support services that have failed;
- Placement in inappropriate services and accommodation;
- Involvement of numerous service providers and agencies who have delivered fragmented specialist services and are not positioned to develop a suitable, integrated response;
- Responses which are crisis-driven with little long-term needs planning; and
- A history of difficulties since childhood (including contact with the juvenile justice and/or child protection systems, difficulties at school and family/housing instability).

Stakeholders strongly believe that individuals in this segment of the homeless population are extremely high users of services in all of the sectors being examined. It is also well established that this blend of services is expensive, and that intervention is required to stabilize and house these individuals so that overall costs can be reduced by investing and targeting resources more efficiently. **It is not possible, however, to project the specific cost savings that will be realized** by doing so.

Research has previously identified cost savings of addressing homelessness in general, but it is difficult to isolate the particular target population for this study within existing data sets. A number of studies, however, point to strong potential for health system cost savings in particular to be realized by ending homelessness for this population. For instance, Permanent

[9] This list mirrors the descriptions provided by stakeholders in Edmonton. The list itself is drawn from: Department of Human Services Victoria (2003). *Responding to People with Multiple and Complex Needs: Phase One Report*.

Supportive Housing has shown promise in cutting costs associated with homeless who have mental health and/or addictions challenges:

- Permanent Supportive Housing in Maine delivered manifold Medicaid savings in the year after housing placement as compared to the year before placement: emergency room costs decreased by 62%, ambulance costs decreased by 66%, and mental health care costs decreased by 41% even though formerly homeless individuals participated in 35% more mental health services after housing placement.[10]
- One study examined the impact of Permanent Supportive Housing on health system use by 236 homeless people with mental illness, substance use disorder, and other disabilities. Housing placement significantly reduced the percentage with an emergency department visit (53% to 37%), the average number of visits per person (1.94 to 0.86), the total number of emergency department visits (56% decrease, from 457 to 202), the likelihood of being hospitalized (19% to 11%) and the mean number of admissions per person (0.34 to 0.19 admissions per resident).[11]
- An evaluation of a Connecticut Permanent Supportive Housing demonstration program found that homeless and at-risk individuals decreased their use of inpatient care by 71% in the three years after housing placement (as compared to the two years before housing), while increasing their use of outpatient medical care and substance abuse and mental health treatment.[12]

Given that different service providers classify and track this population differently, available data is not sufficient to interpolate costs or potential savings specific to this population. With that said, available data does illustrate the significant impact that these individuals can have on resources from multiple systems. **Two samples of cost information from Edmonton stakeholders help demonstrate the potential for cost savings**: a case study from the Edmonton Police Service, and a study of homeless and high frequency users of the health system.

[10] Mondello M, Gass A, McLaughlin T, Shore N. (2007). *Cost of Homelessness: Cost Analysis of Permanent Supportive Housing*. Corporation for Supportive Housing/Maine Department of Health and Human Services.

[11] Martinez TE, Burt MR. (2006). Impact of supportive housing on the use of acute care health services by homeless adults. Psychiatric Services 57(7):992-999.

[12] Arthur Anderson, LLP, as commissioned by Corporation for Supportive Housing. (2001). *Connecticut Supportive Housing Demonstration Program Evaluation Report.*

Sample #1: Edmonton Police Service Case Study

Both the Edmonton Police Commission and the EPS identified homeless people with severe mental health and addictions challenges as some of their highest frequency users – meaning that officers are regularly called to deal with crime, disorder and emergencies associated with these individuals. Current EPS data does not track this population specifically, but police were able to provide a detailed analysis of the costs and system usage associated with one of these high-needs users from within the ICPACT caseload. This example is instructive in demonstrating the magnitude of regular police involvement by this population. The sample case was reviewed in detail over a 19 month span, from January 2010 through to early July 2011. The individual in question is identified as follows:

> *We will refer this male as "Steve". He is a 47 year old Caucasian male. He has a history of Bipolar Disorder, Chronic Alcoholism, Substance Induced Mood Disorder and Cluster "B" traits.[13] Steve has been involved in several relationships that he is not able to maintain. He is currently homeless. He stays at the Inner City shelters on occasion or sleeps "Rough".*

Sample Edmonton Police Service Costs

A single individual cost the EPS $133,000 over 19 months, while also requiring 114.5 days in hospital over 182 hospital visits.

Steve's economic impact on the police service can be summarized as follows:

- 76 calls for police service over 19 months; prorated for a 12-month period this is 48 calls per year.
- Each call is estimated to take *at least* 3.5 hours of time for the responding unit to handle the call and related paperwork.
- The approximate cost of a police vehicle, 2 officers and administrative time in responding to these calls is $500/hour (estimate provided by EPS).
- **Steve's 76 police calls over 19 months cost the service approximately $133,000 – or about $84,000 per year**.

[13] Meaning "Cluster B" personality disorders classified within the Diagnostic and Statistical Manual of Mental Disorders (IV), which include antisocial, borderline, narcissistic, and histrionic disorder. The DSM-IV views these as a subset of personality disorders that are characterized by dramatic, emotional or erratic behavior.

In addition, data within the police case file highlights Steve's high health care system usage over a 19 month period:

- Steve required 182 hospital visits in 19 months (about 115 per year).
- These visits collectively totalled 114.5 days in hospital (about 72 days per year).[14]
- Based on 2007/08 cost data, it is estimated that **Steve's hospital costs total more than $164,000 over 19 months – or more than $103,000 per year**.

Alberta Health Services Costs

- *The ten highest system users among the homeless cost the Capital Health system $3,578,715 in a single year (2007/08 data), representing 8% of the cost of serving the homeless that year.*
- *These ten users represented only 0.3% of the 3,079 homeless identified in Edmonton in 2008 by the homeless count.*
- *This demonstrates the massive cost implications of those homeless who require the most health care resources.*

In total, then, **this single individual with a high-frequency of police and health service usage cost these systems approximately $297,000 over 19 months, or $188,000 per year** if these costs are pro-rated. Although this illustration demonstrates the intensity of services required, it is not appropriate to simply scale these individual costs to the whole population because it is not clear how similar their system usage would be.

Sample #2: Alberta Health Services System Usage

A considerable body of research has demonstrated that homeless people incur significant health care system costs, and moreover that stable housing has tremendous potential to reduce these costs.[15] These costs range from medication and community-based health services to emergency room and hospital admissions.

In 2007-2008, Alberta Health Services (Capital Health Region, at that time) analyzed data on emergency room, hospital and psychiatric facility use in the Edmonton region (the former

[14] This data does not distinguish between emergency room and inpatient admissions.
[15] See, for instance:
Corporation for Supportive Housing with The California Endowment and the California HealthCare Foundation. (2008). *Frequent Users of Health Services Initiative Summary Report of Evaluation Findings: A Dollars and Sense Strategy to Reducing Frequent Use of Hospital Services*.
Culhane DP, Metraux S, Hadley T. (2002). *Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing*. Housing Policy Debate; 13(1):107-163.

Capital Health Region) over a 1-year period. This analysis identified costs for the general homeless population (i.e. those coded as having "no fixed address" at admission) and also a subset of the top ten more intensive health system users among the homeless population for comparison. Although it is not possible to be certain, it is reasonable to assume that at least some of these top ten system users would also fit the population profile of this study. The following costs were observed:

Table 1: *Capital Health Region Costs for the Homeless (August 31, 2007 – September 1, 2008*)

Type of Visit	Cost per Diem per Visit/Admission	Top Ten Users		Total Homeless		
		Service Intensity	Total Annual Cost	Service Intensity	Total Annual Cost	Total Cost per person
ER Visit	$292	235 visits	$68,620	4,358 visits	$1,272,536	$708 (n=1,795)
In-patient Admission	$1,435	637days [a]	$914,095	7,410 days [b]	$10,633,350	$18,655 (n=531)
Psychiatric Admission	$800	3,245 days [c]	$2,596,000	39,530 days [d]	$31,624,000	$236,000 (n=134)
		TOTAL COST	**$3,578,715**		**$43,529,886**	

Notes

a. 49 admissions x 13 day average length of stay
b. 570 admissions x 13 day average length of stay; excludes outliers with significantly higher lengths of stay
c. 11 admissions x 295 day average length of stay
d. 134 admissions X 295 day average length of stay

Costs per day of $1,435 for an inpatient day were calculated based on an average of the per diem rates for the Royal Alexandra, University of Alberta, Grey Nuns, and Misericordia hospitals.

The psychiatric per diem rate was calculated based on costs for Alberta Hospital Edmonton (AHE).

In interpreting this data, it is important to note that:

- Costs reflect 2007-08 data and will have increased since that time.
- The ten highest system users among the homeless cost the health system $3,578,715 in a single year (2007/08 data), representing 8% of the cost of serving the homeless that year.

- These ten users represented only 0.3% of the 3,079 homeless individuals identified in Edmonton by the 2008 homeless count.
- The total homeless data excludes "outliers" with significantly higher service intensity and related costs.

This data illustrates the massive cost implications of selected health care services for homeless individuals, and especially for those receiving the most intensive services.

Summary: the Case for Action

A Clear Case for Action

Given what is known about the homeless population with the most intensive needs, the case for ending their homelessness is clear:

- *For the target population*, there is potential to break the cycle of homelessness, deal with some of the challenges that they face, and improve quality of life.
- *For service providers*, dramatic cost savings are possible, together with increased efficiency and capacity of service delivery.
- *For government and taxpayers,* investing in ending homelessness for these individuals will save money over the long term.
- *For communities,* ending homelessness means fewer people living on the street, in shelters, or in inadequate housing, which translates to less crime, victimization and social disorder.

4. Assessment of Current Housing and Supports

Given the clear case to end homelessness for those individuals with the most intensive needs, an assessment was conducted to explore the current housing, services and supports available in our community to do so.

Current State Themes

Part of the challenge of this study is to describe the current status of housing and supports for a somewhat ambiguous subset of the homeless population with intensive, but varied needs. In consultation with a range stakeholders, a number of strong themes were identified about how this population is currently served in Edmonton, each of which is described in more detail below:

- Housing supply and support capacity is not sufficient to meet demand.
- There are a number of barriers to accessing existing services that are unique to this population.
- Coordination of services and service sectors is not sufficient to address the presenting intensity and combination of needs.
- No single solution currently exists in Edmonton to address the needs of the target population.
- A continuum of supports from multiple sectors is required.
- There is a need for better integration of housing and health services.

Housing supply and support capacity is not sufficient to meet demand

Although available data does not allow a quantitative estimate of service capacity relative to needs of the target population, several indicators suggest that **capacity to serve this population effectively is limited within all sectors examined**. For instance:

- Community agencies report that their housing and support service programs generally experience much more demand than they can accommodate. A limited number of appropriate placements also results in a delay between when people are willing or able to be housed and when an appropriate housing unit becomes available to them. Often, “the first placement available is the one you get”.

- Stakeholders from multiple sectors note the challenges faced by this population in coping with addiction, particularly alcoholism. Very few agencies provide a housing environment that is tolerant of substance use and/or intoxication, however. In addition, wait times for short-term detoxification and for addiction treatment programs can be a barrier to access by the homeless.
- Expertise and resources to address addiction and mental health crises are limited within community agencies, whose services are not designed to handle the intensity of crises that often present.
- Discharges from health facilities are often delayed by a lack of available community placements that have appropriate supports.
- EPS has not traditionally had much expertise in dealing with this segment of the homeless population, a situation that the police service is trying to address by building specialized units (such as the Police and Crisis Teams), and by delivering training and education to build capacity more generally for dealing with homeless, intoxicated and/or mentally ill persons.
- Police report that Edmonton does not have a secure place in which intoxicated persons can be placed and supervised for a short time. This results in police either spending more time with these individuals than required to resolve incidents of public disorder; police can't leave the intoxicated individuals alone at the scene, but neither is there anywhere else for them to be supervised. In some cases, police have to rely on emergency rooms to deal with the health needs of these individuals.

There are a number of barriers to access unique to this population

A number of barriers to accessing appropriate services were reported by stakeholders:

- The "behaviours" and issues faced by this population result in them becoming "known" among community service providers and result in them being rejected from many existing programs and services.
- This population may not meet criteria for access to existing Housing First programs due in part to the intensity and/or complexity of their needs.
- Individuals frequently cannot maintain their housing (e.g., are not able to continue making payments) when they are admitted to health or detox facilities, or the

corrections system, thus compounding their challenges by entrenching them as homeless upon discharge.

- Individuals discharged from the justice system must reapply for government supports such as Assured Income for the Severely Handicapped (AISH) after they are released.
- There is a lack of services and expertise that are appropriate for the unique needs of Edmonton's Aboriginal community.
- Access to community-based health and mental health services appears to be a particular challenge for these homeless individuals due to barriers such as lack of transportation, inability to keep appointments, and inability to navigate the system.

Coordination of services and service sectors is not sufficient

Generally speaking, there appears to be insufficient coordination between different organizations and different government departments in serving this segment of the homeless population, or at least far less coordination than stakeholders suggest would be necessary to serve them well. Specific findings include:

- One of the important areas identified for improvement is the current disconnect in terms of funding for new housing projects in Edmonton. At present, Housing First projects are funded according to their capital and operating expenses, but these are not necessarily paired with appropriate funding for supportive services that reflects the increased acuity, complexity and risks of serving this population – particularly community-based mental health and addiction services. When applying for funding under Housing First, service providers currently have no mechanism to apply concurrently for support service resources from AHS, and this is a major barrier to integrating mental health and addiction supports with housing.
- Community agencies report that a more integrated approach among Government of Alberta Ministries would help to enhance coordination of housing and supports. In particular, the gap in mandates between the health and housing portfolios was seen to be problematic: generally speaking, the health system does not see housing as its responsibility, and the housing system does not provide health, mental health or addiction supports.
- Some stakeholders suggest that multiple community agencies offer similar housing and supportive services, and that there may be opportunities to take a broader and more

efficient approach. Communication between agencies and knowledge of the full range of available resources appears to be limited as well.

- Police and community agencies have begun incorporating mental health supports into new and existing teams. EPS PACTs are taking on some system navigation roles in assisting homeless individuals to acquire detoxification placements, personal identification, financial resources, etc.
- EPS largely relies on informal relationships and the knowledge of individual officers to access community services as alternatives to incarceration or other police intervention.

No single solution currently exists in Edmonton

The target population for this study presents an enormous challenge to existing support systems. No one organization, program, service or model was identified as consistently successful in addressing the scope, intensity and combination of needs that these individuals exhibit. Community agencies assert that **there are community-based services in Edmonton that are showing success** for individuals who fit this profile, but no program, organization or best practice was universally acclaimed. Stakeholders report that:

- Existing Housing First programs are not designed to include the intensive supports and expertise believed to be necessary for this population to maintain housing in community. In particular, addiction and mental health rehabilitation needs are seen to exceed the level of service that current programming is intended to provide.
- No existing Housing First or Permanent Supportive Housing program in Edmonton was identified as a clear best practice; the different programs that are available address different needs as a part of a continuum of supports.
- Intervention by police, EMS and other emergency services are frequently required, but these service providers tend to react to crises and emerging issues, and are seldom equipped to provide proactive or preventative support.
- This population is understood to have frequent need for health services to address acute or crisis situations, including in particular high usage of emergency rooms and inpatient mental health services (acute care beds). The health system does not, with a few possible exceptions, directly provide housing and clinical supports together as a package in the community that meets the needs of this population.

A continuum of supports is required

Stakeholders stressed the importance of **a continuum of support that includes a range of options** to address the diverse needs presented by this segment of the homeless population. The range of supports required to be effective in serving this population spans across multiple service sectors and involves multiple options to address the variety and combinations of needs that present for different people. This continuum of support, then, includes the following:

- A range of housing options that permit meaningful choice based on need. These different options are necessary to address the different needs within this population, such as tolerance for alcohol and drug use, and understanding of respectful ways of delivering service to Aboriginal people.
- A continuum of addiction and mental health services to address the spectrum of individual needs. This continuum includes community-based consultation and therapy, as well as addiction treatment and detoxification, acute care, and inpatient care to stabilize people and address crisis situations that arise. In other words, community-based resources, as well as acute mental health care in hospitals are all required to serve this population effectively.
- A variety of government services including components of justice and corrections, Assured Income for the Severely Handicapped (AISH), employment supports, and supports for Persons with Developmental Disabilities.
- Safe spaces and resources to address short-term issues and crisis situations related to mental health, addiction and public intoxication, thus providing first responders such as police and EMS the required support to deal with these issues.
- Outreach and proactive work to prevent crises and keep people from becoming homeless in the first place.

There is need for better integration of housing and health services

Alberta Health Services, much like health systems across Canada and beyond, has been engaged in a trend of moving addiction and mental health supports from institutional to community environments. The vision is for a continuum of health services available to address a range of clinical and support needs in the community, with inpatient hospital beds available for short-term stabilization for acute and crisis situations. It seems clear from speaking with a

range of stakeholders that there are gaps in this continuum within the Edmonton region, however, as it relates to efforts to end homelessness.

- More capacity is required to pair addiction and mental health supports with community housing efforts to meet the most intensive needs. Few current housing programs are designed or able to integrate the level of addiction and mental health support required to serve the high-needs homeless population effectively.
- Psychological and psychiatric supports are not perceived to be sufficiently integrated into current housing initiatives to serve this population effectively.
- Stakeholders identified a capacity gap in the area of crisis and short-term mental health supports in the community. In many cases, police, emergency responders and community agencies cannot avoid admissions to hospital because they do not have access to alternative addiction and mental health resources, expertise or placements to address crises.
- Inpatient mental health beds are recognized as an important resource for short-term treatment to stabilize patients and address acute mental health issues, and as hubs of expertise and centers for research and training. At present, however, a lack of appropriate supportive housing results in long-term and inappropriate use of these costly inpatient resources.

AHS has identified a number of lessons learned from research and from the experience of other health jurisdictions engaged in shifting mental health care to community-focused settings. These insights, which are strongly relevant to the task of better integrating with housing efforts in Edmonton, are included as Appendix D. In addition, Appendix D highlights the lived experience of Albertans with addiction challenges and mental illness who have transitioned out of hospital into community settings.

Several physician stakeholders who were consulted suggested an additional path to address some of the gaps in addiction and mental health service capacity: redevelopment of the Alberta Hospital Edmonton (AHE) site to include “step-down” housing and a range of community supports (Appendix F includes one proposal to do so). AHE is one of several inpatient psychiatric settings in the Edmonton region, however, and so it would be premature to recommend what should or should not be done with that particular site. **Any shift in service at AHE should be part of a unified approach by AHS and community partners to address the**

continuum of health needs that individuals have, including consideration of both inpatient and community settings.

Given that there has been no community resources developed around AHE to date, any supportive housing established there in the near term would lack community resources and the broader base of community support available in other neighbourhoods. The strength of this potential site, however, would be the relative ease of establishing new housing projects there: **there is space to do so, and little or no potential for opposition by residents nearby**. This is a significant factor, as it has proved difficult to integrate certain housing projects within existing Edmonton neighbourhoods in the past due to community opposition. In part, debates in community have focused on zoning as a point of contention; it can be difficult to define such projects as either purely residential or institutional housing, and so they can be opposed based on residents opposition to adding a health facility or institution to their neighbourhood. PSH projects, especially those that involve harm reduction programming, are likely to elicit opposition from members of some Edmonton communities.

Building housing around Alberta Hospital Edmonton continues to be a controversial notion, therefore, because to do so would sacrifice community resources and integration for the ease of establishing housing near an existing health care facility.

Local Promising Practices

Based on the findings of the study, this section outlines promising practices in Alberta that could be expanded, replicated and/or augmented to better serve the homeless who have intensive needs.

Existing supportive housing options aligned with Housing First

Stakeholders report that **there are long-term, supportive housing programs currently operating in the city that have some success** serving the target population for this study. In fact, community planning to address homelessness in Edmonton identified a number of agencies who already provide supportive housing. Stakeholders emphasize that the stable, long-term nature of this housing is part of the reason that this challenging clientele can be housed successfully in some cases. In addition, the combination of housing and support services is seen to be critical; **The 10 Year Plan defines supportive housing as follows**:[16]

> *Typically provides long-term accommodation with a support component to allow people to live as independently as possible. The housing providers, whether public, private or nonprofit, receive funding to provide the support services to the residents, who also often receive some direct funding. Supportive housing can be called special needs housing.*

It is important to emphasize that work to better serve this particular segment of the homeless population should be conducted in alignment with the Housing First philosophy embraced in Edmonton under The 10 Year Plan. Not only has this philosophy been endorsed by the community and multiple levels of government, but it is showing success in our city and in jurisdictions across North America. Housing First programs in Edmonton have not explicitly targeted the homeless with the most intensive needs, but developing long-term supportive housing units is certainly within the scope of what is envisioned under The 10 Year Plan.

At present, Housing First in Edmonton is primarily delivered through two team-based approaches to supporting individuals to access and maintain their housing:

[16] P.64; Note: There is a distinction between *supportive* housing and *supported* housing. The latter refers to accommodations with support services that are not linked to the housing.

1. The majority of Edmonton's Housing First teams provide a variety of supports to help homeless individuals to secure and maintain housing using an Intensive Case Management (ICM) model.
2. Edmonton also employs Assertive Community Treatment (ACT) teams to bring more intensive clinical supports to people who have need of them. ACT is a well researched, evidence-based multidisciplinary model that includes a broad array of clinical and support services on a consultative basis. The Pathways to Housing program is an example of a Housing First ACT team in Edmonton.

Between these two approaches, there is considerable expertise in our community in providing different kinds and different intensities of support under a Housing First philosophy. It is likely that **this existing expertise can be built upon to specifically target the needs of the homeless with the most intensive needs**.

Harm reduction programming

Harm reduction is particularly important in working with this subset of the homeless. It is important, therefore, to recognize these promising examples in our city of tolerant programming and note that they tend to experience far more demand than they can meet:

- **Urban Manor**, a 75-bed facility with 24-hour staffing that serves men with mental health and substance abuse challenges. Urban Manor tolerates intoxication, and will even store alcohol safely for its clientele ("alcohol rationing"), in addition to providing housing, meals, laundry facilities, home care, access to a nurse practitioner, and assistance from a case worker to manage health and personal affairs.
- **Grand Manor**, operated by the **Excel Society** under contract by AHS, is a 56-unit apartment hotel that provides 24/7 support services for individuals with mental illness and/or other challenges. Grand Manor tolerates some consumption of alcohol on site.
- **George Spady Center** offers a number of services for the homeless, including those in crisis and those with intensive needs, including: drop-in, a tolerant overnight shelter (for people under the influence of alcohol or drugs), a detoxification unit, and referral services to treatment programs.

Stakeholders suggest that **demand for tolerant, harm reduction focused supportive housing far exceeds capacity**, and that this is a critical area of need to better serve the homeless who have the most intensive needs.

A shift in policing in Edmonton

The Edmonton Police Service has been undergoing a shift to enhance their traditional approaches to enforcement, and to work more effectively with challenging populations. Changes are being made that should better enable the EPS to address intoxication, social disorder and crisis situations that frequently present among the population of homeless with intensive needs. These changes include:

Neighbourhood Empowerment Team

- *Partnership of the City of Edmonton, EPS, The Family Centre and United Way*
- *Apply non-traditional policing response to very recurrent community issues such as disorder*
- *NETs combine an officer, community capacity builder, and youth mobilization team*
- *Build and execute Community Action Plans*
- *Combines the skill, expertise and perspectives of traditional law enforcement practices with innovative community development strategies*

- In early 2011, a Vulnerable Persons Unit was established to improve services for vulnerable Edmontonians, including the homeless, through relationship-building and closer coordination with community partners. This commitment is aligned with the focus within the Edmonton Police Commission (EPC) on vulnerable persons – the EPC has in fact created a subcommittee specifically dedicated to this issue.
- PACTs combine police officers with mental health professionals. In particular, the Inner City PACT brings a focus on homeless and vulnerable populations in the downtown core, and actively works with these individuals to resolve issues and prevent future incidents.
- The Vulnerable Persons Unit is delivering some training, information and best practices to the broader police force about dealing with vulnerable persons and intoxicated individuals.
- Neighbourhood Empowerment Teams are being utilized in an attempt to address the root causes of crime through community mobilization, partnerships, and non-traditional police response.

In addition, the EPS and EPC have identified several other leading practices in other jurisdictions for addressing public intoxication and social disorder that may be relevant to the Edmonton context. These are noted in Appendix E.

Integrated Addiction and Mental Health Policy

The release of *Creating Connections: Alberta's Addiction and Mental Health Strategy* in September of 2011 is an extremely promising step toward closer collaboration with the housing sector. In this strategy, AHS commits to improving supports for the homeless, as well as individuals with complex needs, and singles out both of these populations as priorities for action.[17] In fact, the strategy explicitly sets the stage for greater AHS participation in a Housing First approach:

> *This priority* [numbered 3.3] *focuses on matching the continuum of housing options and community support services to meet client need. Emphasis is placed on the importance of adequate housing as a fundamental determinant of health, i.e., the "housing first philosophy." Similarly, since individual choice and self-determination are positively correlated with good client outcomes, a person's fundamental rights and desire to live as independently as possible must be a primary consideration. This priority builds on and aligns with existing work and plans such as Alberta's strategy "Ending Homelessness in 10 Years" and many of the "Safe Communities" initiatives.* (p.25)

This strategy represents a critical shift in service for the homeless with complex, intensive needs, and suggests tremendous future opportunity for partnerships between health and housing stakeholders to address the intensive mental health and addiction challenges of this population.

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[17] "The complex needs of the most marginalized populations such as street-involved youth and the homeless population that also face mental illness are considered throughout the Strategy. Initiatives will be further identified through action planning activities." [p.7]
"People with complex needs require extraordinary services from more than one ministry, and in many cases, from various service sectors and stakeholders. Those who require such services include individuals with complex mental health and health problems and/or severe behavioural problems related to addiction, mental health and mental illness. For these clients, all currently available resources have often been used with limited success; and the fiscal and human resources they require strain the capacity of any one ministry to deliver the required services." [p.27]

5. Permanent Supportive Housing as a Leading Practice

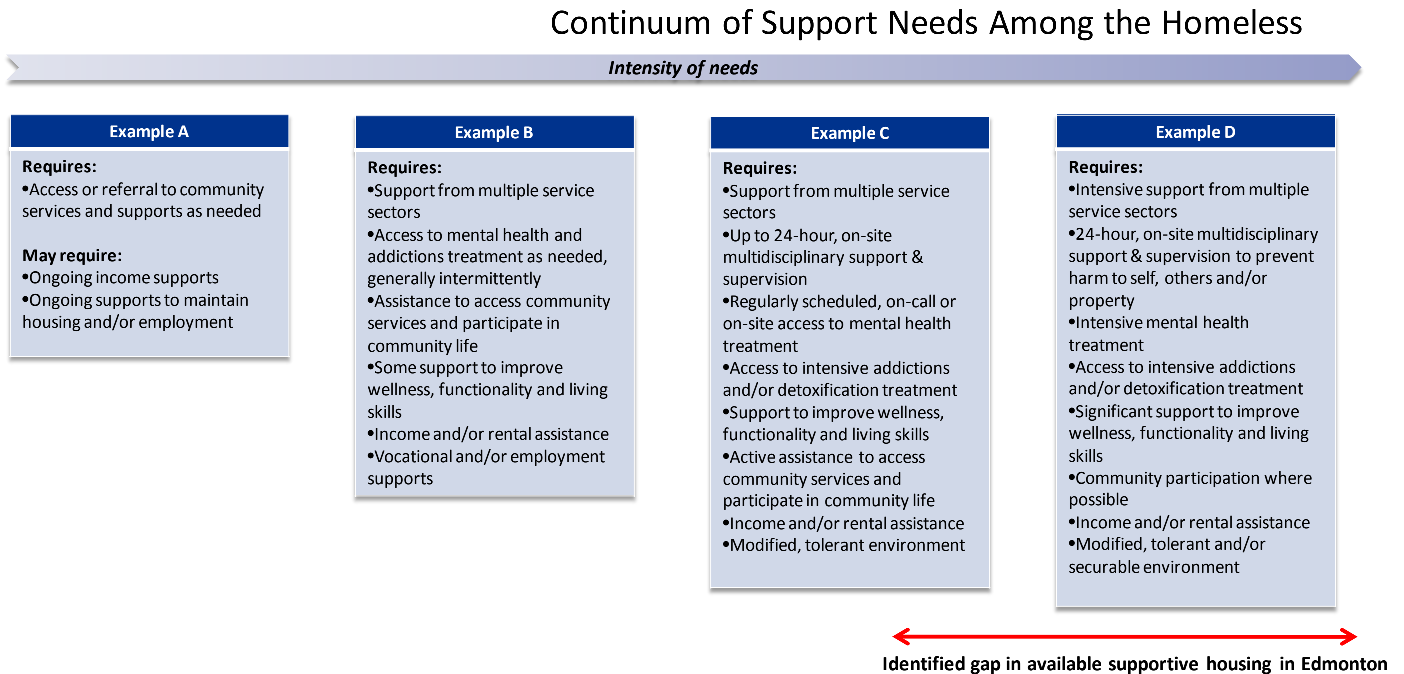
A consistent theme among stakeholders from multiple sectors is that there is simply "no place" for the high-needs homeless at present. More long-term supportive housing is clearly required, because at least 300 to 600 homeless individuals with intensive needs are currently homeless. There are a number of promising supportive housing options in Edmonton, but stakeholders report little or no vacancy among them – in other words, **addressing the capacity gap requires new supportive housing units for this population, since existing spaces are full**.

In addition, it seems clear that **new and different approaches are required to address some of the challenges in successfully housing this population**. The continuum of supportive housing options in Edmonton must be expanded in order to serve the homeless with intensive needs. These individuals could benefit from greater coordination of services, as well as supportive housing that is more appropriate to their unique needs – for example, programs that embrace harm reduction and/or Aboriginal cultural perspectives should be added.

Stakeholders consistently point to a gap, whether due to capacity, coordination, or other reasons, in appropriate community-based housing options for those with intensive needs, as demonstrated in the figure below. This population is seen as unlikely to sustain housing without a bridge between their current situation (homeless or institutionalized) and many of the community housing options that are currently available in Edmonton. This bridge should take the form of supportive housing that makes available a range of supports, including mental health and addiction supports.

Research and the experience of other jurisdictions suggest Permanent Supportive Housing as a leading practice for the target population. Although PSH can take many forms, it is fundamentally aligned with the definition of long-term supportive housing outlined above – PSH embraces the same vision for a long-term combination of housing and supports to break the cycle of homelessness. Notably, PSH is established within existing neighbourhoods so that supportive housing is integrated within a broader network of community resources and supports. The vision for PSH is of individuals housed and supported within the community, as opposed to placing people within a facility environment that isolates them by operating independently of the surrounding community. It is also clear, however, that in order to realize this vision, effective PSH projects require coordination and collaboration between multiple partners, including health.

Figure 2: *A Continuum of Support Needs among the Homeless with Examples*



Note that this figure provides examples only, and it is not expected that any one individual would have all of the needs identified at different points on the continuum. These are typical needs captured in examples to demonstrate how their intensity varies among the homeless population. As such, the identified gap encompassing Examples C and D and should be understood to show a lack of supportive housing in Edmonton for those with the most intensive needs. This is not meant to suggest that a supportive housing solution to address this gap must address all of the needs identified within the examples.

The Local Perspective: Implementation Considerations for PSH in Edmonton

No single model of PSH exists that can simply be transplanted from city to city. In fact, there is a wide range of ways in which different components of PSH have been combined to adapt the concept to meet the needs of a particular city, community or target population. Broadly

speaking, PSH models vary according to the following dimensions (outlined in greater detail in Appendix A):[18]

- **Affordability:** There are variations on the degree of affordability within a PSH model. In Canada, the rent levels are most often set at 30% of the household's gross monthly income.
- **Access:** Different PSH models use different methods to determine who will have access. In some cases, individuals self-select as likely candidates, whereas other models employ assessment or decision making tools to screen candidates.
- **Concentration:** In some models, PSH is a multi-unit residential building where all tenants have access to the supports. Others use scattered site models and congregate living models, head-leasing or single-family homes and townhouses.
- **Building design and density:** The experience of tenants is impacted by a number of factors including size of units, density of building, number of floors, shared accommodation, amount of shared space, etc.
- **Support service delivery:** While all PSH has supports—hence "Supportive Housing"—there are no existing standards about the type, intensity, duration or frequency of the supports. Further, there is no standard about whether the supports are delivered by the operator of the housing, sub-contracted or brokered to the facility.
- **Relationship with community:** Different degrees of engagement with the community are possible, ranging from minimizing the visibility of the project to active involvement of community and even businesses.
- **Specialization:** Some projects target specific populations or specific gaps in services such as harm reduction approaches.

Local stakeholder perspectives

This study gathered input from housing agencies and also from homeless individuals in Edmonton – persons with lived experience – about what kinds of PSH are needed here. The

[18] Appendix B outlines a number of existing PSH models that serve to demonstrate the different ways in which this type of supportive housing can be configured.

following table compiles this input according to the dimensions of PSH outlined above, in order to provide a clearer picture of how PSH should be implemented in Edmonton.

Table 2: *Edmonton Stakeholders' Input about Desired PSH Components*

PSH Components	Input from Persons with Lived Experience	Input from Housing Agencies
Affordability	**Paying Rent** — 74% of people interviewed said that their preference for paying rent was to have their rent paid from AISH, Alberta Employment and Immigration or their pension directly to the landlord. 20 out of 23 people disclosed that non-payment of rent was the reason for at least one eviction in their life.	**Affordability** – It was generally agreed that PSH should be highly subsidized and rent should be as low as possible. In fact, deficit funding for a model that ultimately produces cost savings was seen to be the most viable option. In addition, it is seen as important to have a pool of "stabilization: funding to address major repairs or other issues that may arise.
Access	**Tenant Selection Process** — 35% of the interviewees thought that existing tenants should have input regarding who moves into the housing as opposed to leaving that decision to the sole discretion of the housing provider. **Security** — most interviewees stated a strong desire to have security and/or reception screening to keep drug dealers and other people who may not be a positive influence out of the building. **Guests** — the vast majority felt that guests should be allowed, but there should be a limit on the number at any one time; guests should be asked to sign in and security should make sure that there is no other tenant uncomfortable with that person being there. **Home vs. Street** — interviewees repeated many times that they had a strong desire to "keep the street out of the housing". **Tenant Mix** — the people who were interviewed generally wanted a non-discriminatory mix of tenants. However, almost everyone did not want to mix singles and families in the same building, and many were also concerned about childless couples being in the building. **Housing Priority** — 94% of the interviewees felt that those homeless the longest and with the most complex needs should be housed first, with the caveat that the housing priority rules should be made clear and there should be transparency about how people are selected.	**Access** – Agencies suggested that the process of selecting tenants would need to be transparent so that no single organization was seen as serving their own interests or "creaming" clients. Furthermore, many of the people participating in this process were concerned that other organizations would try to impose their will about which individuals should/would become tenants, due to capacity pressures across the city owing to limited access to supportive housing. There was general agreement that some type of assessment was required, which could include a clinical assessment depending on the type of PSH being considered. Functionality and the ability to undertake the tasks connected to daily living were also considered important criteria for the tenant selection process. In terms of priority, some agency stakeholders spoke of clients who had been re-housed many times and they thought that these clients would definitely benefit from a PSH option. There was a counter-argument as well that preferred people who are not – and never will be – allowed into the existing Housing First programs (including ACT). In addition, these stakeholders affirmed the importance of individual choice as a pillar of the PSH approach, noting giving people choice allows new PSH to crystallize and articulate program specifications without explicitly targeting people – people self-select housing according to their needs, to a certain extent.
Concentration	**Housing Location** — 54% preferred housing to be located in the downtown area of Edmonton and 45% specifically wanted the housing to be far	**Location** –PSH units should be located in a community with good services but not necessarily in the inner city downtown area. Access to

PSH Components	Input from Persons with Lived Experience	Input from Housing Agencies
	away from downtown. There was total agreement among people preferring not to live downtown that they wanted to be far away from specific people or negative influences that existed in the downtown area.	transportation should be given particular consideration due to the car-centric nature of Edmonton.
Building design and density	**Types of Housing** — there was no consistency in the type of housing preferred, and some people had more than one preference. About 33% of people preferred a house blended into an existing neighborhood and it was suggested that several adjacent houses on the same street might work. About a third of the interviewees liked the idea of converting the inside of a warehouse into housing units with a "main street" style hallway. Almost 50% of those interviewed wanted an apartment building with no more than 30 units. **Types of Units** — there was no consistency in the types of units that were preferred within the buildings. Half of the interviewees responded that they would prefer their own place with a bathroom and kitchen/kitchenette. One-bedroom apartments were slightly preferred over bachelor apartments. For bachelor apartments, loft-style units with a large window were preferred. Note: all Aboriginal people that preferred loft style bachelor units.	**Building design and density** – Lower-density options were seen to be better for Edmonton, although agencies supported creating a range of PSH options. Generally, people thought that a very low barrier model such as Portland Hotel in Vancouver would not be very successful in Edmonton.
Support service delivery	**Types of Supports** — interviewees identified the following supports as being the most important to them: help with medication (storage, reminders, refills); a doctor who visits at least once per week; case management; cultural connections—noted by 66% of Aboriginal people interviewed; and scheduled activities available but not required. **Support Characteristics** — the characteristics that the interviewees said they would prefer from the support staff involved "respect" and delineating personal space from shared space. Frequently, those interviewed used expressions such as "nobody getting in my face" and "when I lock my door, they stay out". People interviewed also wanted to make sure that the support staff were knowledgeable – especially about homelessness. There were concerns expressed by almost 50% of those interviewed that staff would try to force them to be clean and sober. More than a third of the interviewees were concerned that staff would attempt to convert them to a	**Support service delivery** – considering the different types of PSH models that may be required, many people thought that a continuum of care needs to be provided that would include specific levels of supervision/services based upon the needs of the population to whom the housing is being provided. Most felt that each PSH building should have a sense of identity based upon the residents and their needs, instead of each building being "one size fits all". On-site mental health and other supports were identified as important in most cases, however.

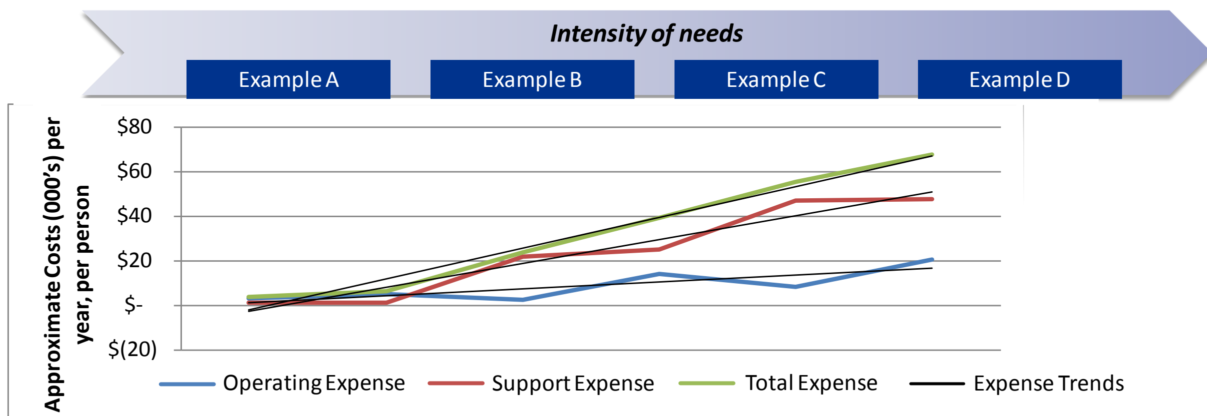
PSH Components	Input from Persons with Lived Experience	Input from Housing Agencies
	religion or go to church. **Staff Availability** — all 31 people who were interviewed wanted a staff person available at the property or on call 24 hours a day, 7 days a week. A staff person located onsite was preferred to having a person on call by 75% of the interviewees.	
Relationship with community	**Blending in with Neighborhood** — all of the people interviewed felt that their housing should blend right in with the neighborhood in appearance—no house name, plaque or external features should "warn" neighbors that the residents of the house were different or living in supportive housing. More than 50% of the people interviewed felt so strongly in this regard that they would refuse to move in if the housing was identified in this way. This objection was noted as a problem even during the construction phases with one person saying, "Every Tom, Dick and Harry do-gooder wants their name plastered on the construction site so people know they put their money into making it happen." Another person commented, "…it's like a spotlight shining on you and everyone knows that poor people are moving into the neighborhood – and not in a good way." **Social Purpose Enterprise** — only 3 of the people interviewed were interested in a social purpose enterprise being connected to the housing, whether on or offsite.	**Relationship with community** – Intentionally building community in conjunction with Permanent Supportive Housing was seen to be important. Some stakeholders even suggested the need for a community facilitator/developer as part of the process. Those interviewed saw the potential for residents to feel a sense of pride and ownership if community was developed properly. In the other hand, caution was expressed about the potential for "ghettoization".
Specialization	**Substance Use** — 87% of the people interviewed felt that drinking should be permitted in apartment units while 67% felt that people should use other types of substances someplace other than the housing. They also suggested that just like any other apartment dwellers, people should be allowed to store their paraphernalia and drugs in their apartment.	**Harm reduction** – Stakeholders identified a lack of housing with a harm reduction approach in the Edmonton area. Each PSH program should explicitly chart the extent of its recovery focus and its expectation for substance use and treatment.

Sample Costs of Supportive Housing for Different Intensities of Need

There is no single model for PSH. Components of PSH are combined in many ways to adapt models to meet the unique needs of different cities, communities, and populations. Therefore, **it is difficult to accurately estimate the costs of implementing new PSH in Edmonton**. It is

clear, however, that costs increase with increasingly complex needs of the people served (as illustrated in the below figure).

Figure 2: *A Continuum of Support Needs among the Homeless with estimated costs*



In reviewing this figure, the following should be noted:

- The costs presented are estimates of the ongoing costs per person, per year, and do not include capital expenditures.
- The costs presented are based on limited, aggregated data from a sample of housing and support models currently operating in Edmonton. Data was not available to estimate actual costs at the highest intensity of needs (Example D).
- The data aggregated for use in this analysis represents best cost estimates only, and comparability of the data cannot be confirmed as it may arise from different years, may not be adjusted for inflation over time, and may include different inputs.

Despite limited data to estimate PSH costs at the high intensity end of the spectrum (i.e. Example D), a small number of existing and planned projects in Edmonton serve to illustrate order of magnitude costs. The figure below presents three options, which are most broadly characterized as single detached, four-plex, and 20-unit housing modes. These examples are only for the purpose of illustrating what it might cost to address the gap at the high intensity end of the need spectrum (i.e. Example D) in different ways.

Table 2: *Estimated order of magnitude costs for three PSH options*

Building Type	Characteristics	Capital Costs	Per person costs, per year		
			Operational	Support	Total
Single detached residence	• Single detached residence for single individual • 24-hour on-site support and supervision delivered by cross-disciplinary paraprofessional teams • Ongoing professional mental health supports • Access to additional clinical supports as necessary	$532,750	$20,294	$160,000	$180,294
Four-plex residence	• Four-plex residence for four individuals • 24-hour on-site support and supervision delivered by cross-disciplinary paraprofessional teams • Ongoing professional mental health supports • Access to additional clinical supports as necessary	$965,250	$18,264	$140,000	$158,264
20-unit residence	• 20-unit residence for twenty individuals • 24-hour on-site support and supervision delivered by cross-disciplinary para-professional teams with mental health support • Ongoing professional mental health supports on site • Access to additional clinical supports as necessary	$2,722,732	$14,385	$120,226	$134,611

Although it seems intuitive that economies of scale could be achieved with larger residence types that can accommodate more individuals, it is important to remember that **larger residences may not appropriately meet the needs of all individuals**. A variety of PSH options will be required to fill the high intensity needs gap. Despite the array of PSH options in use, there is considerable evidence supporting system cost savings across jurisdictions where PSH has been embraced.

6. Conclusions

Analysis of the current state of the housing and support sectors in Edmonton, combined with relevant research, suggests that:

1. **At least 300-600 individuals with intensive needs are currently homeless in Edmonton. This is a conservative estimate as it excludes those currently in transitional housing who are at risk of becoming homeless.**
2. **More supportive housing is required. Current supply is not adequate to meet the needs of homeless individuals with intensive needs.**
3. **The costs of homelessness exceed those to appropriately and permanently support individuals with high needs.**
4. **Permanent Supportive Housing is a leading practice for serving the homeless who have intensive needs.**
5. **Additional supportive housing approaches are required, although there are promising practices in Edmonton that can be built upon. It will therefore be necessary both to enhance current programs and to develop new supportive housing options.**
6. **Supportive housing requires coordinated service delivery from multiple service systems and, in particular, requires strong integration with mental health and addiction supports.**

7. The Road to Success

The initial mandate of this report included identification of the number, size and location of supportive housing facilities in Edmonton. The analysis of research and stakeholder input indicates that while supportive housing is required, there are several more foundational pieces required to ensure successful, long-term housing and supports for individuals with intensive needs. Accordingly, the following sections discuss several actions needed to end homelessness among the target population, including but not limited to discussion of number, size and location of PSH. Readers should note that the recommendations are not directed at any one audience; rather they represent important steps that should be embraced by the wide range of stakeholders involved in this important work. Key recommendations include:

1. Design actions to specifically support homeless individuals with intensive needs.
2. Increase the availability of Permanent Supportive Housing in Edmonton.
3. Improve coordination among partners who have a stake in ending homelessness for this population.
4. Implement PSH in a manner that is customized for Edmonton.

Design actions to specifically support homeless individuals with intensive needs.

Great strides have been made in Edmonton to end homelessness over the past several years. However, as anticipated by The 10 Year Plan, some of Edmonton's homeless require long-term, supportive housing to end the cycle of homelessness. Given the complexity of their situations, it is imperative that actions be specifically designed for homeless individuals with intensive needs.

Multiple service sectors stand to benefit from successfully housing the subset of homeless with the most intensive needs. In particular, health, police, corrections and emergency response systems would increase their capacity to direct resources elsewhere. There is a clear case for investment from multiple sectors focused on this population in particular, based on the tremendous potential for cost savings, as well as the need for coordinated action in order to stabilize this population and reduce usage of multiple service systems.

Increase the availability of Permanent Supportive Housing in Edmonton.

Edmonton's housing sector does not currently have adequate capacity to appropriately house and support those homeless who have the most intensive needs. Demand for supportive housing exceeds supply, and addressing the capacity shortage will require introducing new approaches to the Edmonton sector, as well as building on current strengths. Recognizing that it may take time to establish adequate PSH capacity, it may be possible to expand or enhance existing programming. This study did not specifically explore the feasibility of doing so, but a number of insights about what is required in the Edmonton context were identified, and these insights may help identify those existing programs that could best be enhanced to meet some of the need (see *How to Implement PSH in Edmonton*, below).

Looking forward, it is clear that PSH presents an opportunity to end homelessness for those homeless with the most intensive needs. Not only does PSH align with the philosophy and vision for Edmonton's housing efforts under The 10 Year Plan, but it has also proved to be successful in jurisdictions across North America. In fact, the National Alliance to End Homelessness (USA) recently stated the following:[19]

> *One policy alternative that is proven effective in reducing chronic homelessness, as well as public health care costs, is permanent supportive housing. Permanent supportive housing programs provide affordable housing accompanied by supportive on-site or community-based services such as mental health and substance abuse treatment, health care, and other ongoing supports…A mounting number of studies and documented success stories definitively find not only the cost effectiveness of permanent housing interventions in reducing emergency room costs, but marked success in reducing chronic homelessness.*

Some PSH exists in Edmonton, but more capacity and variety are required to meet the current need. Specifically, capacity for a minimum of 300-600 individuals is required to meet current unmet demand for PSH.

[19] National Alliance to End Homelessness. Federal policy brief released August 4, 2011. Available online at http://www.endhomelessness.org/content/article/detail/4148. Accessed August 25, 2011.

Improve coordination among partners in future Permanent Supportive Housing efforts.

This particular segment of the homeless population not only presents complex needs, but also demonstrates complex interactions with multiple service systems. Systemic gaps must be closed; health, housing, emergency, police and corrections service systems have proven ineffective in isolation in meeting the full scope of needs that present among this population. A more holistic approach that integrates different services with stable housing is required to end their homelessness, improve quality of life, and reduce the need for costly support services.

It is clear that no one program or model will address the entire range of needs faced by the target population. Indeed, stakeholders have suggested that in some cases specialized supports are required, such as tolerant approaches to substance use or programming designed to resonate with Aboriginal cultural perspectives. **A continuum of supports is required to end homelessness for the most challenging subset of homeless in our city** – meaning that multiple supportive housing options are required to address the quantity, variety and combination of needs that present among this population. Providing a continuum of supportive options also aligns with the emphasis on choice within the Housing First philosophy. Coordination among government, community and agency partners should be enhanced in a number of ways:

Coordinating government services

Improved coordination of government services is required to better address the needs of this population. At present, both homeless individuals and the agencies supporting them are often receiving or requesting services from different branches of government, with no way to ensure that these services are coordinated, or that information is shared between them. In particular, greater collaboration and integration is desired between the following branches of government:

- City of Edmonton services, including police and the Community Services Branch;
- Health, including Alberta Health and Wellness and Alberta Health Services;
- Justice and corrections services (including Alberta Solicitor General and Public Security);
- Alberta Municipal Affairs (including the former Housing and Urban Affairs Ministry) ; and

- Alberta Human Services (including PDD and AISH programs, Employment services, as well as Children and Youth Services, especially for youth in care and homeless youth at-risk of becoming chronically homeless).

A specific and tangible output of integration efforts should include attachment of health services resources to the capital and operating funding for PSH projects. Ending homelessness for the very complex, high-needs homeless population requires supportive housing that integrates addiction and mental health treatment. Doing so has tremendous potential to reduce emergency room visits and hospital admissions for this population, reducing the pressure on the capacity of hospitals in the Edmonton region. Indeed, the shared value proposition of investing in this population should be the basis for building shared projects in partnership with AHS. Individual agencies and Housing First teams are not positioned or resourced to develop these partnership opportunities themselves.

A second desired output would be strengthening partnerships between supportive housing projects and institutions from which individuals may be discharged without stable housing (i.e., both correctional and health facilities). Increased PSH capacity will be required, however, in order to effectively bridge between institutional and supportive housing settings for those with intensive and complex needs – partnerships alone cannot address the issue if there are not adequate placements for individuals being discharged.

Resolving gaps and duplication of services in the housing sector

Each Housing First project under The 10 Year Plan has demonstrated success in housing the homeless in our city. As this work proceeds, it is expected that gaps in service and specific populations requiring more or different supports will be identified (i.e. such as the homeless with intensive needs). Stakeholders have suggested that there is a need for the housing sector in the city to **take a broader, more strategic approach to ensure that the efforts of different agencies are strategically aligned with one another**. This would involve bringing these stakeholders together to address gaps in service, resolve duplication of service offerings by different agencies, and explore opportunities to share administrative and specialized resources. Agencies are not funded to undertake this kind of "big picture" strategic work under The 10 Year Plan, however.

Joint efforts to address acute and crisis situations

Ultimately, ending homelessness for this complex population will reduce crisis situations, social disorder and public intoxication – permanent housing solutions should be the primary goal.

Stakeholders have suggested, however, that there are also gaps in shorter-term, reactive services to address day-to-day situations that occur in part because of the fact that these people are homeless, including mental health crises, social disorder and public intoxication. First responders and community agencies have limited ability to address acute and crisis situations for this challenging population, and agree that more capacity is required to enable more efficient use of resources. Stakeholders do not necessarily agree, however, on what solutions are required, only that there is simply "no place for them" at present. A better way to address these acute issues will require police, AHS (including emergency and specialized service areas), and agencies to together define the protocols, partnerships and resources required.

Implement PSH in a manner that is customized for Edmonton.

What clearly emerges from the research and consultations is that **more than one model of Permanent Supportive Housing is required in Edmonton**, and that the delivery of these models should happen concurrently so that people can choose the option best suited to their needs. The tenants served by the PSH must select the housing as opposed to being selected for the housing. They should be fully aware of their responsibilities as a tenant, and fully understand why they were eligible for a PSH option.

Consultation with homeless individuals and other stakeholders identified the following key considerations for how best to address gaps in service for the homeless with intensive needs in Edmonton, including but not limited to recommendations regarding size and location of housing projects:

How to Implement PSH in Edmonton

- More **harm reduction-focused housing** is required that is tolerant of substance use and related behaviours.
- Services that resonate with the **cultural perspective of Aboriginal people** in Edmonton are important in working with many of Edmonton's homeless who have the greatest needs for support.
- In keeping with the opinion generally shared by the Housing First agencies, one of the presenting issues amongst the population to be served in PSH should be persons with **cognitive functioning challenges**.
- Housing models on a **small scale** – less than 30 (or even 20) units – are likely to be more successful at integrating within communities in Edmonton.
- **Transparent access criteria** are important to ensure that PSH is not used as a "dumping ground" for people deemed hard to serve by a given agency or institution.
- **Community-based operators can help make PSH successful** since they have established trust in the community and they have experience with potential clients. However, it was suggested many times that **the best operators may be organizations that are not currently delivering Housing First programs**. This is because of the risk that current providers may employ PSH as another tier of their current service offerings, rather than a separate program with distinct assessment and admission criteria.
- **Assertive outreach** is necessary to overcome barriers to access, and in particular to reach those individuals "living rough" on the street, and those who have not been willing or able to access existing programs.
- **Sustainability and longevity of PSH** were expressed as concerns on more than one occasion. For housing providers to be successful at it, they saw the need for a long-term commitment of resources (i.e. in the order of 25 years).
- **Ghettoization should be avoided, and community resources should be engaged appropriately.** One of the important strengths of PSH models is that many are able engage resources in the community to address a range of needs. This means that PSH **projects should ideally be located in well-developed communities** in order to enable integration, a broad network of support, and opportunities for healthy participation in community life**.** However, it may continue to prove difficult to locate PSH projects, which can be controversial, within established communities do to opposition from residents. Innovative solutions, political will and/or different locations may be necessary to establish adequate PSH in Edmonton.
- **PSH should align with the philosophy and practice of Housing First in Edmonton** (see Appendix C).
- Those with the most complex challenges should be served first.

Appendix A Permanent Supportive Housing

Context

Permanent Supportive Housing (PSH) has been a central component of Housing First since its inception. Some models of PSH even pre-date Housing First as we know it. In various pockets throughout North America and Western Europe, various forms of PSH arose first as part of the decentralization and deinstitutionalization within mental health facilities to more of a community based model. PSH was seen as a viable community response to this movement. There were a range of Permanent Supportive Housing models put in place, from client-centered models with a strong emphasis on community integration, to more institutional models, some of which required compliance with medications and treatment, and sobriety.

In recent years as Housing First has expanded, there has been greater discussion regarding PSH as a compliment to existing Housing First programming. Much of this discussion in the housing field has centered on purpose-built or acquired buildings that are available specifically, mainly or partly for Housing First clients. These models with various types of congregate space and different hours and types of supports are viewed as something distinct from the scattered site support models.

In the context of the present study, the impetus to examine PSH as an opportunity for improvement was a feeling that Housing First was not working for a specific group of individuals, and that one or more complimentary approaches was needed. This sentiment is not unique to Edmonton. For instance, in the delivery of Housing First in New York City there is a combination of programs like P2H with more centralized PSH available through the Street to Home program with Common Ground (see below). In the delivery of Housing First in Toronto, the scattered site model dominates through the Streets to Homes program, but there are also dedicated PSH units available for certain individuals served within the program who are not doing well maintaining housing and life stability within the scattered site approach.

Definition and Scope

No single defined model or history of Permanent Supportive Housing currently exists.[20] It does not have a single defined built form or intended target population, and funding and

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[20] In some jurisdictions, the word "Permanent" is not used to describe the supportive housing but that does not necessarily mean that the housing is temporary or transitional. Moreover, some jurisdictions use "Supported

service models vary widely. **PSH recognizes the need for long-term, supportive housing, and aligns with Housing First ideology, but can vary a number of its components along a continuum**:

- **Affordability** – There are variations on the degree of affordability within a PSH model. Generally, in Canada, the rent levels are most often set at 30% of the household's gross monthly income. However, some jurisdictions outside of Canada will focus the rent within a range of the Area Median Income. For instance, in cities such as Portland, Oregon, there is special emphasis to ensure that housing is affordable to households at 0-15% of the Area Median Income, with focus on the most economically disadvantaged segment of the population. This is not to say, however, that there are no examples of Permanent Supportive Housing that are less affordable. While not overly common, there are examples of projects in Ontario that set the rent at CMHC average market rent for a unit of the same size within the community.

Variable PSH Components

- *Affordability*
- *Access*
- *Concentration*
- *Building design and density*
- *Support service delivery*
- *Relationship with community*
- *Specialization*

- **Access** – Different PSH models use different methods to determine who will have access. In some cases, individuals self-select as likely candidates, and other models employ assessment or decision making tools to screen candidates. The Housing First sector in Edmonton has begun to employ the SPDAT (Service Prioritization Decision Assistance Tool) to determine acuity of need and aid in placement decisions. It is important to note, however, that Edmonton data shows higher acuity at intake is not necessarily a defining criterion for which individuals will not remain stably housed. In some PSH models, there is a strong movement towards controlling access by non-residents. The guest policy at the Buffalo Hotel in Red Deer is an example. In other PSH, there is more of an open door policy that allows more frequent and regular visits by non-residents, which can include people that "couch surf" within units in the building.

- **Concentration** – In some models, PSH is a multi-unit residential building where all tenants have access to the supports, but others use scattered site models and

Housing" or "Housing with Supports" instead of "Permanent Supportive Housing". These alternate terms are used to capture the essence of both transitional and permanent supportive housing.

congregate living models, head-leasing or single-family homes and townhouses. PSH does not have a prescribed scale pertaining to the minimum or maximum number of units per building or housing complex. For example, the Times Square Permanent Supportive Housing that is owned and operated by Common Ground in New York City, has the largest number of units with a single building—652 units—and is heralded as a success. Meanwhile, supportive housing operators such as Ecuhome in Toronto, feature some houses with as few as three occupied units.

- **Building Design and Density** – PSH can include purpose-built facilities as well as buildings that are acquired for this purpose. The experience of tenants is impacted (positively or negatively based upon their own perceptions and interests) by a number of factors: size of units; density of building; number of floors; use of elevators versus stairs; amount of shared space – optional (e.g., a living room) and mandatory (e.g., when the only bathrooms are shared). The perspective of several existing PSH providers is that staff-to-tenant ratios are key for operational effectiveness regardless of the density. When there is a low-barrier environment and the tenants are more likely to use substances and to experience concurrent disorders, it is more likely that the building experiences more significant wear and tear.
    - **Shared accommodation** – While it is common amongst support service providers to think that all people need and want an individual unit, the experience of several PSH providers suggests that there will always be some tenants that prefer shared accommodation as a way of decreasing their social isolation. Anecdotally, it has been suggested that this is a greater preference amongst that have experienced long stretches of institutional living and/or incarceration. While shared accommodation may be a preference for some, however, research conducted in Toronto indicates that people in shared accommodation are more likely to move than individuals in independent accommodation and are less likely to have a positive reflection of their housing experience.
- **Support service delivery** – While all PSH has supports—hence “Supportive Housing”—there are no existing standards about the type, intensity, duration or frequency of the supports. Further, there is no standard about whether the supports are delivered by the operator of the housing, sub-contracted or brokered to the facility. While some PSH has 24/7 supports on-site, many models do not. Similarly, there are no universal models of support for specific populations being served.

- **Separation of landlord and support functions** – If the same individual providing support is also the person who provides eviction notices, there can be a power dynamic created that interferes with a successful therapeutic relationship. In this regard, PSH providers that have this sort of separation indicate that it is one of the defining characteristics of their approach. Defining the landlord role as it relates to the support services and housing operation as a whole is key to defining what type of PSH is being delivered and for determining the threshold for eviction. Some Permanent Supportive Housing providers such, as the Portland Hotel in Vancouver, are guided by a "no eviction" policy. Instead of evicting clients, they meet clients where they are at and move with them through their journey to stability.

- **Relationship with community** – Many PSH providers purposefully make their housing visually indistinguishable from the rest of the neighbourhood. This most often pertains to built form. All the same, they are not so naïve as to think that other residents of the community won't know that there is supportive housing present. To that end, many PSH providers establish committees early on – prior to tenancy occurring – to proactively focus on community development, engage in ongoing community relations, and strategize about what action steps need to occur in the event that situations arise that need to be addressed to relieve community tension. In some instances, PSH is seen as a community resource where there is meeting space available to other groups and this can even be a revenue generating opportunity. In other instances, PSH has been defined by its integration with existing neighborhoods and the preservation of heritage buildings, such as Cornerstone in London.
    - **Social purpose enterprise** – While not common, there are some PSH providers that define themselves by their ability to provide on-site access to a social purpose enterprise. Residents live and work in the same building and the revenue that is generated helps support the housing activities. Examples include franchises such as Ben and Jerry's, coffee shops, catering and ballroom rentals and print shops.
- **Specialization** – In some jurisdictions, there is a sub-set of PSH specifically designed for individuals who want a low-barrier environment. This could be due to their behavioral issues often associated with substance use and/or cognitive functioning and decision-making. There are also examples of PSH models focused on serving youth, which is only

"permanent" until they reach the age of 25 (or 29, depending on the housing situation and source of funding).

- **Harm reduction** – Whether individuals are required to complete treatment as a condition of their housing varies as well. Treatment and compliance-based PSH is generally a direct result of the source of funding and the ideology of government funders rather than the preferred approach of some providers. In this configuration, failure to remain sober, follow treatment protocols, meet with psychiatric counselors, undertake therapy, participate in groups and/or take psychotropic medications—or other types of medications—can be reason for eviction. [21] Other PSH has a strong harm reduction focus and tolerates intoxication and/or substance use on site. The harm reduction approach can vary; some providers have policies in place that allow alcohol consumption in a unit, but not other drugs, for instance. Others still have policies that forbid the use of alcohol in common areas within the building. Establishing substance use and acquisition policies is critical in advance of operating the Permanent Supportive Housing.

Drivers of PSH Models

There is a considerable range of understanding about what constitutes Permanent Supportive Housing. **PSH models in different locations tend to be driven and designed based in large part on:**

1. **The population to be served; and**
2. **The funding source(s).**

Most often, there are one or more unifying characteristic(s) of the target population that assists with the organization of appropriate supports for residents of those PSH models that have proven to be efficient and effective. Examples of the types of unifying characteristics can include the likes of chronic homeless; diagnosed mental illness that is either considered moderate or severe and persistent; substance users; persons fleeing domestic violence; persons who have aged out of other government-sponsored housing; seniors; persons who identify as

[21] It should be noted that the existing longitudinal research on Housing First and the Pathways program in New York City demonstrates that Housing First helps individuals achieve better long-term housing outcomes through its scattered site support model than compliance based, treatment focused, single-use approaches.

Aboriginal; persons with HIV/AIDS; persons with a history of conflict with the law; persons with a brain injury or persons requiring home care and daily living assistance.

In any case, the assumption is that when there are one or more unifying criteria for residents, there is a greater ability to match the housing to the mission and mandate of the housing provider organization. This structuring of support services also helps ensure that the appropriate professional resources can be assembled without losing the ability to address the unique circumstances of each resident.

Funding sources greatly impact the configuration of PSH. For instance, some PSH is funded through health systems. Health acuity is usually determined through formal clinical assessment in these instances. Further, the pathway into the housing is defined by the client's existing relationship to the health, mental health and/or addiction system(s) of service.

In contrast, other PSH is funded through justice/correctional systems. The degree of interaction with the criminal justice system is usually the defining criterion for entry in these cases. Candidates for housing are screened based upon their interaction with the homeless (usually shelter) system and jail and the pathway into housing is defined by the client's existing relationship with the criminal justice system.

Still other PSH is funded through a combination of government and private fundraising initiatives and, as such, these models tend to have considerably more diversity in residents and pathways into the housing. PSH providers involved in this realm of funding often argue that the other "systems" try to use their PSH as the "dumping grounds" for non-compliant or difficult to serve individuals who do not follow rules-based and treatment-focused housing models. These same Permanent Supportive Housing providers remark that there is considerably more competition to gain access to their units because the intake process is seen as being more inclusive.

Appendix B PSH Models in Other Jurisdictions

A total of 14 PSH models from other jurisdictions were explored and analyzed to discover their design, key components and potential relevance to implementation of PSH in Edmonton.

These models include:

1. Portland's Ten-Year Plan to End Homelessness
2. Downtown Emergency Service Centre (DESC), Seattle
3. The Times Square, Common Ground, New York
4. Portland Hotel, Vancouver
5. Bosman Hotel Community, At Home, Vancouver
6. Strachan House, Toronto
7. Buffalo Hotel, Red Deer
8. Mainstay Housing, Toronto
9. Houselink, Toronto
10. Pathways to Housing, New York City
11. Direct Access to Housing, San Francisco
12. Anishinabe Wakiagun, Minneapolis
13. Renato Apartments, Los Angeles
14. Lakefront SRO's South Loop Apartments, Chicago

1. Portland's Ten-Year Plan to End Homelessness

As part of Portland's Ten Year Plan to End Homelessness, the City has committed to the construction of 1,600 units of permanent supportive housing for chronically homeless single adults and 600 units of permanent supportive housing for homeless families with special needs that will be completed by 2015. A little more than half of the units (1,200) will be developed through new construction. The remainder (1,000) will come from existing units—both affordable and private market units—that will be renovated, converted and reprogrammed as permanent supportive housing by attaching rent subsidies and services. This will include leasing some units from the private sector. The City has partnered with Portland's affordable housing developers to achieve the permanent supportive housing goals laid out in the Ten Year Plan.

In the past 15 years, affordable housing in Portland has been developed primarily to be affordable for households with incomes from 30% to 60% Area Median Income (AMI). One of the priorities of the Ten Year Plan is to develop permanent supportive housing for households with incomes between 0% and 30% AMI, with an emphasis on those with the lowest incomes—0% to 15% AMI. The City has recognized that the new units serving 0% to 30% households will not produce enough income from rents to support private debt at the levels that previously funded projects leveraged. As a result, the City has acknowledged that the subsidy per unit will need to increase and that the City's subsidy will have to be programmed as debt-free. To partially deal with the change in approach, the City has created an Operating Subsidy Fund. This fund will support units/projects that have zero or shallow long-term, predictable cash flow from rents or rent subsidies. It is estimated that 1,100 units would need to be supported from this fund and that the fund will distribute about $33,000,000 over a 10-year period averaging just over $3.3 million per year based on the assumption of $3,000 per unit per year.

The City also plans to create a Risk Mitigation Pool. This pool will support damage repair expenses that exceed annual budgets. It is estimated that 1,200 units will need to have access to this fund pool and that this pool will distribute approximately $3,800,000 over a 10-year period, averaging just over $382,000 per year—approximately $10,000 per unit per turnover.

To better connect clients with housing, the City will also develop a Discharge Planning Workgroup that will focus on linking people who are discharged from institutions, particularly jails and hospitals, with permanent supportive housing and other services.

Portland is also selective about the populations it aims to serve and the rationale in each of its Permanent Supportive Housing Projects. For example, the Commons, one of the newer projects on the go has a focus on serving formerly homeless people with a brain injury. This specialization will allow the City to align supports with the needs of the residents.

Potential Relevance of Model to Edmonton – The focus on persons with very low income; focused attention on specific populations in the creation of Permanent Supportive Housing (e.g., Commons focuses on persons with brain injury); Permanent Supportive Housing a consideration through discharge planning.

2. Downtown Emergency Service Centre (DESC), Seattle

DESC owns and manages nearly 1,000 units of supportive housing throughout Seattle, and has two additional building sites in development with projected completions in 2011 and 2013. The 8 DESC housing sites have 24/7 access to supportive services, including: state-licensed mental

health and chemical dependency treatment, onsite health care services, daily meals and weekly outing to food banks, case management and payee services, medication monitoring and weekly community building activities.

DESC housing residents may experience mental illness, drug and alcohol addictions, HIV, physical or developmental disabilities, and extreme poverty, and in some cases, residents are affected by several of these conditions.

DESC manages applicants for Supportive Housing projects by prioritizing them according to a Vulnerability Assessment score. The Assessment rates a person's level of functioning or severity of condition across 10 domains. The domains are as follows: survival skills, indicated mortality risks, organization/orientation, substance use, social behaviors, basic needs, medical risks, mental health, communication and homelessness. The Vulnerability Assessment tool ranks from 1—no evidence of vulnerability—to 5 where there is evidence of severe vulnerability. The client must be homeless and has to confirm her/his disability to be eligible for DESC Supportive Housing.

The "crown jewel"—or at least most celebrated—building in the DESC portfolio is the 811 Eastlake building. Garnering national attention in the US, the building has a strong focus on harm reduction and is considered a "wet" house (low barrier) for individuals who use alcohol and are not ready or interested in sobriety.

Potential Relevance of Model to Edmonton – The use of a tool to assess potential candidates for the Permanent Supportive Housing (for instance, the Service Prioritization Decision Assistance Tool—SPDAT—that is already in use in Edmonton); consideration of harm reduction as part of the overall Permanent Supportive Housing portfolio.

3. The Times Square, Common Ground, New York

The Times Square was acquired by Common Ground in 1991 and is the largest Permanent Supportive Housing project in the United States. It is a reused heritage building, housing 652 low-income and formerly homeless individuals and persons living with HIV/AIDS. The Times Square provides individualized support services that are designed to help tenants maintain their housing, address health issues, and pursue education and employment. Onsite assistance with physical and mental health issues and substance abuse is available to all tenants, six days of the week. Rooms are fully furnished with private baths, kitchenettes and ceiling fans. All residents must sign a lease and to be eligible for residency, must earn less than 80% of the area's median income. Rent is set at approximately 30% of a tenant's gross annual income.

The Times Square combines permanent affordable housing with a range of onsite social services provided by Common Ground's social service partner, the Center for Urban Community Services. Common Ground's affiliated not-for-profit property management company, Common Ground Community, provides property management services that include 24-hour security.

Common areas are accessible to residents and include a garden roof deck (also available for rent to the public); a computer laboratory; a library; an art studio; a medical clinic; 24-hour laundry facilities; a rehearsal space and an exercise room. In addition to the garden roof deck, a community room on the top floor, "Top of the Times", is used for events both for tenants as well as rentable to the public. On the ground floor, the lobby functions as an art gallery and the Times Square Ben and Jerry's Partnership is Common Ground's first social venture business, which offers employment training for tenants and generates income to support programs. Ben and Jerry's donated the franchise to Common Ground and waived its franchise fees.

The total budget for the project was $36,120,019, $9,533,949 for the acquisition of the building and $26,586,070 million for redevelopment and construction costs. Funds for the acquisition and redevelopment were received from the NYC Department of Housing Preservation and Development's SRO Loan Program and the Low Income Housing and Historic Preservation Tax Credits. The annual operating budget for the Times Square is $5.5 million and rental income covers the basic operating expenses of the building.

The operation of the Times Square has been closely linked with Common Ground's *Streets to Home,* street outreach program operated in the Times Square area. Using a by-name registry to identify individuals repeatedly living in the area and resisting other services, the street outreach program has successfully assisted many individuals to move from living outside in Times Square to living indoors but still within the Times Square.

Potential Relevance of Model to Edmonton – the use of a historic building for a new purpose; separation of support services from landlord; integration of common spaces throughout the building; integration of social purpose enterprise to the building.

4. Portland Hotel, Vancouver

The Portland Hotel provides permanent, semi-private housing for 86 adults with concurrent disorders; it is run by the Portland Hotel Society and was developed by the Downtown Eastside Resident's Association. The Hotel became operational in 1991 and the Portland Hotel Society was formed in 1993. The Portland Hotel receives its funding from the Vancouver Coastal Health Authority and British Columbia Mortgage and Housing.

Each room has its own toilet and shower, seventeen of the units have full kitchens and all others have minimal food facilities with each floor having a communal kitchen, laundry facility and lounge. The ground level has a non-profit run café that provides one free meal a day for residents and 3 meals for residents who are HIV positive. Other shared amenities include a television lounge, a multi-purpose room, and small rooms for service providers to work in while onsite.

The Hotel support includes a total of eight mental health workers, two of whom are always onsite in 12-hour shifts, and a doctor and nurse are onsite four half-days each week. The program also arranges for a variety of other services, including: home support services, nutritional counseling, and general counseling.

The Hotel has a no eviction policy with emphasis on accepting clients/residents as they are and moving with the client on their self-determined path.

The Portland Hotel has no formal intake or admissions process apart from the guiding criteria outlining whom the program serves. Similarly, it has few rules and regulations. Emphasis is placed on accepting residents where they are at and being flexible, responsive and creative in working with them to remain housed and as healthy as possible. Sustained housing is evident with approximately 40% of residents staying at the Portland Hotel for 10 years and the balance of residents stay 4 to 6 years.

Potential Relevance of Model to Edmonton – A funding structure jointly from health and housing; the combination of unit types in same building with certain shared amenities.

5. Bosman Hotel Community, At Home, Vancouver

The Bosman Hotel Community is part of *At Home*, a research demonstration project run by the Mental Health Commission of Canada that is investigating mental health and homelessness in five Canadian cities: Moncton, Montreal, Toronto, Winnipeg and Vancouver. The At Home project is based on a Housing First approach and the Bosman Hotel Community site in Vancouver is a congregate living project. The cost of the project is $110 million, funded by the federal government. $30 million has been allocated for Vancouver and the funding for the study ends March 31, 2013.

About 2,285 homeless people living with a mental illness will participate in the entire research project. 58% (1,325) of the people from that group will be given a place to live, and will be offered services to assist them during the course of the initiative. The remaining participants will receive the regular services that are currently available in their cities. Participants will have

to pay a portion of their rent and they will be visited at least once a week by program staff. The emphasis of the project is choice. People will be able to choose housing within a number of different sites within their cities, including apartments and group homes.

The focus in Vancouver is on people with substance abuse and addictions. Vancouver has a total of 500 participants, 300 with high needs and 200 with moderate needs. Of the 500, 200 will be placed in apartments spread across the city and 100 will placed in congregate living at the Bosman Hotel Community, the remaining 200 will function as a control group who will be monitored but offered no housing or services.

The first residents moved to Bosman in June 2010 and, as of March 2011, there were 92 residents. In terms of support and services offered, the Bosman Hotel Community has 3 case managers, 2 registered nurses, 3 licensed practical nurses, a peer employment coordinator, mental health workers, a family doctor, a psychiatrist, a pharmacist and a project manager. In addition to clinical and psycho-social services, the Hotel also offers recovery based programs and workshops, including home support, nutrition programs, First Nations circles, and women's grief and loss groups. When participants arrive, clinical staff conduct baseline health assessments and case managers determine short and long-term goals. The Hotel also offers some employment opportunities. Some residents receive an honorarium for work around the building. The Hotel also has a partnership with the Downtown Vancouver Business Improvement Association gum removal program. As part of its community integration, prior to opening, the Hotel setup the Bosman Neighborhood Advisory Committee to help develop its Operation Management Plans and complaints process.

Potential Relevance of Model to Edmonton – Provision of baseline health assessments at intake; working with downtown businesses to create employment opportunities; advisory committee to create operation management plans and complaints process.

6. Strachan House, Toronto

Strachan House is a converted warehouse located in the west end of Toronto that was redeveloped for permanent supportive housing. Strachan House is based on *StreetCity*, a housing project formerly located in the Portlands in an empty Canada Post warehouse. Strachan House consists of eleven houses, each with their own kitchen, bathroom, and common area and is connected by a network of streets. Strachan House is a first step off the street and there are 76 units for single adult men and women. Each unit has its own front door and a window onto the "street". In June 2003, a twelfth house was added with funding assistance from SCPI and the City of Toronto.

The eligibility criterion for Strachan House is men and women over 21 years of age that are chronically homeless. It is a rent geared to income model with 24-hour staff coverage, shared kitchens and washrooms, a visiting public health nurse and hostel units for potential residents.

The tenant support services provided by Strachan House include: individual case management, individual and group counseling, crisis intervention, mediation and conflict resolution, life skills training including personal hygiene and self-care, nutrition and cooking skills, and home cleaning and basic maintenance, food access programs, housing supports including options counseling and referrals; assistance and advocacy accessing and maintaining income supports, eviction prevention with special reference to rental and hoarding issues, referrals to social services including government programs and those provided by other non-profit agencies; and community development including social and recreational activities.

The Strachan House mandate is to house individuals who have a history of homelessness and are considered "the hardest to house" and providing them with food and a safe and comfortable living environment. Individuals living at Strachan House are men and women with severe mental health and addiction issues.

Strachan House is staffed 24/7 with 10 full-time Community Housing Workers. Strachan House is a hybrid of both shelter and rooming house and so it is governed by both the Residential Tenancy Act and Hostel Standards.

Streets to Homes in Toronto has a contract agreement with Strachan House that allows for the program to have access to a designated number of units on a regular basis as a housing option for specific clients.

Potential Relevance of Model to Edmonton – A warehouse redevelopment that allows for creation and reclamation of space in a new way; potential residents start by living there and are funded as if staying at a shelter before they choose whether to stay.

7. Buffalo Hotel, Red Deer

The Buffalo Hotel is a converted historic hotel in downtown Red Deer. Owned by a private company, Potter's Hands Ltd., the building operations and supports are provided by the Canadian Mental Health Association.

There are 40 units available in the Buffalo and they rent for approximately $450 per month. CMHA staff is available 24/7 onsite while external, professional resources are brought to the housing on a regular basis.

Over the past year, the Buffalo has undergone significant transformation. With a new Executive Director and a strong focus on integrating the Buffalo with the delivery of Housing First in the community, the Buffalo now uses the Service Prioritization Decision Assistance Tool (SPDAT) to determine client acuity at intake and to track case management progress over time. Training is also being upgraded for many of the existing staff members.

While the Buffalo has, at times, been a lightening rod within the downtown community, the City of Red Deer has invested in community development work within the downtown area. Furthermore, Buffalo residents and staff will point out that many of the individuals that local businesses complain about are not residents of the Buffalo.

Potential Relevance of Model to Edmonton – use of historic building; fully integrated with Housing First; use of SPDAT to assist with intakes and case management with residents; investment in community development work to improve relations with local business.

8. Mainstay Housing, Toronto

Mainstay Housing is the largest non-profit provider of supportive housing in Ontario. There are 41 different locations of housing located in many neighborhoods across Toronto, with a total of 867 units. Mainstay's annual operating budget is $14 million.

Twenty of their locations are apartment buildings, of which most contain one-bedroom and bachelor type apartments. Approximately 90 units have two or more bedrooms and are designed for families. The remaining locations are shared buildings with private bedrooms, most of which have a backyard that can be used by tenants. Each unit uses a rent model that sets the rent fee in relation to the individual tenant's income.

The tenants of Mainstay Housing are all people living with mental illness who are capable of living independently. There is approximately one support worker for every 70 households, who mainly assist tenants to find appropriate supports, such as referrals to a therapist or providing information about local food banks.

In working with the street homeless population served by *Streets to Homes*, there is a special case manager within Mainstay Housing that is funded to work specifically in partnership with the other follow-up supports that that the tenant receives.

Potential Relevance of Model to Edmonton – The combination of different types of buildings within the portfolio for the agency; focus on families as well as singles; additional supports for Housing First clients; focus on a specific population (persons with mental illness).

9. Houselink, Toronto

Houselink owns 22 buildings across Toronto and also provides support to people in 20 other properties. Their mission is to provide permanent supportive housing to consumer/survivors with mental illness. The units are a combination of shared, self-contained, and family units. Rent is set to the tenants' level of income, and tenants and support workers come to an agreement about how much support the tenant wants.

Each of their 463 residents is considered a member, and must be able to live independently. The focus of Houselink is on community and members are encouraged to participate in social events and community development. An additional 70 people have become members just to participate in Houselink services. One of the notable achievements of Houselink is the creation of the Dream Team. The Dream Team is a group of men and women living with mental illness and residing in supportive housing who have come together to speak out on behalf of the thousands of people in Ontario suffering from mental illness who need safe, secure, affordable and supportive housing. They are advocates of supportive housing and speak out to politicians, community groups, schools, faith groups and other institutions in order to promote more supportive housing resources to be made available in Ontario.

Potential Relevance of Model to Edmonton – The ability to live independently as a pre-requisite; focus on a specific population (persons with mental illness); combination of different types of buildings across the portfolio of the agency; "membership" orientation; tenants and support workers agree about how much support the tenant wants as opposed to supports being thrust upon the tenant.

10. Pathways to Housing, New York City

Pathways to Housing is one of the best known Housing First projects, started in 1992, Pathways now offers 450 units of permanent supportive housing for people who are homeless, with psychiatric disabilities and substance abuse disorders who have been turned away from other agencies because they were not considered housing ready.

Pathways does not require participation in psychiatric treatment or sobriety as a condition for housing. Pathways fulfills its mission by providing people with apartments of their own and then offers extensive ongoing treatment and support services through interdisciplinary Assertive Community Treatment (ACT) Teams.

Eligibility for the program includes the following:

- the individual must be homeless

- the person has a psychiatric impairment that results in disability
- the person agrees to meet with a case manager a minimum of twice a month during the first year of tenancy
- the person will pay 30% of their income towards their rent by participating in the agency's money management program

Refusal to participate in sobriety or other treatment programs does not disqualify an individual, nor does a history of violence or prison time. Since 2001, Pathways has partnered with the Rikers Island correctional facilities to provide housing for those recently released.

The housing that is available is independent, "scatter site" apartments, rented from over 200 private landlords from the stock of market rental properties. Pathways searches recent vacancies and negotiates with landlords and, as part of their eligibility requirements, the tenants pay 30% of their income towards rent.

Because of the scatter site model, services offered by Pathways are run by an ACT team who function as a single point of contact for tenants with at least one team member being available 24/7. This ACT team eliminates the need for an onsite supports facility. There are several satellite offices around the city and Pathways offers most services directly rather than providing referrals. The staff-to-client ratio is approximately 1:10.

Potential Relevance of Model to Edmonton – There are very clear population criteria (homeless, psychiatric impairment that results in disability, etc.); 24/7 supports through the ACT team.

11. Direct Access to Housing, San Francisco

Established in 1998, the Direct Access to Housing (DAH) program was setup by the San Francisco Department of Public Health in response to the rising costs of "high-utilizers" of the public health system. The program specifically targets chronically homeless adults with disabilities, substance abuse problems, and severe/persistent mental and emotional disorders. The majority of the homeless individuals have been hospitalized on multiple occasions. This approach is extremely low barrier and accepts people with histories of felony convictions, arson, drug addictions, and illegal immigrants.

The program offers 623 units in 10 buildings that are owned privately and used by the program through a long-term lease, this practice is known as "master leasing". Staff from the DAH search for suitable buildings that are mostly vacant and approach the landlord about using the building for supportive housing. Nine of the buildings are Single Room Occupancy (SRO) hotels

and one residential care facility. The sites are between 30 and 100 units each and include three to five onsite case managers. Each building has access to a mobile Behavioral Health Team whose primary goal is to prevent the loss of housing because of exacerbated mental health problems. The tenants in these buildings have access to medical care, on-staff nurses or some of the buildings are purposely located near a public health clinic.

The total cost per resident is approximately $1,200 per month. Tenants pay half their income towards rent, which is an average of $300 per month. The rest of the funding comes from government sources.

Potential Relevance of Model to Edmonton – The use of master-leasing in existing buildings instead of new builds or acquisition; focused attention of population to serve such as persons with high frequency of interaction with public health system; low barriers.

12. Anishinabe Wakiagun, Minneapolis

This housing project was designed primarily to serve Native Americans who were formerly homeless and are chronic alcoholics. It was created through a partnership between Project for People in Living (PPL), a non-profit organization that manages affordable housing services and American Indian Housing Corporation (AIHC), a non-profit housing developer.

This project consists of one building with 40 SRO units that are occupied by 30 males and 10 females. All of the tenants are chronic alcoholics though very few, if any, of the tenants abuse substances other than alcohol. Almost all of the tenants are unemployed, and about 20% receive social security or disability.

Tenants do not have to be engaged in services prior to entry into the housing, nor do they have to meet a sobriety requirement—most are not in active treatment. Over 50% of residents have never held a job and over 50% have never experienced permanent housing. About 75% of the tenants are self-referred and 20% are referrals from the detox center.

Applicants are rejected if their references indicate that they are violent or dangerous.

The project is considered “housing of last resort” and provides a “low demand” environment for chronic inebriates who are not eligible for other housing because of sobriety requirements. While a harm reduction approach is taken, substance use other than alcohol is not tolerated and drinking is not allowed in the building’s common areas.

The building has one case worker, three meals per day are provided in the common dining area and social activities are scheduled. The case worker's primary responsibility is to arrange for medical and health attention.

Tenants are not required to pay rent. The Minnesota Group Residential Housing Program Rent pay rent and service costs—approximately $1,000 per tenant per month.

Potential Relevance of Model to Edmonton – The focus on indigenous peoples; focused attention on presenting issues (chronic alcoholics and homeless; not users of other substances); no sobriety requirement; self-referral possible; drinking in rooms permitted, just not in common areas.

13. Renato Apartments, Los Angeles

Opened in November 2010, this project located on the infamous Skid Row, added 95 SRO units, in a brand new $25 million apartment building. The Renato Apartments offers permanent-supportive housing to residents who earn up to 45 percent of the area median income (AMI). Sixty apartments are reserved for the chronically homeless and those who suffer from mental illness. Section 8 Rental Subsidy of the United States Housing Act subsidizes rent costs.

An organization called SRO Housing provides onsite social services; as well the residents can also access social support, such as free meals and drug and alcohol recovery programs, at the neighboring community center.

Potential Relevance of Model to Edmonton – The use of rent subsidies for the rent; focused attention on population to serve as a percentage of all units (chronically homeless with mental illness); on-site services as well as service at neighboring community center.

14. Lakefront SRO's South Loop Apartments, Chicago

This is a 9-story new apartment building that is located in an underserved neighborhood in Chicago's North Side. It is comprised of 207 units; the first floor is reserved for an employment/job training center as well as offices for support workers and community spaces. The job training center is also available to the public and includes computers with internet access, a used clothes center, a presentation hall, and resource library.

While case managers work to help tenants connect to appropriate services, the highlight of this project is the level of affordability as the tenants are extremely low income and marginalized members of society.

The building cost was $20 million and was financed through a complex capital structuring package that included seven different public sources, three private investors and a number of private contributions combined with extensive use of low-income housing tax credits. The result, however, was that even the unsubsidized units can now be rented at $286 per month and 20 units are subsidized and available at $75 per month with an additional 15 units at $125 per month.

People who are both homeless and disabled can access the designated 60 units and another 10 units are reserved for people living with HIV/AIDS. There are 16 handicap accessible units and another 32 units are adaptable for disabilities.

Potential Relevance of Model to Edmonton – The capital financing allowed rents to be low and unsubsidized; strong emphasis on access to employment; community resource within the building on the main floor.

Appendix C Alignment of PSH with Housing First Ideology and Practice in Edmonton

There are several important ideological components that require consideration to be consistent with the Housing First philosophy in Edmonton – these values have been part of Housing First in Edmonton since its inception, and have been reinforced repeatedly in training with service providers throughout the city:

The first area where consistency is required is in **providing meaningful housing choices—not housing placements**. "Choice" is consistent with a recovery orientation and strength based perspective. Choice places the individual at the center of their journey towards housing stability. Moreover, consumer choice—especially amongst consumer survivors and persons with addictions—has proven to be a core ingredient for program success beyond just housing. Integrating a choice-based approach with PSH in Edmonton will mean that more than one PSH building/approach should be available concurrently, featuring more than one model of support service delivery.

Related to choice, PSH must be **client-centered in its service orientation and service delivery**. The client-centered approach relies on the creation of an Individualized Service Plan that serves as a blueprint for housing and life stability while grounded in housing as the first step. This approach values the opinion of individuals in their support plan and empowers them towards decision-making and greater independence. PSH does not necessarily mean that a dependent relationship needs to be created. Tenants are engaged and they provide direction regarding their future as opposed to taking direction.

To be consistent with Housing First practice, the client-centered approach must also be **strength-based instead of deficit-based**. It is important that providers build upon that which the individuals have to offer rather than what they are lacking. Given the multiple barriers and probable complex needs of individuals within the housing, finding and harnessing strengths may not be the natural orientation for people who have experience with an approach to service delivery informed by a medical model. Strengths for this population will likely include some unusual attributes such as stubbornness, survival, navigating the judicial system, cultural protection, etc. The fact is, people living in PSH cannot be known only by a label of a diagnosis or even as a resident of the housing. Clients are people first with strengths that can be harnessed and leveraged for greater self-awareness and self-management.

Housing First is not a "first come, first served intervention" so it is important to have a link between the candidates for PSH and acuity measurements already taken by Housing First

service providers. This may require a common process or set of criteria to manage access. Presently, Edmonton's ICM teams use the SPDAT to assist in managing access and placements, but ACT are not required to use this tool. In any case, this should be a seamless and transparent process.

Lastly, to be ideologically consistent with Housing First delivery across the various service providers in the City, the **PSH cannot be compliance based;** a more harm reduction focused approach is more appropriate.

Appendix D Lessons and Research Compiled by AHS

Perspective of Albertans Transitioning Out of Hospital

In 2011, AHS interviewed a number of individuals with mental health and addictions challenges across Alberta who transitioned from hospital into community settings.[22] A number of themes emerged from these interviews that are relevant to the design of supportive housing:

- Interviewees felt like they were at home.
- They liked being in their own home better than a hospital or prison.
- Felt that they were safe, safer than in facility (prison or hospital).
- Felt better about themselves as a person.
- Believed they had a higher level of freedom.
- They were happy that they had friends.
- Staff that were associated with their support were indispensible in all cases.
- In almost all cases, support was very important to their recovery.
- If the program/centre were to close, they believed they could be back in the facility or homeless and on the street.
- Without the support (social and financial) they currently have from the addiction and mental health system, they did not know where they would be. Most assumed they would be on the street or back in AHE or CCMHBI, or worse in some cases, back in prison.
- One strong, recurrent theme was that how to access support (for example: housing, learning to cook, financial management, physiotherapy etc.) was not completely understood (how, where) and what kinds of support were available.
- A suggestion was made for communication regarding support services to be specifically targeted to those who needed a specific kind of support.

[22] Alberta Health Services. (2011). *The Patient Journey: The Voice of the Consumer*. Addictions and Mental Health, Acute and Tertiary Care.

- The value of support respondents received was difficult to describe in detail but easy to describe in absolutes. Worry that the return to their former life before their addiction and mental health issues were controlled, was dependent on the support they currently received.
- Without it, it was felt they would quickly relapse into old, unhealthy habits, i.e.: renewing former, unhealthy relationships.
- One respondent who suffers with depression was certain he would not be alive today with the support he now has from the community services he has become connected to.
- Learning from interviews with clients living in the community include:
  - Successful independent living is possible when accompanied by flexible supports focused on client needs, goals and development.
  - Clients repeatedly identified the following needs for which they require assistance/support: advocacy (includes dealing with landlords, applications for financial assistance, accessing available resources, completing income tax, etc.); making and attending appointments (includes psychiatrist, family physician, dentist, etc.); developing healthy habits (Le. nutrition, organization of belongings, living within budget) and refocusing clients towards healthier thinking and relationships.
  - Two critical features of community care providers are meeting the client where they live and treating clients respectfully. Clients indicate that a respectful yet firm manner is an essential provider attribute.

Literature Review

A 2011 literature review by AHS related to Tertiary Care compiled the following lessons learned from research about shifting mental health care to smaller, more community-focused residential settings:

- It is possible to create good local/regional systems if strong leadership is sustained and resources are focused on providing flexible, non-institutional care.[23]

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[23] Lurie, S. (2008). *Arrividerci Trieste: Reflections and Observations about Mental Health Services in Italy After 30 Years of Reform*. Canadian Mental Health Association. Toronto: Canadian Mental Health Association.

- Community-based models of care have been shown to be largely equivalent in cost to the services they replace, so they cannot be considered primarily cost-saving or cost-containing measures. There can be some cost savings but initially the costs for effective and adequately-resourced community services will be the same or more.[24]
- Creating some practical demonstrations of how things can be better, using best practice in how they are set up and run, can increase the likelihood of overall support.[25]
- The increase in quality of life and social determinants of health generally were well beyond expectations.[26,27]
- There was no increase in symptom severity or in incidents of violence when long-stay patients with severe mental illness were transitioned to community-based residential treatment centers.[28,29]
- Re-admission rates actually declined in most jurisdictions.[30,31]
- The trend towards re-institutionalization needs to be considered carefully, as this may not be a result of de-institutionalization but other factors such as risk tolerance.[32,33]

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- Most studies and reviews have shown no change in the pattern or severity of outcomes for people with mental illness who are transitioned into community-based services from long-term institutional residence. International and Canadian provincial evaluations have demonstrated significant improvement in quality of life, sociability and client and family satisfaction and that health care cost savings realized from decreased inpatient stays and emergency use outweigh the costs of developing adequate housing and services.[34,35]
- The urgency of the need for reform and redesign can inadvertently result in ideological dichotomies or in marginalizing important participants in tertiary care, including the mentally ill clients, their families or community-based non-profit service providers.[36,37,38]
- A number of authors emphasize that mental health systems must include specialized intensive and long-term securable care for those people who cannot tolerate the conditions of community living. There must be adequate and timely support for higher risk patients while continuing to provide the least restrictive environment.[39,40]
- It is essential to ensure that cost savings created from moving to community care are re-allocated into community care.[41,42,43,44]

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- System reform must avoid the automatic transplantation of institutional care practices in community care environments – it is possible to replicate the problems that re-design efforts are meant to solve.[45]
- Some initiatives were able to create some continuity by utilizing familiar staff for long-stay patients who were moved[46,47]

In addition, the 2011 literature review identifies **success factors experienced in implementing community-based, rehabilitation focused services like supportive housing**:[48]

- Effective and timely acute and emergency responses
- Community continuing care services
- Assertive rehabilitation teams
- Partnerships with general practitioners and other human service agencies
- Planning was underway very early and any planned moves included the patients and their families
- Intensive treatment continues in the community
- Rehabilitative programs are strongly integrated during all care
- Placements are home-like with environmental considerations such as private bedrooms
- Open social areas, non-medical care staff are present and situated within familiar communities
- Integrated dual diagnosis treatment
- Vocational rehabilitation programming, along with supported employment, is available

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Appendix E Leading Practices in Other Canadian Jurisdictions for Managing Public Intoxication and Disorder

EPS and EPC stakeholders identified several leading practices within other Canadian jurisdictions for serving the high-needs homeless population – and specifically for addressing some of the more visible disorder related to public intoxication that results in regular police contact.

These models include:

- The Calgary Drop-in and Rehab Center
- Alpha House
- The Downtown Outreach Addictions Partnership
- The Main Street Project, Winnipeg
- Vancouver Detox Center

Calgary Drop-In and Rehab Center (The DI)

- The DI provides emergency short and long term supportive services as well as affordable housing to anyone in need for ages 16 and up. Shelter services are provided free of charge and can be accessed 365 days a year. The DI has a nightly shelter capacity for a total of 1100 clients.
- Operating under a single umbrella organization, the DI combines a wide range of services for the homeless, including shelter, treatment, education, and employment supports. In fact, individuals generally progress upward to services located on higher floors as they become more stable and independent.
- Emergency Beds: accessed on a "first come first served" basis daily. The First Floor serves men and women who are intoxicated or under the influence. The Second Floor serves men who are intoxicated or under the influence. The Third Floor serves sober men and women.
- The DI offers long-term and short-term housing and support. Beds are available to both men and women who are actively engaged in a case management program with a goal of moving towards enhanced stability and ultimate independence. The DI's Supported Living programs operate on both the Fourth and Fifth Floors. Both floors provide

assigned beds in a shared setting, private storage, kitchen facilities and case worker supports. Clients wishing to make application for the transitional programs can do so through an Intake Counselor.

Alpha House, Calgary

- Alpha House is a community-based facility providing services for those who are under the influence of or withdrawing from alcohol and/or other drugs, and who require assistance in stabilizing their condition.
- The Alpha House combines both shelter and detox in the same building. Entry is based on alcohol or drug use, and detox services are managed by non-medical staff that provide withdrawal management.
- The Alpha House presently runs five programs; Shelter, Outreach (DOAP), Detox, Housing and Encampment.

Downtown Outreach Addictions Partnership, Calgary

- The Downtown Outreach Addiction Partnership (DOAP) is a partnership between Alpha House and the Calgary Urban Project Society and provides services to individuals in their homes, on the street and in systems like hospitals.
- DOAP Team is a harm reduction outreach program that focuses on transporting people dealing with addiction issues to appropriate places (over 1600 people per month are transported). The team makes sure people who are intoxicated and in the community get to a safe place to stay 24 hours - 7 days a week.
- Often referrals are made by CPS, EMS, Bylaw, Transit, other community agencies, businesses, the three major hospitals and concerned citizens. They also help people get to medical appointments, get connected to housing and engage people in the community.
- In 2009 an outreach nurse was added to the team to help provide support to those experiencing homelessness and addictions in the health care system. The nurse supports social workers and nurses from the three major hospitals to come up with appropriate discharge plans for people who have no fixed address.

- In 2010 the DOAP Encampment Team was created. This team works with Bylaw and the PACT Team to house people who sleep outside and people dealing with mental health issues. In the first 7 months of the program, the team housed 42 individuals.
- In 2009 the DOAP Team had a Social Return on Investment value of $2 million dollars by providing an alternative response to emergency services.

Main Street Project, Winnipeg

In Winnipeg, legislation permits police to forcibly place people in short-term detox spaces. The Main Street Project incorporates a detention area for intoxicated persons within a range of related services:

Intoxicated Persons Detention Area

Operated in cooperation with Winnipeg Police Service, the Intoxicated Persons Detention Area (IPDA) provides a safe and secure environment for individuals detained under the *Intoxicated Persons Detention Act*. The 20 unit facility closely monitors individual detainees for up to a maximum of 24 hours, or until such time as they are deemed safe to be released into the community.

Detoxification Unit

A 25 bed, non-medical detoxification centre that provides a safe place for supervised withdrawal from the effects of an individual's last substance abuse episode. The service is provided at no cost to adults who are assessed to be appropriate for this non-medical setting. The current average stay is 10 days. The unit serves both male and female adult clients that are assessed for suitability for the non-medical program.

24 Hour Crisis Centre

The crisis centre provides continuous support 24 hours a day, 365 days per year and is open to individuals who walk in or are referred by other agencies. The area operates as a drop-in between the hours of 7:00 am and 6:00 pm, and then converts to an emergency shelter between the hours of 7:00 pm and 6:15 am. Some of the primary services provided through this centre include:

- Drop in area open to all adults, providing a safe and stable point of contact, information, support, and social interaction;
- Emergency food services, including soup and coffee/tea provided four times daily;

- Transportation services for clients in need of medical or treatment related access;
- Shower facilities, as well as access to various personal hygiene items, such as shavers, toothbrushes, etc;
- Access at no charge to changes of clothing, outerwear, etc; and
- Access to a nurse paramedic for non-emergency medical assessments and treatment.

Emergency Shelter

The emergency shelter operates 365 days a year, providing safe, supervised overnight shelter for individuals in need. Access to this service is open to adults only, male and female. The shelter can sleep up to 70 people per night and is provided with no upfront costs to clients.

Location of the facility within the Main Street Project provides an opportunity for the experienced staff to provide clients in need with relevant information on supports available, as well as a variety of other community organizations.

Vancouver Detox Center

This facility provides a safe, supportive residential environment for individuals withdrawing from the acute effects of alcohol or other drugs and who require on-site monitoring. The facility provides medical withdrawal management for adults 19 years and older living in the Vancouver Coastal Health Authority region. Services include assessment, individual counselling, referral, educational groups, 12-step programs, acupuncture and other alternate therapies, and assistance in the transition to safe/supportive housing. Within the facility is a five room detox ward that will accept non-voluntary persons from police due to public intoxication.

The facility is staffed by a culturally diverse, multidisciplinary team that uses medical and non-medical approaches to relieving withdrawal symptoms. Bed capacity is 24, with an average stay of five to seven days. There is no cost to the client.

Appendix F Edmonton Wellness Institute Proposal

A proposal for Alberta Hospital Edmonton site redevelopment provided by Dr. Peter Silverstone, University of Alberta Hospital. This is not a proposal developed by AHS.

Background

1. Requirement for mental health services is growing as factors contributing to mental illness (e.g., aging population, economic destabilization, family dislocation, aboriginal alienation, etc.) are projected to increase.
2. Need to address major unmet needs in health service provision which include:
   - Group with high costs for society and unmet needs are those with psychiatric illness and also have drug and/or alcohol problems ("dual-diagnosis patients").
   - Provision of psychiatric services to chronic homeless population, many of whom also have "dual-diagnosis".
   - Significant shortage of provision of secure environment for psychiatric patients who require this, many of these patients also having a "dual-diagnosis".
3. Current plans for Alberta Hospital Edmonton recognize that this site requires change to provide for needs of 200 psychiatric in-patients, approximately 70% of whom have dual-diagnosis. This is in addition to 100 patients in secure accommodation, most being in expensively constructed specialized facilities.
4. Plight of the homeless in Alberta's two major cities denies Alberta's ability to claim general social benefit from the advancement of its economy. This plight is becoming more visible and aggravated by the redevelopment of inner urban areas, removing the low-quality housing and services establishments which formerly provided a daily lifebase for the homeless and the very poor.
5. Major initiatives launched by province to address these needs.
6. Current estimates are that there are approximately 3,000 homeless individuals in Edmonton. Intention to utilize "housing first" approach. Some resistance to relocation of sites in communities ("NIMBY").
7. Current strategy of "housing first" model for homeless population recognizes that 10 – , i.e. 300 – 450 individuals.

8. Aboriginal needs are significant, and are over represented among the homeless, dual diagnosis patients, and those in correctional institutions.

Three-part Proposition Concerning the Edmonton Region:

1. A comprehensive facility ("Edmonton Wellness Institute") which can be made to more efficiently/effectively serve the needs of the dual-diagnosis population, including those that are homeless.
2. The current institutional complex at Alberta Hospital Edmonton (AHE) can be redeveloped to serve as core of a comprehensive health/social services facility.
3. The current AHE core site can be integrated to a local area plan including social housing components and mixed residential/commercial establishments.

Key elements of Proposal

- Build new 200 hospital on current site. Use existing hospital staff so no additional staffing costs required.
- Hospital to be focused on needs of dual-diagnosis patients and provision of secure beds. Will include rehabilitation of this group.
- Pay for $200 million hospital costs via P3 method to gain access to 25% payments from Federal Government, thus potentially reducing cost to Province by up to $50 million.
- Develop surrounding land, owned by province of Alberta, for mixed-income living. Include specific sites for assisted housing in plans to avoid NIMBY issues. Utilize income from this to decrease cost of building facility. Estimated income from this development is $40 million over life of P3.
- Develop surrounding land, owned by province of Alberta, for mixed commercial uses. Utilize income from this to decrease cost of building facility. Estimated income from this development is $20 million over life of P3.
- Total potential net cost to government potentially $90 million.
- Repurpose existing buildings to meet needs of 300 homeless individuals with dual diagnosis.
- Note that current costs of caring for homeless are approximately $100,000/year/person, including police, hospital, social care, etc. Thus, total annual cost for 300 chronically

homeless dual-diagnosis individuals currently approximately $30 million/year. Clear economic rationale for proposal.

- At a second stage of development, plan to relocate existing 72-bed Henwood facility (which is 40 years old) into Edmonton Wellness Institute site (currently 1.5 km north of AHE site)
- At a second stage of development, plan to develop specific Aboriginal Wellness facilities onsite and for purpose built homeless housing