Vancouver CoastalHealth
*Promoting wellness. Ensuring care.*

**DRAFT**
**FOR DISCUSSION PURPOSE ONLY**

# VANCOUVER COMMUNITY

# VANCOUVER COASTAL HEALTH

## A MENTAL HEALTH & ADDICTIONS SUPPORTED HOUSING FRAMEWORK

April, 2006

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# SECTION 1

# INTRODUCTION

Vancouver Coastal Health (VCH) seeks to improve health status of the population through a population health approach that acknowledges the existence of determinants of health, including education, employment, income, adequate nutrition, social supports and housing.

Housing has been widely identified as a both a fundamental right and a critical determinant of a person's health. Individuals who are unable to access safe, secure, affordable and appropriate housing will have both a reduced quality of life and an increased need to access other social and medical support and treatment services. Evidence has clearly shown a relationship between inadequate housing and a broad range of health conditions. Inadequate housing and supports results in more frequent use of emergency departments, lengthier and more frequent stays in hospital and a decreased ability to access ongoing medical treatment. The lack of adequate and appropriate housing will directly result in increased costs in the health, social service and criminal justice sectors.

In order to implement a population health strategy in relation to housing, key VCH activities will include:

- Leadership:

  Recognition of the interaction between health and housing issues, and the impact of inadequate housing on health status.

  VCH will take responsibility to redress housing-related health issues, partnering with others where appropriate. VCH has taken a leadership role with respect to many housing developments for populations with a broad range of health risks.

- Partnership:

  Development of partnerships as a consequence of the complex nature of health issues: solutions require action across several jurisdictions.

  Development of housing for these vulnerable populations requires VCH partnerships with the City of Vancouver, BC Housing and non-profit housing providers.

- Advocacy:

  Articulation of relevant issues to the public, media, local organizations and government while supporting capacity building to influence health outcomes without direct health service expenditures.

  There is clearly a role for VCH in advocating for a public policy shift that would increase emphasis on affordable social housing not only for individuals with a mental illness and/or addiction, but also for needy seniors and families.

- Policy development:

  Development and implementation of policies directly impacting health outcomes on a sustained basis.

  VCH has created a strong housing services arm as part of its array of health interventions.

VCH has taken an active role with respect to housing for many years. In *The Strategic Plan for Housing Services* (2000), the then Vancouver/Richmond Health Board clearly identified the key role of the Health Authority with respect to housing. The report provided a strategic plan to guide the planning, development, funding and evaluation of the Health Authority related housing services. The recommendations outlined in that report have guided the work of the health authority over the past five years.

This plan, specifically focused on Vancouver, is an update of the previous strategic planning and is designed to link with the *City of Vancouver Homeless Action Plan* (2005). The City plan to address homelessness identifies the need for both independent affordable housing and supported housing for a broad range of vulnerable populations over the next 10 years. The VCH plan looks at a similar timeframe; however, this plan focuses specifically on the housing needs of individuals with mental illness and /or substance use issues and co-occurring chronic health conditions. While not addressed in this plan, housing and support planning and development related to individuals with physical disabilities, acquired brain injuries and seniors with health conditions are being undertaken simultaneously.

## SECTION 2

# HEALTH & HOUSING LINKS – A Literature Review

Given the pressures on health care dollars, there must be a strong case to support housing interventions as an effective and cost efficient component of a broader health strategy. Evidence-based research supports the link between health and housing.

The information reflected in this report is not intended to reproduce other more comprehensive literature reviews, but rather to give a flavour of some of the more pertinent findings from a health perspective.

There is a general consensus in the literature that adequacy of housing, along with related low socioeconomic status, is one of the most powerful factors affecting health and health status (Millar and Hull, 1997). People with inadequate housing, and the frequently associated poor socioeconomic status, tend to be less healthy.

- Increased community integration (Aubrey & Myner, 1996; Boydell & Everett, 1992; Ridgeway & Zipple, 1990a, 1990b)
- Individuals satisfied with housing were less likely to report they curtailed their daily activities because of illness and had better self-reported health status (Fulrre etal., 1993; Elliot, Tayler & Kearns, 1990)

Nowhere is the impact of housing more apparent than in relation to the homeless. Research on homelessness has provided significant evidence of the impact of the lack of housing (absolute homelessness) or the lack of adequate housing (relative homelessness) on the health of individuals:

- Homeless people are at much greater risk for infectious disease, premature death, acute illness, suicide, mental health and alcohol and drug problems than the general population (Golden et al., 1999)
- A Vancouver study found 36% of Vancouver SRO (single room occupancy) hotel residents reported their health as poor or fair compared to the 10% of the general population who rated their health as poor or fair (Butt, 1993)
- Alcoholism among the homeless has a reported rate 6-7 times higher than the general population (Springer et al., 1998)
- Up to 40% of homeless individuals are reported to have chronic disorders such as heart disease, emphysema, diabetes and high blood pressure (2-4 times higher than the general population) (Wright et al., 1998)

- When homeless children are compared with other children they have twice as many upper respiratory infection, 4 times as many skin disorders, 3-4 times as many gastrointestinal disorders, 2 times as many ear infections and 10 times as many dental problems (Wright et al., 1998)
- Tuberculosis is reported to be 25 times higher (Daly, 1996) to 100 times higher (Wright et al., 1998) for the homeless than among a general urban population
- 37% of female street youth reported having a sexually transmitted disease compared to a 2% of females attending school (McCreary Centre Society, 1994)
- Drug use among street youth is 14 times higher than among students living at home (Addictions Research Foundation)
- Approximately one-third of the homeless population experiences mental illness (Golden et al., 1999)
- Homeless people require treatment for trauma at a much higher rate than the general population (Wright et al., 1998)
- Alcoholism among the homeless is reported to be 6-7 times greater than the general population (Springer et al., 1998)

Homeless individuals frequently use hospital emergency rooms as their point of contact with the medical system. Due to the fact that treatment many have been delayed, and therefore the condition become more serious, medical treatment becomes more costly. Research findings include:

- A US study found that 20-30% of the homeless people were hospitalized for a physical problem in the past years as opposed to 18% for poor individuals who were adequately housed (Piliavin et al., 1994)
- A Canadian study found homeless individuals on average were in hospitals 15 days versus 9 day for those individuals with a home (Dautovich, 1998)
- Homeless patients stayed 4.1 days (36%) longer per admission on average than other patients (Salit et al., 1998)
- Homeless patients hospitalized for psychiatric conditions stayed on average 84 days in hospital versus individuals with homes who stayed 14 days (Salit et al., 1998)
- Homeless children were 11% more likely to be hospitalized and 20% more likely to have emergency room visits than housed children (Weinreb et al, 1998b)
- A City of Vancouver study found that the hospital admission rate for people living in Single Room Occupancy (SRO) hotels was approximately 29% compared to 18% admission rate for individuals in social housing. Once admitted to hospital, individuals living in SRO's required an average stay of 15 days, versus 9 days for those living in social housing (Butt, 1993)

Studies have also highlighted the positive impact of adequate housing on health outcomes and service utilization. These studies highlight the connection between the adequate housing, improved health and potential reduction in health expenditures:

- Access to supported housing for homeless people can reduce hospital stays by as many as 70 days per admission (Salit et al., 1998)
- A UK study found that providing supported housing for persons with HIV/AIDS can reduce the need for acute services and achieve average savings of 40% in the costs of care (Molyneux & Palmer, n.d.)
- A comparative review of hospital utilization by 17 residents of the Dr. Peter Centre showed 1,485 hospital bed days one year before admission of the Centre and only 33 hospital bed days one year after admission and a similar reduction in emergency department visits from 76 to 34 in the same time period (Davis, 2000, personal communication)
- In Vancouver a 2002 study of 96 individuals with mental illness who were provided with supportive housing found a 34% reduction in admissions to acute care for mental health reasons one year after being housed compared to the year before; a 36% reduction in average length of stay (reduced by 1.5 day) one year after housing: reduced overall utilization of 250 psychiatric hospital bed days in the year post housing for the 96 clients; and an 18% increase in admissions for non-psychiatric reasons (50 days) – a total of 200 hospital bed days saved (VCH, Vancouver Community, 2003)
- A study completed in January 2006 studied 263 individuals across the VCH who entered mental health supported housing in 2003 and 2004. The study compared emergency room visits and hospital bed use in the one-year prior to entry to supported housing and one year after. The number of emergency room visits was reduced by 38 visits from 118 in the 1-year pre-supported housing entry to 80 in the year post- supported housing – a reduction of 32%. The hospital bed days were reduced from 2,927 to 1,270 days – a reduction of 1,657 days or 56.6%. The reduction in bed days represented a 52% reduction (1,323 days) related to psychiatric problems and 86% (344 days) related to medical issues. There were 52 less hospital admissions and the average length of stay was reduced from 21.8 days to 15.5 days.
- A San Francisco study of 250 individuals (almost all with concurrent disorders) moved from the streets and shelters to supportive housing found in the year post housing a 58% decrease in use of emergency rooms (from 535 to 255 visits); 57% reduction in hospital bed days (from 531 to 221 days); also found further impacts in second year of housing – further 20% reduction in hospital bed use (Corporation of Supportive Housing, 1999)

Within the mental health arena, research into housing models or elements of housing models that produce the best outcomes suggests that the favorable outcomes associated with the provisions of affordable, adequate, secure and supported housing include:

- Reduction in hospitalization rates (Brown et al., 1991; Burek et al., 1996)
- Reduction on symptoms (Dixon et al., 1994)
- Increased residential stability (Dixon et al., 1994; Hurlbut et al., 1996; Nyman et al., 1994; Nelson, in press)
- Increased consumer satisfaction (Champney & Dzurec, 1992)
- Increased independence and empowerment, and gains in role achievement (Boydell & Everrett, 1992; Nelson, Hall & Walsh-Bowers, 1995; Nelson et al., 1997; Nyman et al., 1994; Ridgeway and Rapp, 1997)

There are few studies applicable to the Canadian health system, which address the costs of homelessness to the health care system. Stable, supported housing for homeless people creates cost savings in health care, criminal justice and social services. Some service costs will increase (e.g. clinic use, income assistance payments) while others will be significantly decreased (e.g. hospital, jail, prison and criminal justice system use).

Studies have identified varying savings but overall are in agreement that the cost to develop housing can be offset by savings in other areas. Capturing these savings through service reductions in the impacted areas would need to be undertaken to realize a true saving in public expenditures.

The following represent some key studies that have attempted to quantify the savings resulting from the provision of housing and support.

1. Small study of 10 homeless and 5 formerly homeless but housed individuals.

   Health care costs increase for housed individuals – increased use of out-patient health clinics, Pharmacare and mental health services ($4,700 to $7,000 on average -$2,300 annual increase). It is likely that while these costs would initially increase as individuals had their health problems attended to on a pro-active basis the costs would level out.

   Social Service costs increase for housed individuals – increased access to income assistance ($7,900 to $9,400 on average - $1,500 increase).

   Criminal justice costs decrease for housed individuals – decreased use of correctional institutions, community supervision, police-arrests & charges ($11,400 to $1,850 on average – $9,550 annual decrease).

   Summary:

- Significant savings in criminal justice identified -$9,550 annually/person housed.
- Overall savings $6,000 per person (from $24,000 for homeless to $18,000 housed).

(Eberle et al., 2001)

2. Comparison of hospital bed use by 96 individuals with a mental illness in the year pre and post accessing supported housing.

   Reduction of 250 in - patient psychiatric hospital bed days 1 year post supported housing (34% reduction).

   Increase of 50 medical hospital bed days 1 year post supported housing (18% increase).

   Summary:
   - Significant savings in hospital bed use identified as $1,050 annually per person in supported housing (@ $500 per bed day).

   (VCHA, 2002)

3. Study of 250 homeless individuals 1 year pre and post low barrier supported housing.

   Reduction of 280 emergency room visits for 204 persons 1 year post supported housing (58% reduction).

   Reduction of 310 hospital bed days for 132 persons 1 year post supported housing (57% reduction).

   Summary:
   - Significant savings in hospital bed use identified as $950 annually per person (@ $500/bed day).

   (Proscio, 2000)

4. The study of the use of shelters, psychiatric hospitals, medical services, prisons and jails by 4,679 homeless people with a mental illness 2 years pre and post supported housing. Compared service use to homeless individuals not placed in housing and adjusted findings to correlate with impact of housing.

Reduction in use of psychiatric hospitals by 14.1 days per person (50% reduction).

Reduction in use of hospital bed days (psychiatric and medical) by 1.7 days per person (21% reduction).

Increase in outpatient services by 23.3 days per person (75% increase).

Decrease in use of jail (38%) and decreased use of prisons (85%).

Summary:

- Identified $16,282 per year saving for each unit of housing built.

(Culhane et al., 2001)

# SECTION 3

# HOUSING CONTINUUM

To appropriately address the needs of individuals with health conditions such as mental illness and/or addictions, a three-pronged approach to housing will be required.

This will include development of:

1. Affordable housing for individuals who can live independently

2. Affordable, supported low barrier housing for individuals who are homeless and who are not yet ready to engage in mental health and/or addiction treatment services as a requirement to access housing

3. Affordable, supported transitional and permanent housing for individuals actively engaged in recovery-focussed mental health and addictions treatment

**1. Affordable Housing for individuals who can live independently and can access existing health services without any housing based interventions.**

In Vancouver there are presently 21,276 social housing units built under Federal/Provincial or Provincial programs to accommodate low and modest income households. However, in 2003 the BC Housing Registry had a waitlist of close to 10,000 households waiting for social housing. The majority of those waiting would be seniors and families given that the majority of available units are intended for these populations. As a result, low income singles who have a mental illness and/or an addiction often are underrepresented on waitlists and are under served by available social housing options.

Individuals coping with mental illness and/or addictions are generally unemployed or underemployed and many receive BC Benefits, which provides only $325 a month for shelter. Given that the average studio apartment rental cost in Vancouver is presently $695 a month, it is understandable why individuals on income assistance are drawn into the Downtown Eastside and Downtown South to access hotel accommodation where rents are geared to the shelter portion of the BC Benefits payments. Clearly the provision of affordable housing would assist individuals attempting to cope with mental illness and /or addictions to focus on recovery and to

avoid being drawn into the downtown core where totally inadequate accommodation and ready access to drugs can make recovery more difficult.

The *City of Vancouver Homeless Action Plan (2005)* identifies that 400 social housing units are needed each year to maintain social housing at its current 8.5% of the total housing stock. The plan calls for 4,200 units to be developed over the 10 year plan.

As part of its advocacy role in a population health approach, VCH strongly supports the need for increased affordable housing, through either new construction to increase availability of rental stock, or the application of rental subsidy to increase access to existing rental accommodation. In order to increase affordable housing, increased funding will be required from the federal and provincial levels; partnership will be needed with the City of Vancouver who can provide land, grants and density bonusing and the non-profit housing providers who will develop and manage the housing. While not directly involved in the affordable housing arena, VCH would be a partner in providing community based health services to individuals living in the affordable housing.

**2. Affordable, supported low barrier housing ("Housing First") for individuals who are homeless and who are not yet ready to engage in mental health and/or addictions treatment services as a requirement to access housing.**

Housing First is direct provision of permanent, independent housing to people who are homeless. Individuals will receive individualized services and assistance that they request. Housing is primarily a place to live, not a place to receive treatment.

It has been clearly shown in studies in the large American cities, such as New York and San Francisco that providing housing with supports to individuals who are homeless without requiring them to actively engage in treatment services for mental illness and/or addictions has been very effective. In order to access low barrier housing, individuals need to be willing and able to be safely housed without risk to other tenants, staff or themselves. Evidence is available that housing is essential *regardless* of treatment. The most significant changes for tenants is housing stability, improved mental and physical health and a natural reduction in substance use.

In more traditional models, access to supported housing was contingent on a willingness to actively engage in treatment. However, it appears the provision of affordable, supported, secure housing significantly increases the ongoing

housing stability of this population and decreases by almost 60% their visits to emergency rooms and hospital stays. Evidence also suggests provision of this housing does increase the likelihood of tenants establishing links to a variety of mental health, addictions and medical treatment options.

In March 2005, a point-in-time homeless census in the Greater Vancouver Regional District identified 1,300 individuals as homeless in Vancouver- 700 in shelters and 600 on the street. In a similar census done in 2002, it was identified that one-third of the homeless had been without housing for more than 6 months. This chronically homeless population could benefit from a Housing First/low barrier option. Many of these chronically homeless individuals are frequent shelter users and account for a significant number of the shelter bed days. If they could be housed it would create a significantly improved capacity for the shelters to address the needs of the street homeless and decrease the level of turnaways from the shelters.

Description:

Low barrier options are primarily located in the Downtown Eastside area of the city. They represent rooming houses, single room occupancy hotels and social housing developments. The housing is located where it is most accessible to individuals who may be willing to move from shelters or the street directly to accommodation. In some cases all units provide housing and supports for individuals identified by a housing or service provider as being in need, while in others only some units are specifically designated for individuals needing support. While support staff may be designated for a specific tenant group they are available to provide supports to other tenants in the building as requested.

Though low barrier in approach, Housing First does provide individuals with on-site support services. These services focus not only on maintaining a safe and secure environment but also work with tenants to create linkages whenever possible with medical, mental health and addictions treatment. As well, on-site support is available to assist individuals to gain basic daily living skills which will improve their capacity to be successful tenants and to avoid a return to homelessness. These on-site supports are bolstered through intensive case management and physician support from the Community Health Centres which is designed to engage these individuals in ways which may be outside the traditional health approaches (e.g. Urgent Response Teams, Assertive Community Treatment teams).

It is critical to have ready access to low barrier housing in the area of the city in which those most in need presently live. However, this housing must to be balanced with other housing options distributed across the city. There will

need to be active support to assist people in low barrier housing options in the downtown to move to other areas of the City if they want to take that step.

Access:

Access to low barrier housing is generally managed by the housing provider, not by VCH, although in some developments there is direct access through VCH referrals. A number of the low barrier housing options are linked to emergency shelter providers who utilize this accommodation as a transition from their shelters. In Vancouver there are approximately 650 year-round shelter beds and about 200 additional beds during the cold wet weather. VCH provides funding to two shelter providers for 106 beds. The funding allows for increased staffing levels and specialized services to specifically focus on addressing the needs of individuals who predominantly have a mental illness and/or addiction. These two shelter providers have approximately 3,000 admissions each year and almost as many turnaways. Some low barrier housing units are linked to providing housing for clients of programs such as the Urgent Response Team or Community Care Transition Team.

### 3. Affordable, supported transitional and permanent housing for individuals engaged in mental health and /or addictions treatment.

The BC. Ministry of Health's *Best Practices in Mental Health Housing Report (2000)* clearly identified supported housing as a key strategy in assisting individuals live successfully in communities. A VCH *Best Practices Report on Addictions Housing (2005)* substantiates the need for a similar supported housing approach for individuals who are in recovery from addictions.

Description:

In supported housing, individuals are provided with a rental subsidy to access affordable rental accommodation along with support services offered either on-site or by outreach workers. Housing may be permanent, for individuals who continue to need support on a longer term basis, or it may be transitional, as individuals complete recovery programs and move on to other housing options.

Types of Supported Housing:

1. Purpose built apartment buildings in which all or a large portion of the units are receiving supports. These may include buildings with limited amenity space or those in which there are enhanced design features with a centralized dining space and commercial kitchen that allows tenants to

have a communal dinner. Generally, in these buildings there is on-site staff for periods ranging from day time support to around the clock support in enhanced apartments.

Individuals in recovery from addiction can benefit particularly from apartments in a dedicated building that can be designated alcohol and drug free. This will allow for the development of a supportive alcohol and drug free community which is especially critical in the early stages of recovery when individuals are practicing strategies to avoid relapse.

2. Scattered apartments in private market rental buildings rented by the individual from a private landlord, often with support and assistance from the support worker. Agencies that provide the support services often establish good working relationships with landlords and will be offered a number of units in a building. Landlords find these supported housing arrangements very effective since the service providers ensure that they are available to assist in supporting the tenant if any difficulties arise with respect to their tenancy.

3. Residential care is communal and generally consistent with a group homestyle model. Staff is available on site around the clock and includes professional (generally nursing) staff supports. These sites are for individuals who require higher levels of support and cannot live in independent settings. Residential care settings generally house between six and 12 clients per home.

Support services in Vancouver are delivered by a variety of non-profit service providers who operate under contract to VCH. These providers have significant expertise in the delivery of these services.

Support services are flexible and are individually tailored to the particular needs of the client. They may include all or some of the following tasks:

- Assistance to learn basic life skills – budgeting, housekeeping, meal preparation
- Linkages to medical care and treatment services
- Crisis support and intervention
- Links to education and vocational programs
- Medication support if required for individuals taking medication for their mental illness
- Locating appropriate housing at the completion of a transitional program

Access:

Access to supported housing is managed by VCH and individuals must be assessed by professional staff to ensure suitability and eligibility. Both mental health and addictions housing have clearly identified eligibility criteria. Specific housing assessment tools have been developed for both populations.

In order for individuals to be eligible for access to mental health supported housing, they must meet the following criteria:

- have a mental illness that interferes significantly with their work, personal life, leisure and education and which requires ongoing psychiatric treatment and support provided by a mental health team , a private psychiatrist or general practitioner
- be willing to participate in planning for services
- be able to be safely housed

In order for individuals to be eligible for alcohol and drug free addictions supported housing, they must meet the following criteria:

- have a serious dependency on substances which cannot be effectively managed without an alcohol and drug free environment with daily supports
- be actively engaged in addiction treatment
- have been referred from addiction treatment system
- be willing to engage in developing an individual recovery plan

A fundamental shift has occurred in planning housing services for individuals with mental illness and/or addictions. In the past there has been a heavy reliance on highly staffed community based residential facilities where individuals lived in communal arrangements with limited autonomy. Research has shown that supported housing is preferred, as it allows individuals in need of supports more independence, choice and control. Research shows that not only is supported housing more acceptable to individuals who need services, but it also results in better health outcomes.

While there continues to be a need for highly supported residential settings for some individuals, increasingly the emphasis is on viewing residential housing as transitional in nature, with the goal of enabling individuals to move as quickly as

possible to purpose designed apartments or scattered units with supports, where they can live as independently as possible. There is not expected to be any increased development of the residential care housing options. It is expected that the existing stock of residential care will continue to be reduced and to be converted to supported housing, although a core stock will be retained.

There is a shift toward an increased emphasis on prevention, health promotion and services for individuals who do not met the threshold for housing under the present mandate. It is envisioned that housing services for both populations could be expanded to provide outreach assistance to these individuals in locating and acquiring independent housing.

# SECTION 4

# DEMAND PROJECTIONS

Available literature does not provide any benchmarks for supported housing which appear to be transferable to the conditions in Vancouver. This has required the development of local need/demand projections utilizing a series of assumptions. These projections will need to be revisited along the course of the 10 year plan to adjust projections upward or downward based on actual experience.

The table below sets out the incremental increase to supported housing stock required to meet the assumed need.

| | Existing Units | New Units over 10 years | Total Units at 2016 |
|---|---|---|---|
| **Low and Moderate Barrier Housing (mental health and addictions)** | **775** | **725** | **1,500** |
| **Mental Health Supported Housing** | **1,300** | **800** | **2,100** |
| **Addiction Supported Housing* (alcohol and drug free)** | **175** | **675** | **850** |
| **TOTAL** | **2,250** | **2,200** | **4,450** |

* There are 90 beds in short stay (60-90 days) support recovery and addictions treatment which are not viewed as part of the supportive housing continuum but which act as significant referral sources to supported housing.

With respect to Low and Moderate Barrier Housing, the projection has been initially set at an additional 725 units to bring the total number of units of supported low barrier housing to 1,500. This will move some individuals presently in the shelter system to low barrier housing to create capacity to address the needs of those living on the street. The needs of those living in shelters will also be addressed by the development of affordable housing options, both in the downtown area and across the City, and of supported housing options for individuals with a mental illness and /or addiction.

Mental health supported housing need/demand projections were created by using the existing waitlists as a starting point and then applying a blended formula of population (60%) and mental health team caseloads (40%) to adjust for future need. There are presently 680 individuals waiting for mental health supported housing. Due to the cyclic and persistent nature of mental illness, many of the individuals will require permanent access to supported housing, both the affordable housing and the support services. As a result there is only about a 6% annual turnover rate in mental h ealth supported housing, representing about 65-75 units each year. The projection is for 800 units to be added to bring to total stock of mental health supported housing to just over 2,000 units. Projections are assuming that natural turnover may address new demand while the additional units will address the backlog of individuals on the waitlist, many of whom have been waiting for years.

Addictions supported housing projections were created through an analysis of current dependent users of alcohol and illicit drugs and assumptions regarding both the stability of their housing and their willingness/interest to enter into addictions recovery. In Vancouver there are estimated to be 16,970 dependent users of alcohol and 14,900 illicit drug users split between the DTES and other areas of the City. It was assumed that 5% (840) of those currently dependent on alcohol were unstably housed and of those dependent on illicit drugs 65% (4843) of those in the Downtown Eastside and 20% (1490) of those in the rest of the city were unstably housed. It was further assumed that of this total group of 7,173 unstably housed dependent users, only 20% (1,435) would be interested in supported housing. Of these, 600 were assumed to be interested in low and moderate barrier housing as a first step and the remaining 850 were assumed to be prepared to actively engage in addictions recovery by living in alcohol and drug free supported housing. The projection is to add 675 units to bring the total stock up to around 850 units of alcohol and drug free supported housing for individual in recovery.

Unlike mental health supported housing, addiction supported housing is generally seen to be transitional (18-24 months) in nature. Individuals who recover will likely move on to market housing as they acquire employment, or they will be able access affordable social housing. Only a small portion, possibly 10%, may require permanent alcohol and drug free supported housing in order to maintain their recovery. It will be important to continuously assess the appropriate balance between transitional units and permanent housing units over the 10 year plan.

**SECTION 5**

# PROPOSED DEVELOPMENT PLAN

The proposed timing of the housing development is contingent on the funding for the housing component being made available by the Federal and Provincial levels of government and concurrently the housing support services funding being available within the Health Authority budget. The development plans as set out below are completely subject to that funding availability in any given year.

The housing development plans are based on the assumption that development will take two forms:

1. new construction (purpose designed /stand alone sites)

2. rent supplements in existing private market rental buildings

The use of rent supplements will allow for quicker development of housing options given the lengthy timelines associated with construction. Purpose designed and dedicated buildings will allow for increased supports to individuals in recovery from mental illness and/or addictions. It will be an especially important component of the addiction housing options as it will support an alcohol and drug free environment.

It is anticipated that the majority of the mental health and addiction supported housing development will be through the application of rental supplements to existing market apartments. While it is not possible to make an absolute determination of the form of housing given the unknowns related to funding opportunities, it is expected that the development will likely be 25% new construction (370 units) and 75% rent subsidies (1,100 units). The size of the new construction projects will vary and may in some cases form part of a larger project; however, in general it is anticipated that size will on average be from a low of 20 supported housing units to a high of 40 units. These sizes will allow the buildings to readily integrated into residential neighbourhoods.

The low to moderate barrier housing will more likely be located in or near the City centre to provide accommodation to individuals in the communities in which they live . This may be new construction but will also the addition of on –site supports for tenants in existing social housing and single room occupancy (SRO) hotels. The new construction will provide for a replacement of inadequate accommodation presently offered in poor quality SRO's and to keep pace with the loss of SRO stock over time. The provision of on-site staff through non-profit

organizations will ensure that individuals living in SRO's will be able to live in an environment that offers safety and security and supports them in living successful in the community. It is likely that 60% of the supportive housing will be created through the application of accommodation subsidies and support services in existing sites with about 40% of the need being addressed through new construction of 280 units in dedicated buildings.

**SECTION 6**

## COMMUNITY ENGAGEMENT PROCESS

It is essential that a comprehensive and inclusive community engagement process be undertaken so that plans for providing supported housing to individuals in recovery from a mental illness or an addiction can move forward with the maximum understanding, support and involvement from those parties who may feel they will be impacted.

The community engagement process has two critical components:

1. PUBLIC EDUCATION

- Bringing factual information to all communities related to mental illness and addictions and how supported housing is a key element in the recovery process. The information would focus on creating opportunities for members of the general public to discuss any fears or concerns they have with regard to persons with a mental illness or addiction and to counter any myths or misperceptions.

- Providing general information with respect to existing supported housing and planning principles with respect to future distribution of supported housing development across the City. It is planned that supported housing be located in a variety of neighbourhoods in Vancouver to support individuals to stay in their own communities and to avoid any over concentration in particular areas.

Some of the possible approaches to public education could include:
- pamphlets sent to homes, schools, shops , neighbourhood organizations
- local community discussions, open to the public
- articles in local newspapers
- outreach to multilingual/multi-ethnic communities

2.COMMUNITY INPUT INTO SPECIFIC PROJECTS

When a specific project is planned for a neighbourhood it will be important to involve neighbours, schools, businesses, churches and other neighbourhood organizations as early as possible in the housing development planning. This will ensure that community members are well-informed, confident that the process is open and transparent and that there is a clear avenue for the expression of any concerns or issues.

VCH and the relevant supported housing provider will need to be open to input from the community to design a housing option not only to meet the needs of the individuals living in the housing but also to ensure the housing is a positive presence in the neighbourhood. Input from the community is sought in relation to possible impacts of the housing on the surrounding community e.g. security, building design etc.

One of the ongoing ways in which neighbours can maintain their input into the supported housing projects is through a Community Advisory Committee (CAC). These Committees are an essential part of developing an ongoing engagement with diverse neighbourhoods/stakeholders. With a formal venue for identifying concerns, gathering input and building solutions, community members and the other parties can work together to ensure a stable and safe neighbourhood for everyone.

Experience from other housing projects has shown that CAC's with broad representation from the local community are an effective way to address and resolve community concerns related to the project. Key members may include ( but not be limited to )the following:

- Schools and Parent Advisory Committees
- Business Improvement Associations
- Neighbourhood houses and community centres
- Service organizations
- Faith-based organizations
- Police
- City housing/planning staff
- Rate Payers Associations

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