SFU SIMON FRASER UNIVERSITY

HOMELESSNESS, ADDICTION & MENTAL ILLNESS: A CALL TO ACTION FOR BRITISH COLUMBIA


BC Government
Reintegration Leadership Team
SFU
Recovery-oriented Housing Specialist Teams
COAST MENTAL HEALTH
PHOENIX SOCIETY
Lu'ma Native Housing Society
raincity HOUSING
JohnHoward SOCIETY PACIFIC
Human Rights, Equity
HEALTH JUSTICE
Coordination, Practice Fidelity, Assessment & Referral, Evaluation
CARMHA Centre for Applied Research in Mental Health & Addiction
BUILDING COMMUNITY SOCIETY OF GREATER VANCOUVER
Indigenous Service Leads
Lu'ma Native Housing Society
BC First Nations JUSTICE COUNCIL
Individual Placement & Support
Canadian Mental Health Association British Columbia Mental health for all
JohnHoward SOCIETY PACIFIC
Recovery Coaching Harm Reduction Liaison
THE SALVATION ARMY VANCOUVER HARBOUR LIGHT GIVING • HOPE • TODAY
UNION GOSPEL MISSION

INTRODUCTION

Highly effective methods have been developed that promote housing stability, improved health and reduced crises among people who experience prolonged homelessness, mental illness and addiction. SFU researchers have led the development of these practices, showing their vast superiority over existing services in BC, despite the fact that existing services cost as much to implement as far more effective approaches. To date SFU's research findings and experience have not been put into practice in BC. This document is a call to action, proposing the immediate implementation of SFU's proven approach to be delivered in four regions of BC and assisting at least 1,500 people between 2021-2024. This call is issued jointly by SFU and leading not-for-profit (NFP) organizations addressing the health and wellbeing of Indigenous and non-Indigenous peoples, and including NFPs that partnered with SFU in the development of today's best practices.

Proposed actions integrate existing provincial investments in housing and support programs and add a coherent and well defined standard of care that is not otherwise available and that has been shown to be essential to reduce chronic street disorder, homelessness, crime, and acute psychological, social, and medical crises. Effective immediately we seek Provincial support to accept referrals from all BC communities for up to 500 clients per year for three years.

This call integrates the organizations and institutions who have scientifically proven their ability to effectively end homelessness and promote recovery among people who are persistently alienated from existing services. Our service model – recovery oriented housing - has been rigorously investigated in BC with outcomes reported in over 100 peer reviewed publications and reports, demonstrating crime reduction, social reintegration and cost effectiveness compared to the status quo. High quality research also confirms that without the care we describe, people in need are overwhelmingly likely to remain homeless and become increasingly involved with police, corrections, and acute medical services.

Our call responds to the stated preferences and needs of people in crisis and costs roughly the same as supporting sustained homelessness.

Answering our call will enable mainstream and specialized services to better support people whose needs are aligned with their resources and missions. Our proposed actions aim to make a difference immediately and on an enduring basis by province-wide workforce development, cultivating communities of practice, rigorous reporting of results, and public engagement. Led by Simon Fraser University, our plan anticipates the redevelopment of səmiq̓ʷəʔelə/Riverview, fostering practices rooted in both Indigenous and non-Indigenous knowledge and replacing the institutional model of the past century with a campus community that exemplifies leading edge prevention of addiction and mental illness. SFU's commitment to action includes robust training, rapid and ongoing evaluation, and the implementation of effective practices throughout BC. There is no area of social policy that is more urgently in need of "building back better" and we are ready to act to create substantial change.

OUR CALL

We call for the implementation of evidence-based services for 1,500 people to decrease entrenched homelessness, mental illness, and addictions in BC between 2021-2024.

We call for a new approach to supporting people who have been persistently excluded and harmed by current practices, using proven methods and building on neglected sources of strength.

We call for Indigenous and non-Indigenous peoples and organizations to work in parallel and in partnership, guided by the report of Canada's Truth and Reconciliation Commission and BC's Declaration on the Rights of Indigenous Peoples Act.

We call for Simon Fraser University to convene people with lived experience (PWLE), not for profit agencies, branches of government, and community members and to scale up the highly effective model of person-centred services developed by SFU, PWLE, and community partners.

We call for transparency and accountability in the delivery of services and in the measurement of effectiveness, comparing the outcomes of services with established benchmarks.

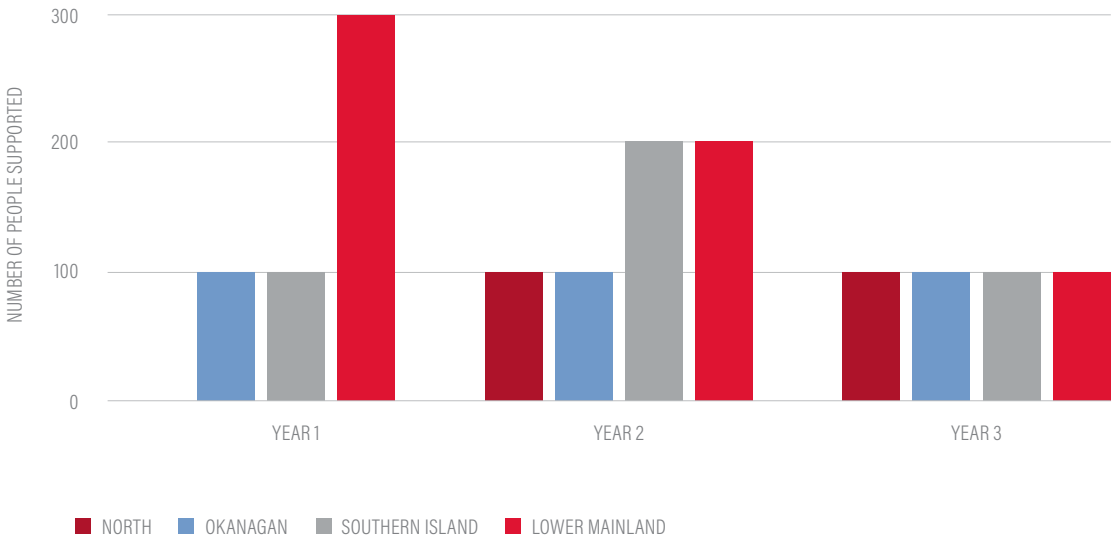
IMPLEMENTATION

Indigenous-led housing with support will be established in Year 1 in the Lower Mainland, serving as a model and foundation for Indigenous-led services in the Southern Island and North in Year 2.

Services for people of all ethnicities will be established in Southern Vancouver Island, Lower Mainland, and Okanagan in Year 1, with additional services added in Year 2 including services in the North.

Services in all regions will be added in Year 3 and details of the models of care (e.g., proportion that are Indigenous-led) will be informed by experiences to date and knowledge of demand.

Implementation Timeline



PRINCIPLES

Since 2007 people with lived experiences (PWLE) of homelessness, mental illness and substance use played central roles in the design, implementation, and evaluation of recovery-oriented housing in Canada (Somers et al., 2013; Bingham et al., 2019). Based on the guidance of PWLE, our service "creates a recovery oriented culture that puts consumer/tenant choice at the centre of all its considerations with respect to the provision of housing and support services" (McEwan, 2008 p11). PWLE are integral to the current project and at all levels, from service delivery to project governance.

Our actions are guided by the Calls to Action of the Truth and Reconciliation Commission of Canada and advance obligations under BC's Declaration on the Rights of Indigenous Peoples Act (DRIPA, 2019). We affirm the fundamental importance of cultural continuity as a determinant of health and wellbeing among BC's Indigenous peoples (e.g., Chandler & Lalonde, 2004). Our research reinforces that "solutions to Indigenous homelessness—both prevention and treatment—must involve practices that restore social and cultural power to Indigenous communities" (Bingham et al., 2019b).

Indigenous PWLE have designed and implemented recovery-oriented housing in Canada and, through PWLE and Indigenous-led organizations, will continue to shape services in BC, consistent with psychological best practices and with DRIPA.

Mindful of the power of two-eyed seeing, Indigenous-led services will be developed in parallel with non-Indigenous services and in the spirit of mutual learning, exchange of experiences and knowledges, and continuous improvement.

Our service emphasizes the importance of social inclusion and psychological meaning for all persons: "The key to understanding a healthy community, Indigenous or not, is appreciating that cultivation of the human spirit is grounded in emplaced networks of significance." (Thistle, 2017 p7).

Our services embrace the psychological experience of recovery, meaning they are person-centred with goals, progress and success defined by the individual accessing services. We practice harm reduction while also supporting clients to define their own paths to improved wellbeing, health, and meaningful social inclusion.

"Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions."

(DRIPA, Article 23)

EVIDENCE

15 YEARS

of Canadian research and development supported federally by over $120 million dollars.

OVER 100

peer reviewed publications and reports demonstrating transformative effects on Indigenous and non-Indigenous clients including housing stability, quality of life, **70% reduction in crime** and **50% reduction in medical emergencies**.

A scientific foundation

as robust as that underlying current COVID vaccines, including large randomized controlled trials in Vancouver and across Canada.

Recovery-oriented housing

costs the same as alternative public services that perpetuate homelessness and suffering.

PERSISTENT GAPS

Unmet Need:
Over 2,200 British Columbians experience mental illness as well as addiction, and over 5 years have an average of 4.9 hospital admissions, 4.2 sentences to custody, 4.4 sentences to community supervision, and receive $19,155 in shelter payments and $36,258 in income support. Communities with high concentrations of people who meet the above criteria are distributed across BC, including many towns and regions where appropriate resources are known to be absent.

Migration in BC:
Over 80% of the people who experience long-term homelessness, mental illness, and addiction in Vancouver's Downtown Eastside have moved there from outside the Vancouver area, while increasing their involvement with criminal justice and acute medical resources over the decade preceding their arrival in the DTES.

Crises & Community Safety:
The proportion of BC's custody population who experience Schizophrenia, Bipolar disorder, and Substance Abuse doubled between 2010 and 2017. Involuntary admissions to hospital increased by roughly 50% over the same period.

Destructive Spending:
The public cost of managing people while they experience prolonged homelessness is over $50,000 per person per year in BC while contributing to long-term declines in personal health and community safety.

Ignoring Agency:
Independent housing is preferred by 84% of people who experience homelessness and mental illness (Moen et al., 2020) and causes large reductions in street crime and medical emergencies compared to similarly priced alternatives.

Avoidance of Evidence:
There are no empirically-sound standards in BC related to the assessment and placement of people who require supported housing. There are no standards or supports ensuring consistent delivery of effective interventions.

Flying Blind:
There are no routinely collected indicators of when a person is homeless in BC. And there are no credible ongoing evaluations of outcomes from current spending.

2,200+

British Columbians experience complex co-occurring challenges including long-term homelessness and repeated criminal justice involvement

80%

of the people who experience long-term homelessness, mental illness, and addiction in Vancouver's Downtown Eastside have moved there from outside the Vancouver area

People who require our service have been identified throughout BC

BUILDING ON BC'S STRENGTHS

Our call to action adheres to the value of strengths-based practice, which we apply to our work with clients and in our relationships with all stakeholders. Established strengths in BC include numerous organizations, provincial and municipal branches of government, and individuals who have contributed to the advancement of best practices. The provincial government's housing agency, BC Housing, has cultivated extensive partnerships with not for profit (NFP) and non-governmental organizations who have collectively played essential roles in the delivery of housing and supportive services to British Columbians in all regions of the province, and have contributed internationally to the advancement of effective interventions.

Major collaborative initiatives in BC featuring NFP's include the Homelessness Intervention Project, Downtown Community Court, Vancouver Drug Treatment Court, At Home/ Chez Soi, and the development of provincial plans addressing mental illness and addiction. Additional sources of strength specific to the needs of Indigenous peoples include community-based Elders, Chiefs, and people with lived experience, the First Nations Justice Council, First Nations Courts, Native Court Workers, Friendship Centres, the First Nations Health Authority, and a growing network of Indigenous academic expertise at BC universities. The disproportionate marginalization of Indigenous peoples is a continuing legacy of colonization, and reconciliation requires engaging Indigenous leaders and communities in the design, implementation, and evaluation of responses.

Our call honours the necessity for Indigenous peoples to determine, develop, and administer the "health, housing and other economic and social programmes affecting them" (DRIPA, 2019). Lu'ma Housing and the First Nations Justice Council are the organizational leaders of services for Indigenous people within our call, enabling a substantial expansion of culturally rooted services while also advancing the urgency of reconciliation and strengthening knowledge and practices through the cultivation of two-eyed seeing.

A further source of strength is BC's status as a world leader in the use of government information to better assist individuals, identify needs, and evaluate the effectiveness and costs of interventions. Few large jurisdictions are capable of centrally aggregating data corresponding to services spanning health, social welfare, and justice for their entire population. BC data have been linked and analysed continuously for two decades via a partnership between Ministries and Simon Fraser University. These data enable a cross-government perspective with implications for improving support for citizens with interdependent needs. Numerous BC interventions have been evaluated using inter-Ministry data, providing benchmark values to assess the effectiveness of future programs while also promoting public transparency.

Our call to action adheres to the value of strengths-based practice, which we apply to our work with clients and in our relationships with all stakeholders.

An Inflection Point:

Calls for equity and inclusion have gained strength in tandem with the establishment of evidence and the capacity to safeguard and promote the human rights of people who experience homelessness, mental illness, and addiction.

Family & Work:

Paid employment is an immediate priority for nearly everyone who experiences long-term homelessness, mental illness, and addiction in BC, and two-thirds have worked continuously for at least one year at some point in the past. One in four have children who are under someone else's care.

Human Resources:

Non-profit organizations throughout BC have been the backbone of BC's response to homelessness among people with complex challenges including mental illness and addictions and have demonstrated the ability to deliver world class interventions when appropriately resourced.

Evidence of What Works:

Randomized controlled trials led by SFU have compared (1) existing services, (2) congregate housing and (3) independent recovery-oriented housing. Results show that recovery-oriented housing caused a 71% reduction in crime, a 50% reduction in medical emergencies, and fundamentally improved clients quality of life and community wellbeing.

Information Systems:

BC is the leading international jurisdiction in the use of linked population-level information spanning health, justice, and income assistance sectors. These data have been used to identify community-level needs and to evaluate interventions addressing housing, crime, mental illness, addiction, and recovery.

SFU will report the impact of services on crime, medical emergencies, and community integration through semi-annual analyses compared against peer reviewed benchmark values.

Large impacts on community safety, street disorder, and medical emergencies by 24 months

Recovery-oriented housing caused:

70% ↓
Reduction in crime

50% ↓
Reduction in medical emergencies

ACHIEVING CHANGE BEGINNING SEPTEMBER 1ST, 2021

Fostering Agency:
Grounded in human rights as well as empirical science, our service engages each client's motivation and fosters personal efficacy in all aspects of community living and social reintegration.

Addressing All of BC:
People from any BC community will have access to screening, assessment and referral, facilitated by collaborating community-based organizations (e.g., CMHA, Salvation Army). Consent to access administrative data will facilitate screening.

Implementing What Works:
Partnering organizations with experience delivering high-quality recovery-oriented housing will begin implementing services in the Lower Mainland, Southern Vancouver Island, Interior, and Northern regions. SFU will provide training and ongoing practice support based on established effective interventions.

Augmenting What Works:
Reinforced supported related to community inclusion and addiction will be provided via evidence-based Individual Placement and Support, Harm Reduction practices, Motivational Enhancement Therapy, and Recovery Coaching.

Leveraging Assets:
SFU will lead the development of a comprehensive inventory of community-based services specific to people who experience homelessness with mental illness, addiction, and concurrent challenges at all levels of service intensity.

Supporting The Workforce:
Partnering organizations will promote standards in employment as well as standards in the delivery of services.

Monitoring Outcomes:
Existing sources of data will be used to monitor outcomes and compare rates of improvement against peer-reviewed benchmarks achieved in BC.

AN OVERVIEW OF CHRONIC HOMELESSNESS IN BRITISH COLUMBIA

People who experience mental illness and addiction in British Columbia (BC) are increasingly at risk of death, incarceration, involuntary hospital admission, and long-term homelessness. The financial costs of services received by people who experience homelessness, mental illness, and addiction exceeds the cost of responses that have been shown to end homelessness, reduce crime and hospital emergencies, and promote recovery. This document describes a pathway forward that integrates high-quality evidence and relevant expertise in BC. We describe a three year plan to deliver effective and evidence-based interventions for 500 people each year, spanning multiple BC communities, and using established benchmarks to confirm benefits to client wellbeing, community safety, and public value. The model of service that we describe has been investigated internationally, including two randomized controlled trials conducted in Vancouver. We propose to scale up what has been shown to work and add evidence-based improvements that respond to our clients' requests for additional support addressing addiction and employment. Our proposal will establish communities of practice supported by world class training and supervision, with long-term benefits to workforce development and the availability of effective practices addressing all forms of addiction and mental illness in BC.

BROADER CONTEXT

Multiple sources of evidence indicate that BC has substantial room for improvement in the prevention of addiction, mental illness, and poverty. BC has the highest prevalence of concurrent substance use and mental illness in Canada (Rush et al., 2008). Poisoning deaths per capita are higher in BC than any other region of Canada (Orpana, Lang, Halverson, 2019), and people who experience homelessness, addiction and mental illness are less likely to receive stable housing in Vancouver than in other Canadian cities (Adair et al., 2016). Life expectancy at birth continues to increase in Canada when studied at the national level. However between 2000 and 2016 life expectancy in BC declined (Orpana, Lang, Halverson, 2019), replicating similar results observed in the united States and caused by what are described as "deaths of despair", including suicide and consequences of alcohol and drug use (Case & Deaton 2020). Between 2000 and 2015 US counties in which economic insecurity increased were significantly more likely to record higher rates of "deaths of despair", suggesting that changes in economic wellbeing are important indicators of risk in addition to absolute measures of poverty (Knapp et al., 2019). BC was one of only two Canadian provinces to record an increase in poverty between 2006 and 2015, rising from 11.4% to 14.6%, and BC was the last Canadian province to implement a strategy to reduce poverty, announced in 2017 (Plante, 2018).

Homelessness is an experience shared by a wide variety of people whose primary commonalities are poverty and limited social support, and over 80% exit homelessness by accessing extant resources in their communities (Caton et al., 2005; Kuhn & Culhane, 1998). The roughly 10-20% who experience chronic homelessness are extremely likely to also struggle with mental illness, addiction, and to have been arrested or criminally convicted (Caton et al., 2005; Kuhn & Culhane, 1998). Prolonged homelessness is well known to disproportionately affect Canadians who struggle with mental illness and addictions (Goering et al., 2011) and has increased dramatically in BC communities. In 2008 then Senator Michael Kirby called for a 500 million dollar investment in recovery-oriented housing in Canada (Kirby, 2008), a call that remains unanswered despite accumulating evidence of benefits to individuals, communities, and substantial economic benefits (Somers et al., 2015; Latimer et al., 2020).

Several sources have strongly criticized BC's under-investment in treatment and recovery from mental illness and addictions. Police departments in Victoria and Vancouver issued a series of reports detailing adverse effects on public safety stemming from our province's collective failure to implement community-based care following deinstitutionalization

BC has the highest prevalence of concurrent substance use and mental illness in Canada

(Rush et al., 2008)

(Wilson-Bates, 2008; Vancouver Police, 2013; Victoria Police, 2017). BC's Auditor General investigated tertiary mental health and addiction care and concluded that "the Ministry of health (ministry) and health authorities collectively are not doing enough to ensure that people with serious mental health and/or substance use problems and illnesses can access the care they need" (Bellringer, 2016, p.4). The paucity of resources for people whose needs are most urgent is reflected in the alarming increase in involuntarily hospitalization under BC's Mental Health Act, which between 2008 and 2016 rose from 13,005 to 20,483 (Vigo et al., 2019). In addition, people diagnosed with schizophrenia, bipolar disorder, and the combination of addiction and mental illness doubled in prevalence among those held in custody in BC between 2010-2017 (Somers et al., 2021).

Nearly all of the modifiable burden of illness associated with substance use and mental illness is socially determined (WHO, 2013). A body of research integrated by the World Health Organization affirms that mental health and addiction are determined by social, economic, and physical environments, and that the inequitable distribution of these determinants has profound effects on individuals and societies (Allen, Balfour, Bell, Marmot, 2014; WHO, 2013).

80%

exit homelessness by accessing extant resources in their communities

(Caton et al., 2005; Kuhn & Culhane, 1998)

Poisoning deaths per capita are higher in BC than any other region of Canada

(Orpana, Lang, Halverson, 2019)

People who experience homelessness, addiction and mental illness are less likely to receive stable housing in Vancouver than in other Canadian cities

(Adair et al., 2016).

EVIDENCE TO GUIDE ACTION IN BC

SFU clinicians and researchers have worked closely with the BC Public Service to identify the number and location of British Columbians who require integrated supports addressing addiction, mental illness, housing, employment, crime desistance, and community integration. During a five year period about 2,200 British Columbians experienced the combination of homelessness, an average of nine criminal sentences, three psychiatric hospital admissions, and five acute hospital admissions, while receiving shelter payments and income assistance (Somers et al., 2016). Only 20% of the people who met these criteria were located in Vancouver, with additional concentrations in Surrey, Victoria, Prince George, Central Okanagan, and Maple Ridge (Somers et al., 2016). Other research conducted in Vancouver's downtown illustrates potential harms caused by current services and attests to the resilience of people who are compelled to live in prolonged crisis. A sample of 107 people experiencing concurrent mental illness and addiction were followed for 5 years in downtown Vancouver. On average they experienced 59 days in hospital, received income assistance in 48 out of 60 possible months, had 19 criminal convictions, spent 590 days in custody and another 631 days under community supervision (Somers et al., 2015).

The financial costs of the status quo have been calculated by several teams led by investigators within and outside BC. A comprehensive economic analysis completed by SFU for the BC Ministry of Health estimated that on average, each homeless British Columbian who experiences Severe Addiction and Mental Illness (SAMI) "costs the public system in excess of $55,000 per year" (Patterson et al, 2008; p.11). The 107 individuals described in the above mentioned study in Vancouver (Somers et al., 2015) received services valued at $246,899 per person over the five year study period, or roughly $50,000 per person/per year. Latimer and colleagues (2017) conducted an economic analysis of public services received by people experiencing homelessness, addiction, and mental illness in Vancouver, concluding that costs were $53,144 per person/per year. Canadian research has demonstrated that recovery-oriented housing offsets between 69% (Latimer et al., 2020) and 96% (Aubry et al., 2016) of the cost of intervening, a rate of return that is uncommon in other domains of health and social spending. Moreover, the amounts reported in the above studies do not include costs associated with lost productivity, which comprises the single largest category of cost attributable to substance use in Canada (Canadian Substance Use Costs and Harms Scientific Working Group, 2020).

The necessity for Indigenous-led services is enshrined in international commitments, in BC law, and in scientific investigations homelessness in Canada. Despite the effectiveness of recovery-oriented housing overall, SFU researchers urge that: "Further research and Indigenous leadership are required to investigate how culturally safe, trauma informed care can be incorporated into existing housing policy and programming." (Bingham et al., 2019a)

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(Somers et al., 2015)

WHAT WORKS BEST

Recovery-oriented housing, employing independent housing and multi-modal psychosocial care, is the current best practice for people who experience homelessness alongside mental illness and addiction (Goering et al., 2011; Pleace, 2018). The term "recovery" refers to the subjective experience of people who at one time experienced profound psychological symptoms including addiction, and who at a later time transcended those symptoms and established a new experience of wellbeing. The central features of person-centred recovery have been systematically analysed and distilled by the acronym CHIME: Connectedness; Hope and optimism about the future; Identity; Meaning in life; and Empowerment (Leamy et al., 2011). Recovery-oriented housing embraces practices associated with harm reduction while simultaneously promoting change in alignment with client motivation. Effectively mobilizing client agency and motivation for change are central to the benefits of recovery-oriented housing and have a pervasive effect on service design as well as delivery. A recent systematic review and meta-analysis confirmed that the overwhelming majority (84%) of people who experience homelessness, mental illness, and addiction have a strong preference for independent housing, leading the authors to conclude that "In a given service planning area, the rate of independent housing settings should exceed the rate of more institutionalized settings by a wide margin" (Richter & Hoffman, 2017; p.817).

To be maximally effective recovery-oriented housing must be integrated with other services including sources of referral (Pleace, 2018).

Canadian multi-centre trials demonstrated that recovery-oriented housing achieves far superior housing stability compared to usual care (Stergiopoulos et al., 2013; Aubry et al., 2016). Research in Vancouver used administrative data from hospitals, courts, and corrections, finding that recovery-oriented housing caused a 50% reduction in emergency department visits (Russolillo et al., 2014) and a 71% reduction in offending compared to usual care (Somers et al., 2013). Clients receiving recovery-oriented housing in Vancouver provided detailed narrative insights into their experiences following homelessness (Patterson et al., 2013; Patterson et al., 2015). Thematic analyses underscore the importance of two inter-related experiences related to personal change. First, recovery-oriented housing provides a secure and stable foundation that enables diverse improvements, "e.g., health, substance use, social ties, identity, financial, leisure time" (Patterson et al., 2013; p.3). Second, it causes subjective improvement in positive identity, experienced as "a gradual process of shifting toward new social roles, networks, and routines" (Patterson et al., 2013; p. 5). These findings reflect a body of evidence demonstrating that the process of positive change is overwhelmingly interpersonal, described by clinical researchers as "the relational essence" of recovery (Mudry et al., 2019).

To be maximally effective recovery-oriented housing must be integrated with other services including sources of referral

(Pleace, 2018)

Our proposed actions complement existing services addressing homelessness, mental illness, and addiction in BC. For example, people who are discharged from institutional settings such as the redeveloped səmiq̓ʷəʔelə/Riverview site may require referral to recovery oriented housing in order to maintain and enhance improvements, representing a step down in care. Another step down in service arises when clients in recovery-oriented housing no longer require the same intensity of support. Alternatively, people who are currently housed and who experience a worsening of symptoms may require referral to recovery-oriented housing (i.e., step up) as an alternative to an in-patient admission or potential eviction.

Our call anticipates these dynamics and is poised to address them by integrating key stakeholders around BC and by using existing high quality data to generate an integrated understanding of the population of people who experience homelessness in BC as an ongoing basis for improving the effectiveness of public services.

84%

of people who experience homelessness, mental illness, and addiction have a strong preference for independent housing

"In a given service planning area, the rate of independent housing settings should exceed the rate of more institutionalized settings by a wide margin"

(Richter & Hoffman, 2017; p.817)

ADDICTION RECOVERY AND SUPPORTED EMPLOYMENT

The majority of people who experience multi-year homelessness, addictions, and mental illness in BC have worked continuously for over one year in the past and state that they want to resume paid work (Somers et al., 2013). International literature confirms that between 70-90% of people who experience addiction and mental illness want to work (Morgan et al., 2017; Peterson, Gordon, Neale, 2017). Individual Placement and Support (IPS) is the international standard of practice for promoting employment among people with severe psychological challenges, as demonstrated in over twenty randomized controlled trials (Drake et al., 2016). Despite very strong evidence that IPS produces engagement in competitive employment, this model of support is unavailable to many in BC and across Canada. To illustrate, in a year-long Vancouver study involving people who experience addiction and mental illness, participants received injectable opioids up to three times a day and "[o]nly 2 (1%) participants were employed at all 5 timepoints" (Nikoo et al., 2018 p20). People seeking help for opioid dependence must often choose between a day at work or a day on methadone. Canadian opiate agonist therapy guidelines do not incorporate evidence-based practices that assist patients returning to or maintaining employment. In Ontario, each year on methadone "was associated with a 7% increase in the odds of women engaging with criminal activity", while three-quarters of the women who received methadone remained unemployed (van Reekum et al., 2020 p1).

ABOUT US

Our coalition members bring lived experience and formal expertise in addiction, mental illness, and wellness, alongside commitments to human rights and reconciliation. Members of our team played lead roles in previous relevant interventions including At Home/Chez Soi, Vancouver's Drug Treatment Court, the BC Homelessness Intervention Project, Surrey's Situation Table, the BC & Yukon Collaborative Care initiative, and Vancouver's Downtown Community Court. Our members have designed and delivered curricula on best practices addressing mental illness and addiction for professionals, allied workers, family members, and self-care for individuals. We include practitioners with deep expertise in the prevention and treatment of addictions and mental illness and with the experience of recovery. Members of our team include agencies that have scientifically demonstrated the ability to successfully reintegrate people who would otherwise remain homeless in BC.

Our call to action includes short, intermediate, and long term objectives that integrate strengths in BC and promote the successive growth of evidence-based practices. The institutional strengths of SFU are essential to our success by consolidating longstanding collaborations and providing a sustained commitment to workforce development, education, and relevant research. Our call integrates Indigenous and non-Indigenous sources of knowledge and practice in the creation of a new and justifiably hopeful era in the prevention and treatment of addiction and mental illness in BC. To ensure that reconciliation is embedded in our approach we recommend integrating our call with the ongoing redevelopment of səmiq̓ʷəʔelə/Riverview. The short term focus of our call is the implementation of recovery-oriented housing, while our intermediate and longer term objectives concentrate on preventing addiction and mental illness and promoting wellness in all BC communities.

ORGANIZATION	RESPONSIBILITIES	MEMBERSHIP
Reintegration Leadership Team	Develops and provides management structure Ensures coordination with public & private orgs Approves memoranda of understanding Prevents & resolves conflicts	Indigenous & non-Indigenous PWLE; Applied/Clinical Researchers; Housing Specialist; Indigenous Service Lead; Addiction Specialist; Assessment Specialist; Employment Specialist; Human Rights Specialist
SFU/CARMHA	Coordinates service providers Develops & supports delivery of best practices / fidelity Evaluates & reports outcomes	
First Nations Justice Council **Lu'ma Native Housing**	Leads inclusion of Indigenous communities, knowledge and practices	
SFU/CARMHA, BCS	Develops and administers Provincial assessment, referral, and monitoring procedures	
Housing Specialist Teams	Builds and maintains housing portfolio Deliver Service per Best Practices	
HealthJustice	Ensures that practices are grounded in knowledge of human rights and law	

NORMALIZING HOPE (YEARS 1-3)

Our immediate objectives are to replicate and extend the proven benefits of recovery-oriented housing by integrating existing strengths and capabilities.

- Beginning September 1st, 2021, recruit 500 people per year for three years into high-fidelity recovery-oriented housing.
- Create and maintain a comprehensive inventory of provincial resources related to housing and social re-integration for people who experience homelessness, mental illness, and addictions.
- Establish housing portfolios that include independent housing alongside existing supported housing resources in: Lower Mainland; Capital; Interior; Prince George.
- Convene, train, and support established service providers in the delivery of high-fidelity recovery-oriented housing, and introduce best-in-class assessment and referral in DTES.
- Engage service providers, service recipients, and municipal governments across BC to plan roll-out, recruitment, referrals, and priorities for service expansion.
- In regions where recovery-oriented housing will be concentrated engage with major allied services and stakeholders to ensure synergy between existing and new services.
- Collaborate with leaders of organized labour and employers to establish wage and benefit protections for employees and standards for the delivery of addiction and mental health services.
- Expand Individual Placement and Support (IPS) with links to employers and staff trained and supervised in IPS.
- Develop institutional dialogue with səmiq̓ʷəʔelə/Riverview redevelopment to create a campus of excellence applying Indigenous and non-Indigenous knowledge and practices to prevent and treat addiction and mental illness,.
- Consult with relevant post-secondary programs to document, disseminate, and support the implementation of evidence-based practices to prepare future members of communities of practice.
- Implement province-wide screening and centralized recording of homelessness. Promote widespread use of strengths-based measures (e.g., Recovery Capital).
- Report effects of interventions in comparison to established benchmarks including emergency department visits, criminal justice involvement, and housing stability.

BROADENING THE BASE (YEARS 3-5)

Preventing an ongoing need for recovery-oriented housing requires broadening the base of effective policies and services.

- Expand post-secondary training and continuing education for practitioners on evidence-based practices in addiction and mental illness prevention, treatment and recovery.
- Engage additional employers, municipalities, schools, and post-secondary institutions in effective practices to retain and assist people at risk for addiction and mental illness.
- Disseminate and support the application of self-care resources for people at risk for addictions including youth and people who currently use drugs (e.g., alcohol, smoking/vaping).
- Demonstrate adherence to reconciliation by showcasing the distinct and combined benefits of Indigenous and non-Indigenous pathways to wellness and reduced harm.
- Guide the expertise and resources at səmiq̓ʷəʔelə/Riverview to support all BC communities with workforce development, on site training and sustained outreach.

PREVENTION AND WELLNESS PROMOTION (>5 YEARS)

- Normalize the practice of evaluating all public policies and services as they relate to reducing addictions and mental illness (AKA., recovery-oriented systems of care).
- Consolidate səmiq̓ʷəʔelə/Riverview as an internationally acclaimed community that exemplifies and disseminates practices that promote reconciliation, equity, social inclusion and wellness.

DETAILS OF ACTIONS AND LEAD ORGANIZATIONS

500 people per year for 3 years
(MPA; Coast MH; RainCity; Phoenix; John Howard Society; Lu'ma Native Housing)

Referrals from all parts of BC
(CMHA; Salvation Army; SFU/CARMHA)

Services provided in Lower Mainland, Southern Island, Okanagan, North
(MPA; RainCity; Coast MH; Phoenix; John Howard; UGM; Harbour Light; CMHA; Lu'ma Native Housing)

Screening conducted with consent to access existing linked administrative data
(SFU/CARMHA; Building Community Society)

Assessment to follow protocol used in Vancouver At Home
(SFU/CARMHA; Building Community Society)

Progress assessments conducted via interview and with consent to access linked administrative data
(MPA; Coast MH; Phoenix; Building Community Society; John Howard Society; SFU/CARMHA)

Two-eyed knowledge and practices: Strengthening All my Relations & Recovery Capital
(Lu'ma Native Housing; SFU/CARMHA)

Protocols, training, supervision in recovery-oriented housing practices
(SFU/CARMHA)

Individual Placement and Support, Vocational Reintegration
(CMHA; John Howard Society)

Recovery Coaching
(UGM)

Integrated recovery services "from shelters to homes"
(Harbour Light; UGM; RainCity; MPA; Coast MH; Phoenix; John Howard Society; Lu'ma Native Housing)

Human rights foundation, principles, practices
(HealthJustice)

500 People per year for 3 years

Services provided in:

LOWER MAINLAND
SOUTHERN ISLAND
OKANAGAN
NORTH

TIMELINE TO IMPLEMENT THIS CALL TO ACTION

June 25, 2021
Approval to develop details as needed to authorize First Year budget.

July 31, 2021
Completion of full First Year budget details for approval (Treasury Board, etc.)

September 1, 2021
Implementation of services

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