Pervasive Homelessness and the Gaps in Canadian Mental Health Policy
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Canada has historically been characterized by a lack of leadership in mental health policy, which has had devastating impacts by perpetuating issues of homelessness. Those who suffer from mental illness face disproportionately high barriers to accessing adequate housing. The responsibility of caring for this population has been constantly shifting since deinstitutionalization left many on the streets – from medical facilities to community service providers, and now finally back into the hands of government. The federal government has very recently announced its intention to develop a national strategy and has acknowledged the potential for investing into Housing First initiatives such as the “At Home/Chez Soi” pilot project. This paper aims to examine the relationship between mental health and homelessness, and consider the history of policy changes that has led us to where we stand today. In moving forward with its national strategy, it will be important for the federal government to look towards recent recommendations made by experts, stakeholders and academics regarding its next steps.

Introduction

Many studies have identified causal relationships between mental illness and homelessness. While a lack of safe and sufficient housing can trigger a deterioration of one’s mental health, the presence of a mental illness can also make it difficult to maintain a stable living situation and in turn lead to homelessness. This paper aims to further understand the dynamics of this relationship by investigating how the lack of adequate support for those with mental illness contributes to the problem of homelessness in Canada. The literature suggests that gaps in Canada’s mental health policy are perpetuating the problems of homelessness in cities across the country.
A major policy change occurred in the 1960s with the deinstitutionalization of psychiatric wards and hospitals. Facilities closed their doors and reduced available beds throughout Canada, resulting in a large quantity of inpatients discharged into the community. These inpatients were largely left to their own devices and without adequate transitional support, leading to an increase in homelessness and later to new residential and institutional forms of care. Community services emerged as a response to the lack of government action over time, as well as the distrust and reluctance of vulnerable populations to use traditional administrative approaches. After decades of shifting responsibilities, these services are now provided through a complicated collaboration of public, private, and community initiatives. Provincial and federal governments are only now beginning to acknowledge that this system is often difficult to navigate, and may be exacerbating other issues such as homelessness.

While Canada is beginning to make progress as a nation, there is much to be done. On any given night in Toronto, the city with Canada’s largest homeless population, there are approximately 5,000 people without shelter. According to a diagnostic interview study in Toronto, about two thirds of respondents had a lifetime diagnosis of mental illness, and 24 per cent felt that they would require mental health support in order to obtain adequate housing (Hwang, 2012). These figures shine light on the gaps in mental health policy – gaps that too many Canadians have fallen through.

Transforming mental health and housing policy alike is crucial for the obvious reasons of improving the standard of living for an important segment of the Canadian population. In any event, there are significant costs involved with maintaining the status quo. Health problems among the homeless are vast: seizures, hypertension, respiratory tract infections, HIV, tuberculosis, and skin and dental problems. In general, homeless people are admitted to hospital five times more frequently than the general population (Hwang, 2001). Not only are these visits more frequent, the hospital stays are significantly longer, resulting in excessive
costs and pressures on the healthcare system. Mental health specifically accounts for 52 per cent of these hospital stays among the homeless, compared to only five per cent of the general population (Hulchanski, 2009).

Change has been slow, but several milestone publications have framed the discussion on the issue, and Canada has announced its intent for a national strategy. Some innovative policy experiments are also currently being pursued in Canada, and the results to date seem promising. Rather than traditional methods of providing housing as a final stage of treatment for addiction and mental health problems, some initiatives now focus on providing housing first and without being conditional on treatment. Modeled after New York City’s “Pathways to Housing”, Canada’s “At Home/Chez Soi” pilot project was launched in 2009 in Montreal, Toronto, Moncton, Winnipeg, and Vancouver. While no long-term data is available on these new Housing First initiatives, the immediate results of these pilot projects have shown success for participants and potential savings for government.

This paper will first walk through a brief history of the deinstitutionalization process and its implications, followed by an analysis of the relationship between mental health and housing. A review of the key literature that frames the current policy discussion will be addressed, along with an examination of the current framework for Canadian mental health policy and service delivery. Finally, a series of policy responses will be considered, as well as recommendations for policymakers moving forward. In further developing its national mental health strategy, the federal government should take careful note of the core recommendations in the literature, particularly in outlining clear roles and responsibilities, maintaining its commitment to the issues at hand, and improving data collection and evaluation.

Deinstitutionalization

The story that leads to Canada’s current position in mental health policy
and service delivery can be broken down into three phases. The first phase was largely triggered by the publishing of the Bedard Report in 1962. Prior to this report, those who suffered from mental illness were institutionalized in psychiatric wards and hospitals. After World War II, these institutions became overcrowded, understaffed, primitive, and restrictive. Treatment was not focused on therapy but rather on custody, using seclusion and chemical and physical restraints on patients (Kirby & Keon, 2004). The study was commissioned by the Liberal government to examine psychiatric wards and concluded, “hundreds of patients continue to live in hospitals when their mental state does not require hospitalization” (Ballon, 2014). Central to their recommendations was deinstitutionalization, and many similar studies began to emerge that outlined the negative consequences of these establishments. Furthermore, the report suggested patients should instead receive treatment close to home in order to avoid social uprooting, ideally in smaller hospitals or psychiatric centres that provide a range of services.

This resulted in the closing of 80 per cent of psychiatric beds and wards in Canada, based on the consensus that these outdated institutions were doing more harm than good and that patients deserved to live their own independent lives. While the effort was warranted, adequate funding and resources were not allocated to other service providers to care for inpatients who were suddenly discharged into the community. This led to a high frequency of relapse and hospital admissions, increases in criminal behaviour and incarceration rates, and most noticeably an increase in homelessness (Kirby & Keon, 2004).

A second wave occurred with the coming of psychopharmacology and the emergence of new medicine to treat certain mental illnesses. While psychiatric drugs were primary used for sedation earlier on, scientific developments and new research methods evolved rapidly over the 1960s and 1970s. This evolution introduced the concept of placebos and “double blind” experiments, as well as an understanding of biochemical brain responses, synaptic transmission, and action mechanisms of certain drugs. These new clinical research efforts caused a cultural shift towards
looking at mental illness as simply another type of illness that could be treated with medical help. Subsequently, mental health services were integrated with other medical facilities such as general hospitals.

The third phase was characterized by the uptake of services by community centres, and recognition that more comprehensive approaches to mental health, beyond medical treatment, would be necessary (Ballon, 2014). In 1988, a federal discussion paper by the name of “Striking a Balance: Mental Health for Canadians” was released and the focus shifted from the role of hospitals to the role of the community. This led to the first provincial document to outline community mental health reform in 1993 with Ontario’s “Putting People First”. The 10-year strategy aimed to reallocate 60 per cent of funding to community initiatives and only 40 per cent towards hospital services by 2003 (Ballon, 2014). Attitudes also moved away from the need to “treat” mental illness and towards support for other determinants of mental health, with housing being established as a priority.

Community organizations emerged in response to the initial lack of government progress on the issue. In addition, it was becoming clear that this vulnerable population was distrustful of the government after deinstitutionalization and reluctant to use traditional approaches provided in hospitals. These new community initiatives included outreach services that served as a point of first contact and assessment for long-term treatment, assertive community treatment (ACT), intensive case management, and service integration. Today, most provinces utilize a complicated delivery system of community services working in conjunction with psychiatric wards and general hospitals.

**Mental Health And Housing**

Issues of mental health are broad and complex, ranging from poor mental health (feelings of loneliness) to moderate mood disorders (depression and anxiety) and severe mental illnesses (schizophrenia). Today, addiction and substance abuse are typically included in definitions
of mental health as well. Studies find that substance abuse is consistently the largest predictor of housing loss, as addictive substances tend to deregulate the mind’s “dopamine-based” rewards system, which conventionally recognizes the safety of having shelter. Similarly, those with schizophrenia and bipolar disorder fundamentally lack the insight to recognize illness-related symptoms and are less likely to seek treatment (Schutt and Goldfinger, 2009). The unpredictable nature of mental illness and untreated symptoms often result in a “revolving door” of care that makes housing difficult to obtain and maintain (Munn-Rivard, 2014). Financial instability also results from these symptoms by constraining employment and income opportunities necessary for stable housing.

At the same time, access to housing is largely a social determinant of mental health outcomes. Those who face housing insecurities are more likely to have poor coping skills and high levels of stress, and as a result, they may develop concurrent issues such as substance abuse and mobility impairment (Munn-Rivard, 2014).

Unsurprisingly, the occurrence of mental illness is disproportionately higher among the homeless compared to the general population. According to the Parliament of Canada, the country’s total homeless population lies somewhere between 150,000 and 300,000 people, with 25 to 50 per cent suffering from a mental illness. However, due to the transitory nature and lack of diagnosis, this population is difficult to measure and some estimates are as high as 74 per cent. As a benchmark, the Mental Health Commission of Canada suggests that the homeless population suffering from mental illness is approximately 119,800 people (Munn-Rivard, 2014).

Access to housing is also incredibly complex. Canada’s social housing faces an overall shortage and lengthy waiting lists mean more people remain in limbo, living in hospitals, shelters, or on the streets. Supportive housing for those with complex needs is especially lacking, with only about 11 per cent of units considered “high support” (CAMH, 2014). There is also a lack of flow within social housing systems, as
tenants feel restricted from moving due to either a lack of awareness or a fear of losing their place given such high waitlist times. Stigma plays a role in access to housing for those with mental illness, as many communities oppose supportive housing on the assumption that they are associated with lower property values and high crime rates, although no strong evidence confirms this (CAMH, 2014).

In a recent Toronto Street Needs Assessment that interviewed homeless people who suffer from a mental illness, 24 per cent of respondents said they would first require support for their mental health in order to achieve adequate housing (Hwang, 2012). For Canada to tackle the issue of homelessness, policy must begin to address the needs of those suffering from mental illness. The relationship between mental health and homelessness embodies the classic chicken-or-egg debate, and the literature suggests that the correlation runs both ways. However, it is clear that the gaps in Canada’s mental health policy are allowing too many people to fall into both relative and absolute homelessness.

**Shifting Responsibilities**

Despite the massive failure of deinstitutionalization, re-institutionalization was not an option. Similarly, despite the impressive developments in psychopharmacology, the integration of mental health services into general medical facilities was too narrow a solution for such a complex issue. To address the lack of comprehensiveness, community initiatives came forward with a more holistic approach. While these services have provided new forms of support and care, such providers often face fiscal constraints, limited staff, and scarce resources. It has been a slow progression and the system has now become deeply fragmented, with most provinces currently providing coordinated services with several community organizations in conjunction with medical facilities. Fragmentation comes with its own host of issues, signalling the need for yet another shift towards public leadership and new innovative approaches.
Over the past 10 years, promising actions have begun to surface at the federal and provincial levels: researching the devastating social impacts of poor mental health; recognizing the importance of concrete strategies; and reallocating funding to meet complex needs, particularly in regards to housing. The following are the most noteworthy efforts:

In 2006, the Standing Senate Committee on Social Affairs, Science and Technology released its final report “Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada”. Recognized as the first truly comprehensive examination of mental health issues at the national level, the report announced the creation of the Mental Health Commission of Canada (MHCC). The Commission would serve to develop a national strategy and ensure that these issues remain salient and on the public agenda (CPA, 2006). Other recommendations in the report called on the need for a Mental Health Transition Fund as a designated mental health transfer from the federal to provincial governments, as well as for extensive research, evaluation, and improving access to existing community services. Importantly, the report also emphasized the need for appropriate housing approaches, acknowledging that the percentage of Canadians living with mental illness who require access to housing is double that of the general population (Hulchanski, 2009).

The Canadian Institute for Health Information (CIHI) also released a 2006 report by the name of “Improving Health of Canadians: An Introduction to Health in Urban Places”. The extensive report covers many areas in which health outcomes can be improved in urban neighbourhoods, looking at health indicators and trends across the country. The report dedicates an entire chapter to “Housing and Health” with a focus on Canada’s homeless population and Aboriginal population. The chapter makes crucial linkages between physical structures and mental health outcomes, and provides persuasive evidence for the correlation between a lack of affordable housing and psychological distress (Hulchanski, 2009). The recommendations highlight the need for more appropriate housing policies to address
mental health outcomes, particularly regarding adequacy, suitability, and affordability of housing (CIHI, 2006).

Most recently, the Centre for Addiction and Mental Health (CAMH) released its 2014 Housing Policy Framework. As an organization with an expertise in mental health research, the report seamlessly ties together issues of mental health and housing, making several recommendations for policymakers. Central to these recommendations are ensuring that people with mental illness have secure, affordable, and accessible housing with recovery-based supports for diverse needs, and designed with flexibility to meet those needs as they change. The report calls on government to convey commitment to mental illness at all levels, promote cross-sectoral and cross-governmental collaboration, and coordinate and streamline housing-related services. Finally, and perhaps most importantly, is a call on government to ensure that decisions are made based on evidence, research, and best practices (CAMH, 2014).

Current Framework

The current system is ridden with inefficiencies and fragmentation. There has been no comprehensive strategy to date, but rather a complex array of services delivered by different levels of government, the private sector, and community organizations. These providers still do not offer the continuum of service required for a wide variety of needs, and have historically been underfunded and understaffed (Kirby & Keon, 2004). With fragmentation typically comes issues of accountability, disconnected funding, and unclear roles and responsibilities for service providers.

Sections 91 and 92 of Canada’s Constitution do not clearly identify housing or mental health under provincial or federal jurisdiction. After withdrawing from its responsibilities in 1996, the federal government downloaded housing responsibilities to the provincial and municipal levels of government. Since local context is so crucial in matters of homelessness and housing, municipal government may seem well-suited, although capacity is often limited and resources tend to be scarce. Access
to adequate housing, as outlined in article 25(1) of the UN Declaration of Human Rights, is internationally recognized as a fundamental human right. Although Canada has ratified this agreement, there is no explicit mention of it in the Charter of Rights and Freedoms.

While healthcare undoubtedly falls under provincial jurisdiction, transfers from the federal government do not include a designated transfer for mental health and addition treatment. In the 2002 Royal Commission on the Future of Healthcare in Canada, the Honorable Roy Romanow famously called mental health the “orphan child” of Canada’s healthcare system, falling under no clear authority and remaining neglected (Romanow, 2002).

As usual, Canada is also at a geographic disadvantage given its massive size. While pervasive homelessness is typically associated with cities, service provision is also lacking in rural areas. Those who are suffering from a mental illness must travel long distances to receive treatment, pulling them away from important support systems (Kirby & Keon, 2004). Furthermore, challenges arise in a publicly funded healthcare system. When funding is cut, licensed mental health specialists are increasingly seeking work in the private sector (Cohen, 2014). This leaves Canadians who do not have the financial means or extended insurance coverage neglected, and those who are unable to access private services end up waiting for months to receive care from the public sector. For this reason, much of mental health treatment is provided through emergency services.

Until very recently, Canada was the only G8 country without a national mental health strategy. Historically, the primary role of the federal government has been only fiscal in nature, having no centralized departmental capacity but providing transfers to other levels of government. Even so, the provinces have never received a designated transfer for mental health and addiction services. The federal government has only been responsible for the health of very specific groups of people, such as Aboriginals, offenders under the federal correctional
system, veterans, active members of the Canadian Armed Forces, newly landed immigrants, and refugees. With no overarching federal framework, the government of Canada has been characterized by “a serious lack of leadership in mental health” (Kirby & Keon, 2004).

Policy Responses

Maintaining The Status Quo

Beyond issues of morality, the fiscal consequences associated with a high incidence of mental illness among the homeless are immense. For example, mental health accounts for 52 per cent of hospital stays among the homeless but only five per cent among the general population. Similarly, emergency room visits for mental health related problems accounted for 35 per cent among the homeless but only 3 per cent of the general population, with the most commonly reported problems being substance abuse, followed by schizophrenia (Hulchanski, 2009). Very often these patients do not have a family doctor to utilize or are unable to present proof of identification for coverage, leaving emergency services as their only option. Once admitted, the hospital stays are also significantly longer, which puts excessive costs and pressure on the healthcare system. From this point of view, it appears cheaper to house the homeless than to pay for the problems associated with living on the street, such as healthcare, policing, and temporary shelter expenses (CBC, 2014).

Federal Leadership

The Mental Health Commission of Canada (MHCC) put forth the nation’s first mental health strategy through its 10-year mandate, “Changing Directions, Changing Lives” in 2013. Funded by Health Canada, the commission aims to reduce stigma and investigate best practices in assisting people who are homeless and living with mental illness. In addition, the Homelessness Partnering Strategy was announced in 2013 under the Department of Employment and Social Development
to invest in Housing First initiatives, which are outlined below. Transitional supportive housing will receive $119 million per year over a five-year period, for a maximum of $600 million (Munn-Rivard, 2014). This was reaffirmed in the 2014 budget.

The recently announced strategy is too new to determine whether or not it will translate into significant change, but the government has received recommendations from several academics and stakeholder groups on the matter. The MHCC suggest that drivers for change should include strategic investment, clear indicators for progress, and strong social movement. They also identified the need for current funding to be reallocated but also the need to engage with private and philanthropic investment further (MHCC, 2012).

In his interim report, former Senator Michael Kirby called on the federal government to make the long overdue step towards federal leadership in mental health policy. At the very least, the new federal framework should set standards for service delivery in the provinces and develop a suicide prevention strategy. The structure should address four main priorities: education and awareness, a national policy framework, research, and surveillance (Kirby & Keon, 2004). As an employer, the federal government recently took an important step last year in doubling insurance coverage for psychological services for their employees (Cohen, 2014). There should be a call on other employers and private insurance providers to follow suit.

**Housing First Model**

Regarding innovative solutions, it is worth mentioning the potential for Canada’s “At Home/Chez Soi” pilot project that has been modeled after the “Pathways to Housing” project in New York City. Traditionally, many supportive housing initiatives have followed a “treatment first” standard, where the provision of social housing was the final step of psychiatric and substance abuse treatment. Housing First initiatives have recently emerged in its place, providing immediate housing that is not conditional
on sobriety or treatment. Instead of promoting abstinence, these approaches promote harm reduction. New York City’s “Pathways to Housing” was the first to pursue this and although only short-term evaluation data is available, results show that 88 per cent of participants have remained housed within five years, compared to 47 per cent in traditional “treatment first” programs (Hulchanski, 2009).

The “At Home/Chez Soi” pilot project was launched in 2009 across five Canadian cities: Montreal, Moncton, Toronto, Vancouver and Winnipeg, providing homes for 2,000 people with mental illness. The MHCC has evaluated the effectiveness of the program using a federal grant, making it the largest study in the world to target mental health and homelessness. The pilot found that for every $10 spent on Housing First programs, taxpayers save $21.72 on other services (MHCC, 2014). The federal government claims that these types of programs will continue to be implemented, as Minister of State Candice Bergen commented that those receiving federal funds in the future would be required to invest 65 per cent into similar programs (CBC, 2014). The aforementioned Homelessness Partnering Strategy confirmed by the federal government in 2014 emphasized that funds will be dedicated to implementing the Housing First approach.

Next Steps

In further developing a national strategy, the federal government and the Commission should take note of the recommendations made by in some of they key literature outlined above.

1. Clear roles and responsibilities. A formal framework should identify what exactly the role of the federal government will entail, how it will communicate with the provinces, and how it will support municipalities in delivering services on the ground. Given the tumultuous history of shifting responsibilities, it will also be crucial to formally acknowledge the functional role of community-based services.
2. **Commitment and saliency.** It will be important for the federal government to convey its commitment to supporting those with mental illness and ensure that it remains a priority on the public agenda. A good indicator of this commitment could be through a dedicated transfer from the federal to provincial governments to provide mental health and addiction supports.

3. **Data and evaluation.** Obtaining accurate and up-to-date information on matters of mental health and housing is difficult for many reasons – underreporting and inconsistent diagnoses due to stigma and difficulty identifying a transient population are among them. However, understanding this population the best we can will be crucial. This can be done through more frequent scans such as Toronto’s Street Needs Assessment. It will also be important to consistently evaluate ongoing projects and collect long-term data, especially new and innovative Housing First initiatives. This will ensure that the government is making responsible investments.

**Conclusion**

Canada has historically been characterized by a lack of leadership in mental health policy. While the process of deinstitutionalization in Canada largely followed similar trends in the United States and Europe, the policy responses over subsequent decades have been inadequate. The closing of psychiatric hospitals left a large and vulnerable population to fend for themselves without any transitional support, leading to an increase in homelessness. Although community services slowly emerged to compensate for this, the current system represents a disorderly and ineffective arrangement of services provided by different levels of government, the private sector, and community agencies. Social housing and especially supportive housing in Canada is deeply insufficient.

The costs of maintaining the status quo are too high to ignore. Lack of recognition and stigma surrounding mental illness have disruptive social consequences. The high incidence of mental illness among the homeless
presents even higher costs due to excessive burdens on the healthcare and policing systems.

The federal government is finally taking long overdue action towards a comprehensive national strategy. The “At Home/Chez Soi” project also gives reason for hope as a new way to tackle homelessness and mental illness in an effective and appropriate way. The MHCC’s study on this pilot project could be an opportunity for Canada to step forward as a leader in mental health policy. As we move into a new phase of mental health policy and service delivery, policymakers should take note of the recent literature that highlights key recommendations for their new federal strategy. Importantly, the government should ensure that a formal framework is clear in its delegation of roles and responsibilities, that the government maintains its commitment to mental health as a priority issue, and is thorough in its data collection and evaluation of new projects.
References


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