



Mentally Ill and Homeless

Lack of affordable housing pushes thousands onto the street

Text and photos by Cheryl Mahaffy

Heather lies awake at night, worrying about whether she'll keep the roof over her head. All too familiar with the limited housing options for a mentally ill Albertan whose disability pension brings in a princely \$600 a month after taxes, she's determined to hold onto the condo purchased from a distant cousin a few years ago. "I'm trying to stay out of warehousing, as I call it, because that can be very damaging," she says on the phone from Calgary, recalling 15 years punctuated by frantic searches for apartments and all-hours visits from neighbours in crisis. "I have a kidney disorder and I'm severely bipolar. Between both disorders, I have to be very, very careful about keeping my environment routine and healthy."

In truth, the odds seem stacked against Heather (who asked that her last name not be used, due to the stigma still surrounding mental illness). Having patched together mortgage payments by finding two roommates, she discovered that the resulting income makes her ineligible for the provincial support needed to meet living expenses. Until kidney failure puts her on dialysis, she won't qualify to deduct medical costs, despite having to take a \$100 regimen of medications each month. "They have pages and pages of rules, but I don't fit within those rules," she says. "It doesn't seem to matter what way I turn; trying to better my situation works out to be the same or worse."

Yet, among mentally ill Albertans, Heather is fortunate—and she knows it. Unlike many, including her own brother, she worked for 20 years, gaining life skills, before illness forced a halt. For now at least, she has a place to call home, coupled with the support she needs to not only stay stable but also volunteer significant energy as a mental health advocate. She's seen first-hand that chronic mental illness sentences thousands in Calgary alone to a scramble for housing. "I defy anybody to go into the situations some people are in and come out so-called normal," she says. "They have no hope. I often call it a hopeless situation rather than homeless."

Indeed, housing is Alberta's most urgent mental health issue, says Dr. P.J. White, acting director of mental health for the Capital Health Region and psychiatrist at Alberta Hospital Edmonton. While people in crisis wait for psychiatric beds, others remain institutionalized far longer than necessary because there's no place for them to go. Or they relapse, when, in the right homes, they could cope just fine. "Nobody wants to see people in hospital an extended length of time," White says. "It's not right, not therapeutic."

There's no doubt that persons with mental illness have suffered injury and injustice in asylums, from being put on display for British high society of old to being sterilized (still legal in Alberta as recently as 1972) ostensibly to protect genetic stock. Ironically,

Guido Baccaert has been sleeping lately at Edmonton's Herb Jamieson Centre, a 250-bed homeless shelter. It's part of Hope Mission, www.hopemission.com, which also has a transitional complex for women and outreach/recreation for youth. Born in Belgium and trained as a finishing carpenter, Baccaert has been chased by alcohol and other demons. At least he's sleeping in the main dorms, not in the 30-mat detox trailer next door.

today's housing crisis for the mentally ill began as an attempt to improve on that past by drawing the mentally ill out of institutions and into the community.

Among those who've watched deinstitutionalization unfold is Ron LaJeunesse, executive director of the Canadian Mental Health Association's Alberta Division and author of *Political Asylums*, an overview of Alberta's response to what he terms "the 20th century's equivalent of leprosy." He recalls the forces fueling downsizing at Alberta's mental health hospitals: exposés of dreadful care, promising pharmaceutical treatments, escalating

dropped to 940 new units by 2000. As the stock of affordable housing dwindled, vacancy rates dropped and rents rose, a trend exacerbated in Alberta when the economy heated up.

Meanwhile, government cutbacks tore gaps in nearly every corner of the social safety net, shrinking incomes for those hardest hit by rising shelter costs. The provincial shelter allowance now pays less than half the average rent for a single person, notes Jim Gurnett of the Alberta Housing Coalition, whose staff at Edmonton's Mennonite Centre for Newcomers spends fully one-third of its time navigating shelter barriers. "It's ridiculous," he says. "It's inhuman."

In cities across Canada, the chickens came home—with no place to roost. As the 1990s advanced, increasingly acute and visible homelessness spawned new advocacy networks intent on tracking and redressing what they termed a national disaster. A one-day count conducted by the City of Calgary in 2002 found 1,737 on the streets or in shelters, a 400 per cent increase from the community's first count in 1992—three times the rate of population growth. The Edmonton Joint Planning Committee on Housing, meanwhile, counted 1,915 homeless in 2002—a 65 per cent overall increase (and 82 per cent increase in families) in two years. Higher counts may reflect improved methodology, as bureaucrats point out. But even the most sophisticated counts miss entire subsets, including the many women, children, Aboriginals and teens who double up with often reluctant friends and family before showing up on the streets or in emergency shelters.

A strikingly high proportion of the homeless are mentally ill. Social workers at the Calgary Drop-In Centre estimate that about 30 per cent of the 1,000-plus people they serve each day are mentally ill, while a 2002 study (using assessments by psychologists to sidestep our continuing reluctance to self-label as mentally ill) tallied 69 per cent. Frontline workers at the Women's Emergency Accommodation Centre in Edmonton, where clients regularly sleep in shifts due to overcrowding, estimate that about half are mentally ill. Typical afflictions include schizophrenia, bipolar disorder, chronic depression, post-traumatic stress syndrome and personality disorder.

"There's no doubt people with chronic mental illness are overrepresented in the homeless population," con-

firms Jim Dunn, whose research at the University of Calgary underscores the physical and psychological importance of having a home. Any homeless person lives at markedly elevated risk of disease, abuse and death, Dunn adds. For the mentally ill, who often require stable surroundings, the impacts are compounded. Lost ID, stolen medication, rape, missed meals, non-stop worry—it's all part of life on (or near) the street. Recalling a national consultation that heard from 500 stakeholders on housing's role in health, he adds, "One of the things that came out big-time was the need for housing for people with mental illness."

While concentrated in Calgary and Edmonton, mentally ill Albertans go homeless in rural regions as well. Some appear on Brenda Brochu's doorstep, at the Peace River Women's Shelter. As director of the six-bedroom facility, 200 miles from the nearest secure psychiatric ward, she almost always has one or two clients who are or should be on anti-psychotic medication. "These are probably our most difficult clients to house," she says. "It's a serious, persistent problem."

The biggest barrier is money. "These women don't have enough to live on, and the expectation that they are able to work is often unrealistic," says Brochu. Many have lost the care of their children (along with child tax benefits). Even those who have succeeded in qualifying for Assured Income for the Severely Handicapped, or AISH, (a feat requiring more persistence than many can muster) receive little more than \$800 a month; others exist on \$400 a month welfare. "I've seen grossly inadequate accommodations—space heaters with no outside vents, leaky roofs, collapsing foundations, no running water, tenants having to go to the gas station to use the washroom," Brochu recounts. "I know women diagnosed as mentally ill who've spent a whole winter in a northern Alberta tent, and another who lived in a vehicle for three years, occasionally finding someone who would take her home for a shower. Basically, these situations expose women to further abuse; they end up in prostitution-like conditions, exchanging sex for a room."

Mentally ill individuals aren't necessarily model tenants, particularly when left to monitor their own medications, Brochu notes. "As a result of the disease, they don't

always look after their property as well as others. It's a risk for the landlord, which is why the government must be involved: someone has to assume that risk." A few subsidized apartments are available in Peace River, but those are shared units. "That means having two severely mentally ill people together in a single apartment, which might be affordable but is not always the most appropriate," she says. "Many are very focused on their own needs, because of all the symptoms they're experiencing."

Inevitably, caring for the chronic mentally ill affects a shelter's central mandate of providing a haven for women and children fleeing abuse, while exposing staff and clients to behaviours they're not trained to handle. "At

Transitional and emergency housing is particularly ill-suited to the mentally ill, increasing their isolation, stress and time in hospital.

times we feel like we're a psychiatric institution ourselves, which is never what we were intended to be," says Brochu. "If there was a really integrated system of services for people with mental illness that encompassed all of their needs—medications, housing, income and recreation—that would greatly lighten the burden on us."

The justice system is feeling an equal burden, notes CMHA's LaJeunesse. "Prisons are becoming the mental institutions of old, full of people who have mental illnesses and are not bad," he says. Indeed, 80 per cent of the homeless mentally ill interviewed in a 2002 Calgary Homeless Foundation study had been incarcerated at least once, averaging 26 times in jail—mostly for minor infractions such as unpaid fines.

"Once you have a record of incarceration, it's another strike against you," observes Helen Gardiner, whose surveys of homeless populations for housing coalitions in Calgary and Edmonton highlight the marked complexity of issues keeping the mentally ill on the streets. Most have (or acquire) a physical disability, and many abuse liquor or drugs in an attempt to self-medicate or mask their despair.

Any homeless person lives at a high risk of disease, abuse and death. For the mentally ill, who require stable surroundings, the impacts are compounded.

costs. Psychiatric beds were closed in the 1960s, but the anticipated support for released patients failed to materialize. "We sent literally thousands of people to live in environments that were really very unhealthy," he says.

Families and non-profit agencies stepped forward where they could, but many mentally ill individuals ended up visibly adrift. "You can't close down beds until you offer support," LaJeunesse says. Instead, Alberta developed a patchwork system of care. "In fact, it's not really a system at all. And the biggest hole is that we have very few homes for people who've been discharged."

In an unfortunate (some would say short-sighted) collision of events, the three decades following the 1960s saw a marked reduction in government support for affordable housing, culminating in a 1993 federal decision to withdraw from financing new projects. Instead of picking up the slack, provincial and territorial governments cut \$480-million from housing programs in the ensuing seven years, more than a third of that in Alberta. From an average of 20,000 new units a year across the country in the previous three decades, publicly funded construction



1907 • Passage of the Insanity Act: a person considered insane or dangerous can be committed by a Justice of the Peace.

1911 • Hospital for the Insane opens in Ponoka.

1922 • A discharge process is added to the 1907 Insanity Act.

1923 • Provincial Mental Institute opens near Edmonton. Ponoka changes its name to Provincial Mental Hospital.

1924 • Mental Diseases Act: physicians' powers expanded to admit patients; allows for psychopathic wards in general hospitals.

1928 • Sexual Sterilization Act: provides for sterilization of persons "in danger of transmitting mental diseases or deficiency." Five years later Nazi Germany does the same.



Dr. J.M. MacEachran, U of A professor and head of the Eugenics Board from 1929–1964.

1929 • Eugenics Board established.

1931 • Psychopathic ward opens at University of Alberta Hospital.

1933 • Claresholm Provincial Auxiliary Mental Hospital opens.

1937 • Insulin shock therapy introduced. Ponoka hospital population peaks at 1,707 patients.

1945 • Electroshock therapy (ECT) introduced.

“Every time you layer on another risk, it becomes increasingly difficult to be employed, to find housing, to remain stable,” she says. “I don’t know how any reasonable person or reasonable society can expect the seriously mentally ill with these additional barriers to somehow navigate the system or house themselves without assistance.”

People on the street do bump into some excellent services, Gardiner says, but those services are neither consistent nor flexible—and certainly not linked together in a way that would guide people out of poverty and into appropriate homes. Virtually everyone tells stories of trying vainly to get all the pieces in place, only to become discouraged and stop trying. “We need to address head-on the severity

While emergency accommodations were going up, the province lost five times as many permanent rental dwellings to condominium conversion and demolition of rooming houses.

of need, and deal with those who have most severe needs so at least they can lead decent lives,” Gardiner says.

Housing needs have finally begun to attract some public support, but again the efforts are piecemeal. Naming Claudette Bradshaw to the new role of federal coordinator on homelessness in 1998, the Liberal government launched a \$753-million initiative to expand emergency accommodations. That program (recently extended to 2007) brought \$15-million in federal funds to Alberta in three years, supplemented by \$9-million from the province and significantly more from municipalities and other sources. Results include about 2,000 new shelter spaces in seven Alberta communities. For individuals such as Guido Baccaert, a carpenter chased by alcohol and other demons, those beds improve the odds of survival, however stark.

Yet it’s like sticking one finger in a dike that’s being flooded from above. While those shelter spaces were going up, the province lost five times as many permanent rental

dwellings to condominium conversion and demolition of rooming houses that, while substandard, at least provided people with a roof. Meanwhile, evidence mounts that transitional and emergency housing is particularly ill suited to the mentally ill, increasing their isolation, stress and time in hospital. “We’re better off to help them find a permanent place to live and adjust the supports around them, rather than moving them to different facilities according to the care they need,” observes Tania Kyle, whose University of Calgary masters thesis examines the links between housing and quality of life among mentally ill clients in Calgary. “Having emergency shelters, or transitional houses where people can live for two years and then have to move on is, I think, a bit short-sighted.”

Recognizing the need for permanent affordable housing, the federal government again took the lead as the new millennium dawned, committing \$680-million over five years to cost-shared social housing. Only after gaining assurance that matching funds could come from sources other than provincial coffers did Alberta belatedly sign on, accessing up to 67 million federal dollars.

As plans for use of those dollars develop, it’s becoming clear the results will leave many mentally ill citizens unserved. The funds target the working poor, while many with chronic mental illness cannot work. What’s more, the dwellings will come nowhere near meeting pent-up need. Edmonton’s Joint Planning Committee on Housing, for example, proposes building 713 units in the next three years (two-thirds of them emergency or transitional) while acknowledging a need for 5,700 new units of affordable housing in the current year alone.

Many predict Alberta’s housing crisis is sure to get worse. Simply keeping the homeless out of the cold will become an increasingly expensive proposition, says George Coppus, chair of the Alberta Housing Coalition, formed last year in the hope that a united front might effect political change. Already, he estimates the direct cost of homelessness in Canada is \$1.4-billion a year.

Across the country, advocates are touting a “1% Solution,” a return to spending 1 per cent of budget on social housing. That would mean 2 billion federal dollars a year, plus \$2-billion across all provinces and territories. But U of C’s Dunn isn’t holding his breath. Barring the

way, he says, are “all kinds of perverse incentives,” from pull-yourself-up-by-your-bootstraps values to fragmented zones of responsibility. According to Dunn, the national homelessness initiative under Human Resources Development Canada and the affordable housing fund administered by Canada Mortgage & Housing Corporation are incredibly disconnected. While politicians fret about subsidizing low-income renters at a cost of about \$4,000 a year, every Canadian homeowner receives an almost equal amount in annual tax benefits. While appropriate housing reduces health costs, it remains a low priority. “Housing is outside the perceived mandate of health,” says Dunn. “There’s no mechanism to funnel those savings between ministries.”

In our own province, housing is buried within the department for Alberta Seniors, raising another bone of contention. “Fifteen years ago we thought quality housing for all Albertans was important enough that we actually had a government department focused on housing and put significant amount of money into it,” says the Mennonite Centre’s Gurnett. “Now, the policy framework on special needs housing makes it clear that housing should be looked after by municipalities and the private sector, even though constitutionally it is a provincial responsibility.”

While eliminating homelessness is a noble goal, current measures come nowhere close to the visionary policy that’s really required, Dunn points out. “I like to think of the analogy of defensive driving,” he says. “To get out of a skid, you focus on the road ahead. If you focus on the ditch, you’re in it. It seems to me we’ve been focusing on the ditch—and staying out of the ditch is not a visionary strategy. Why don’t we think about having everybody adequately and stably housed?”

Those on the streets due to chronic mental illness need more than bricks and mortar to come in out of the cold: they need carefully calibrated support. Some simply need an alert outreach worker to drop by regularly to check medications and spot signs of relapse; others require 24-hour “wrap-around care” that extends beyond psychological needs to housekeeping, finances and numerous other daily tasks. Further, it’s not unusual for an individual’s needs to shift as crises loom, then retreat.

Peers and family may provide invaluable help, but

trained, appropriately paid staff are crucial—and dollars for staff are in short supply. Talk to any organization serving mentally ill residents and you’ll soon hear of a project stalled, or at least significantly affected, by that reality. A recent addition to the Edmonton City Centre Church Corporation (E4C) constellation of dwellings for mentally ill residents, for example, is limited in who it can serve because it has no funding for onsite workers. “We can find money for a building, something donors can put a plaque on,” says director of housing Sundari Devam, “but nobody wants to say, ‘For the next 35 years we’re going to fundraise for you.’ And operating dollars are in the hundreds of thousands a year.”

Evelyn Doberstein tells of her family’s vain attempts to

Homeless persons supplied with supported housing cost the B.C. government about one-third less than people still without homes.

find or create a home for their mentally ill daughter. Evicted twice for hoarding massive amounts of food, bounced through increasingly expensive yet ill-matched accommodations while spending four years on a waiting list for a staffed group home, their daughter finally agreed to enter Alberta Hospital for treatment earlier this year, offering a short reprieve from the inevitable housing search.

Along the way, the family became active in Prosper Place, a clubhouse that assists mentally ill members in social and work skills—and discovered that their housing woes are far from unique. With another family, they laid plans to buy a house and equip it for assisted living, but requests for operating dollars fell on deaf ears, even though the provincial government is staffing similar homes for children with developmental disabilities. “So if your child has a low IQ, you know they will be looked after, whereas people dealing with mental illness are not,” Doberstein says. “There will come the day when our daughter is ready to come out of hospital, and then we’ll



Early psychosurgery instruments used in Alberta hospitals.

1950 • Psychosurgery (lobotomies) introduced in Ponoka.

1954 • Tranquillizers introduced. Calgary’s first psychiatric unit opens at the General Hospital.

1955 • The Canadian Mental Health Association is founded in Alberta. Mental Disease Act: changes term “psychopathic ward” to “psychiatric ward”; limits hospital stays to three months in every 12.

1957 • National Hospital Insurance Plan excludes funding for mental hospitals.

1960 • Deinstitutionalization of mental patients begins. Psychiatric units open in a number of general hospitals.

1962 • Insulin shock therapy discontinued and ECT curtailed.

1964 • Mental Health Act: redefines mental disorder as “suffering from mental illness or retardation.” Apprehension and committal to hospital is now based on the welfare of the individual or protection of others.



Glenbow Archives NA-2864-19590

1966 • First group homes opened by the Canadian Mental Health Association in Calgary.

1967 • National Health Plan includes funding for psychiatry.

1970 • Mental Health Act: “promiscuous and immoral” people excluded from mental disorder definition.

1971 • Conservatives elected on mental health reform platform.

start all over. We're getting older, and what we want is something permanent, before we go."

Hearing such litanies, "the public tends to respond by saying deinstitutionalization failed, so let's reinstitutionalize, but that's not the answer," LaJeunesse says. "Once people reach the stage where they should be discharged, they get worse by staying in hospital. And it costs a huge amount of money—between \$300 and about \$1,300 a day—for the taxpayer to keep them there." Other jurisdictions, he adds, have proven it's possible to both improve quality of life and reduce costs by providing a

Even when housed, mentally ill residents feel they're viewed as nuisances. Projects aimed at serving them are regularly seen as LULUS (locally unwanted land uses).

continuum of care that enables all but the most acute mentally ill to live in the community.

Research is beginning to quantify the savings possible when shelter teams up with support. Mentally ill residents who moved off the streets into a supported group home in B.C., for example, were hospitalized five times less than before. In another multi-year study, homeless persons supplied with supported housing cost the B.C. government about one-third less than people still without homes. Dunn admits those studies involved small populations, but he hopes to spur action by validating the results with data from other housing initiatives. "To be honest, if it doesn't quite break even, it's still worth doing—from a moral perspective, but even from a nuisance perspective," he says.

Even when housed, mentally ill residents feel they're viewed as a nuisance, noting that projects aimed at serving them are regularly seen as LULUS (locally unwanted land uses). Yet those who receive (and accept) appropriate support can contribute significantly to their neighbourhoods. Take Chris Leclair, whose subsidized unit in Edmonton's McAuley Apartments is owned by Capital

Region Housing Corporation and managed by E4C. Although Klinefelter's syndrome, a personality disorder and depression keep him from holding down a paid job, he fosters a cat, writes for the community newspaper, serves on the community league board and lends a hand to the onsite community development worker.

That's exactly the stereotype-defying outcome E4C envisioned when choosing to staff the McAuley complex with a worker whose main job is to meet community needs, Devam says. Neighbours now interact with E4C residents through hockey programs, spring cleanups, a food co-op, summer camps, free fax and photocopy service, art classes and guitar lessons. "Eight years ago, I would have been thrilled to have a home in a community and hear the neighbours say, 'No problem, we hardly know they're there.' Now I'd be incredibly pissed off," Devam says. "I don't want our people to be invisible. I want them to develop a sense of community—I want them to walk down the street and people to know who they are and not be afraid of them. Most of the people we have aren't going to have girlfriends and get married. They've lost a lot of their connections to their families. The only thing they really have left is to try to connect with their community."

Yet all the trust built within a community can evaporate when a client spiraling into a dark period cannot access crisis services or find space in a hospital, says Devam. "When the final crisis comes, there's nowhere to take them, which means people in the community see them walking around screaming, not knowing who they're talking to, looking awful, being scary." What's needed is increased capacity at all points in the continuum of care. "It's not that people don't know what the best practices are," she says. "We just need the dollars to put them into effect."

CMHA's LaJeunesse sees reason to hope. Alberta Health & Wellness is beginning to heed such advice under Minister Gary Mar. In addition to integrating mental and physical health services within regional health authorities (a move that makes philosophical sense, while raising widespread concern about funding), the minister has called for a comprehensive community mental health service plan by April 2004. "We're on the cusp at this point; we have a real opportunity here," LaJeunesse says.



Chris Leclair, who has Klinefelter's syndrome, lives in McAuley apartments, owned by Capital Region Housing. He volunteers as a reporter for the community newspaper and fosters a previously abused cat for the Animal Protection Society. He has served as vice-president on the Boyle McAuley Community League.

"A real test, once this plan is developed, is whether there will be any money to go with it."

Concerted action is long overdue, according to Calgary Alderman Bob Hawkesworth. "As the numbers of homeless people get larger and larger, the problem becomes more potent politically, because it has so many spin-off effects on our community," he says. Like it or not, the government of Alberta must take a leadership role in mastering this crisis, he adds, and that means not only providing affordable hous-

ing, but addressing poverty and providing the support people need to battle mental illness, addictions and other risks. "For me the challenge is whether the province will address this in time for our centennial," he says. "What are we going to celebrate in Alberta if we have an unmanageable homeless population? What sort of accomplishment for 100 years is that?"

Cheryl Mahaffy is an Edmonton freelance journalist and co-author of *Agora Borealis: Engaging in Sustainable Architecture*.

1972 • Sterilization Act repealed. 2,832 sterilizations performed 1928–1972. New Mental Health Act: changes mental disorder's definition to "lacking reason or control." Citizen's Advisory Council established; provision made for registering therapists.



Ponoka Nursing Class of 1935.

1980 • Revised Mental Health Act: responsibility for mental hospitals shifted to Social Services; provision for therapist registration eliminated. The Schizophrenic Society of Canada formed.

1981 • Psychiatric nursing training discontinued at Alberta Hospital Edmonton.

1988 • Mental Health Act: definition of a mental disorder includes judgment, behaviour, recognition of reality and the ability to meet ordinary demands of life.

1991 • Capacity has grown to 500 psychiatric beds in 15 general hospitals. Criminal Code replaces "insanity" with "not criminally responsible on account of mental disorder."



1996 • Leilani Muir is first sterilization victim to win judgment against Alberta government: \$740,000.

1997 • Mental Health Branch of government dissolved.

1999 • Alberta Alliance for Mental Illness and Mental Health formed.

2000 • Health Minister Gary Mar plans a reformed mental health system.

2002 • Premier's Council on the Future of Health Care: recommends that mental health care be integrated with general care, and that community based mental health services be expanded.

2003 • The Alberta Mental Health Board operating 887 beds in four facilities: Alberta Hospital Edmonton, Alberta Hospital Ponoka, and the Claresholm and Raymond care centres.