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VIGNETTE:
THE BELL HOTEL SUPPORTIVE HOUSING PROJECT:
EARLY OUTCOMES & LEARNINGS

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INTRODUCTION

The Bell Hotel was built on Main Street Winnipeg in 1906 near the Canadian Pacific Railway Station. In its infancy, the Bell was considered to be one of Winnipeg's finer medium-sized hotels. Over the years, the hotel deteriorated and became a single room occupancy (SRO) hotel – home to 72 persons with little or no income and few other housing options, many of whom were dealing with poor mental health and substance abuse issues. Health and safety violations eventually closed the hotel. In 2007, the hotel was purchased by an arms-length development corporation of the City of Winnipeg and a first-of-its-kind partnership involving multiple housing, health and business-focused sectors was formed to redevelop the hotel into The Bell Hotel Supportive Housing Project (The Bell). Four years later, The Bell opened its doors to provide 42 self-contained suites of permanent supportive housing for single adult men or women who are chronically homeless and who have complex health and social needs.

In this chapter, we describe The Bell partnership model and approach. Next, we present an analysis of tenants' housing history, visits to hospital emergency departments and involvement with police services 13 months pre- and 13 months post-tenancy at The Bell based on data obtained from The Bell, the Winnipeg Regional Health Authority and Winnipeg Police Services. Following that, we present an analysis of the successes and challenges of the partnership model drawing on qualitative data gathered through individual interviews (15) with Bell project partners and non-partner stakeholders. Finally, we discuss the project's early outcomes and learnings.

THE BELL PARTNERSHIP MODEL AND APPROACH
Collaboration and Partnership Across Sectors

The redevelopment of The Bell was made possible by an innovative model of partnership in Manitoba across a number of organizations and sectors:

1. CentreVenture[1] – as property owner and developer;

2. Manitoba Housing and Community Development[2], Manitoba Health, Healthy Living and Seniors[3], Manitoba Cross-Department Coordination Initiatives[4] and the federal government's Homelessness Partnering Strategy[5] – as project funders;

3. Winnipeg Housing and Rehabilitation Corporation[6] – as property manager; and

4. Winnipeg Regional Health Authority[7] and Main Street Project[8] – as service providers.

The Cross-Department Coordination Initiatives (the project lead) and the Health Authority were the project champions who pulled the project components together to develop a service and system response to address the needs of long-term chronically homeless persons with high and complex health and social needs who were high users of emergency services. Two formal mechanisms for partner communication and relationship building were the steering committee and the operations and services committee where partners provided education around their roles and responsibilities as partner functions and mandates were being clarified.

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1. **CentreVenture Development Corporation** – an arms-length agency of the City of Winnipeg that is an advocate and catalyst for business investment, development and economic growth in downtown Winnipeg.

2. **Manitoba Housing and Community Development** – a department within the Government of Manitoba with a broad mandate that includes a range of housing and community development programs and activities.

3. **Manitoba Health, Healthy Living and Seniors** – a department within the Government of Manitoba that guides the planning and delivery of health care services for Manitobans.

4. **Manitoba Cross-Department Coordination Initiatives** – a partnership between Manitoba Family Services, Manitoba Health, Healthy Living and Seniors, and Manitoba Housing and Community Development that, in concert with Regional Health Authorities and community service providers, develops and implements cross-government policy and programs that improve access to health and social services for vulnerable populations.

5. **Homelessness Partnering Strategy** – a federal initiative that seeks to address homelessness by working in partnership with communities, provinces and territories, other federal departments and the private and not-for-profit sectors.

6. **Winnipeg Housing and Rehabilitation Corporation** – a non-profit charitable corporation involved in the development, renovation, ownership and management of affordable housing primarily in Winnipeg's inner city.

7. **Winnipeg Regional Health Authority** – the public corporation responsible for providing health care to the citizens of Winnipeg and the surrounding rural municipalities of East and West St. Paul and the Town of Churchill, located in northern Manitoba.

8. **Main Street Project** – a 24-hour crisis centre that provides emergency shelter and food services, a drug and alcohol detoxification unit, on-site counseling, transitional housing and a range of other critical services.

Project partner roles evolved over the first year. As planned from the outset, toward the end of the first year the leadership role for coordinating The Bell services transitioned from the Health Authority to the Main Street Project. The Main Street Project became responsible for providing tenant-related supports and the Health Authority provided support around clinical services and service coordination. Also late into the first year, the leadership of the project was taken on by the Department of Housing and Community Development (HDC) when the HDC assumed leadership within the provincial government for homelessness. Project leadership and oversight was led by HDC staff in collaboration with other project participants. After the first year, other agencies were engaged. In the second year of operation, for example, Canadian Mental Health Association's Winnipeg Community Housing with Supports Program became a partner in the referral process and began to operate a scattered site supportive housing model.

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The Bell Approach

The Bell is managed using housing first[9], harm reduction[10] and client-centred[11] approaches. On-site supportive services address health needs, education, employment and substance abuse. The Bell is not a 24-hour institutional care model and participation in programming is not a condition of tenancy. Rather, supportive programing supports independence and helps tenants build successful tenancies and address the underlying causes of their homelessness (e.g. mental health, addictions, trauma, poor rental histories or lack of life skills). On-site staff and tenants meet weekly to set goals. Once stable, tenants are supported to move to other community housing if they identify they have outgrown the need for support and wish for more independence. Tenants have lease-based rights and responsibilities – an unusual feature in congregate housing first settings where providers or programs own the buildings. Tenants pay rent-to-income; rent supplement is available for all units over a 15-year period. Units are self-contained bachelor suites that contain a kitchenette and bathroom; six are fully accessible.

In order to be considered eligible for tenancy at The Bell, persons have to be chronic or chronically episodic users of emergency shelters. Chronic is defined in one of two ways: use of emergency shelter for over 90 days in the past six months with high service needs and poor housing history *or* long-term shelter use (i.e. continuous shelter utilization for six months or more). Chronically episodic is defined as repeated admissions over the course of six months or more, regardless of length of stay.

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9. An approach that centres on moving people experiencing homelessness into independent housing where on-site tenant-related supports are available but are not a requirement of tenancy.

10. An approach aimed at reducing the risks and harmful effects associated with substance use and addictive behaviours for the individual, the community and society as a whole.

11. An approach supporting the client to take an active role in his or her decision making and focusing on the clients' definition of success.

The Bell Tenants: Socio-demographic Profile

The majority of the tenants in the first 13 month period were male (70%). Tenants ranged in age from 25 to 77 years (average 46.3); three quarters were in their prime working years (25–54 years old), one fifth was approaching retirement (55–64) and a small portion was of retirement age (65+). Most were of aboriginal ancestry, were unattached to mental health or substance abuse supports and were in receipt of general or disability benefits from Employment and Income Assistance; a few were employed or collected Canada Pension Plan disability pension. The tenants are reflective of Winnipeg's shelter population (Gessler & Maes, 2011; University of Winnipeg; Hwang, 2001).

Of the 43 chronically homeless persons who moved in to The Bell during the start-up period, 35 continued to reside at The Bell 13 months later – a retention rate of 81%.

Tenant's Housing History

Immediately prior to moving into The Bell, almost all tenants (95%) had been housed in a shelter – in either transitional or emergency housing. One tenant had been housed in a single-room residency (SRO) hotel unit and another had been in a substance abuse treatment facility. Length of residency in the housing immediately prior to The Bell ranged from one to 61 months, with the average length of residency 10 months (for those in transitional housing in a shelter) and 14 months (for those in emergency housing in a shelter). The majority of tenants had moved one to four times in the year leading up to residency at the Bell – typically moving back and forth between shelters and social housing/private market housing. One female tenant, for example, had the following 13-month housing history pre-Bell: transitional housing in a shelter (two months), SRO hotel (two months), emergency housing in a second shelter (one month), back to transitional housing in the first shelter (four months) and finally transitional housing in a third shelter (one month). One male tenant had lived in private market housing (two months), transitional housing in a shelter (one month), short-term transitional housing at an agency for persons working on recovery from substance abuse (five months), emergency housing in a second shelter (two months) and transitional housing in the first shelter (three months).

Of the 43 chronically homeless persons who moved in to The Bell during the start-up period, 35 continued to reside at The Bell 13 months later – a retention rate of 81%. Of the eight tenants who were discharged, two were evicted and three abandoned their units. The other three discharges were due to a death, a transfer to a personal care home and a tenant decision to leave The Bell to find accommodations closer to the tenant's place of employment.

TENANT INVOLVEMENT WITH POLICE SERVICES:
PRE- AND POST-TENANCY AT THE BELL

In the 13 month post-tenancy period, 40% of tenants experienced reduced involvement with Winnipeg Police Services. As a group, contact hours declined 82% – from 13 hours/month to two hours/month. The number of contacts specifically related to intoxicated persons declined 71%. Some reductions were particularly dramatic: among the three tenants who had the highest involvement with police prior to tenancy at The Bell, contact hours declined by 90%, 60% and 100%. For one quarter of the tenants, involvement was constant: zero hours of involvement pre- and post-tenancy.

The remaining quarter had more hours of police involvement after moving into The Bell. In terms of police call types (categories used by the Winnipeg Police Services that describe the nature of the police involvement), tenants who were previously police-involved had more of the same types of calls – intoxication, involved in a dispute or creating a disturbance. Among those who previously had zero contact hours with police, calls were for accused theft, loss of property, involvement in a dispute or victim of robbery.

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Exterior view of The Bell Hotel before transformation

Photo credit: Bryan Scott

TENANT VISITS TO HOSPITAL EMERGENCY DEPARTMENTS:
PRE- AND POST-TENANCY AT THE BELL

Exterior view of The Bell Hotel after transformation

Photo credit: CentreVenture Development Corporation

For the group of 35 tenants who had resided at The Bell for 13 months, a dramatic drop in emergency department (ED) use was evident: from 251 visits for the group in the 13 month pre-tenancy period to 118 visits for the group during 13 months of tenancy – a decline of 53%. The average number of visits per tenant in the 13 month pre- and post-tenancy period was 7.2 and 3.4 respectively.

Reductions in ED use were even more dramatic when comparing pre- and post-tenancy ED use among the top five ED users in the pre-tenancy period – frequent users who accounted for over 70% of all ED use among the group in the period prior to moving into The Bell. Reduction in ED use among these five users was 63%, 66%, 78%, 80%, and 100%.

As was the case with involvement with police services, there was substantial variation in hospital ED use and change in use between the pre-tenancy and post-tenancy period among the 35 individual tenants. While half visited the ED less, approximately one quarter visited the same (having a low number of visits pre-and post-tenancy at The Bell) and one quarter visited more.

With regards to the scale of emergency of the ED visit (i.e. CTAS level[12]) for the group of 35 tenants as a whole, Level 1– the most urgent – increased slightly (from zero to two percent) while Levels 2 through 5 decreased (19%, 33%, 52%, 81% respectively). The number of ambulance mode-of-arrivals decreased by 75% and the proportion that left without being seen by a doctor decreased by 30%.

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12. Canadian Emergency Department Triage and Acuity Scale (CTAS): Level 1 – resuscitation; Level 2 – emergent; Level 3 –urgent; Level 4 – semi-urgent; Level 5 – non-urgent.

SUCCESSES AND CHALLENGES AROUND THE PARTNERSHIP MODEL

In addition to securing stable and supportive housing for tenants and reducing their use of emergency services, the partnership model was powerfully successful in terms of the impacts it had on partner organizations and systems. Partners resolved differences in philosophies, approaches and deeply ingrained system and sector practices to converge on a solution. The partnership would not have been possible without partners' willingness to shift their scope of practice beyond their own sector (i.e. housing, health, business) and find new and different ways to practice their respective business in non-traditional delivery models.

Nonetheless, the never-before-tried partnership experienced significant challenges – particularly around establishing roles and protocols, reaching consensus on the project principles (housing first, harm reduction and client centred), operationalizing the service provision approach (i.e. supporting independence or autonomy – in contrast to the 'doing for' approach often undertaken by the shelter sector), navigating organizational silos and integrating and coordination services in ways previously untested. Also especially challenging was managing differences in practices and expectations around tenant privacy and consent (e.g. how much information about tenants the service provider would share with the property manager) – an issue that was resolved with the establishment of operational procedures that were informed by all partners around the collection and sharing of tenant information that supported key functions but respected confidentiality within the Personal Health Information Act. Tenants signed confidentiality releases but information was shared only on a 'need to know' basis to maintain appropriate confidentiality while respecting key areas that partners required for their business functions.

Other key themes arising from the interviews with project partners and other stakeholders were: the project's success has made an impact on political leaders, funders, decision makers and the corporate community; the concept of harm reduction is not well understood and/or remains an undesirable model for many; visitors pose significant risk to tenants' tenancy; visitor management impacts heavily on staff resources; and aspects of the physical building design are integral to project security and safety.

Also arising were factors critical in supporting the success of inter-sectoral collaboration for supportive housing solutions that address the needs of a chronically homelessness high needs population:

- A **champion** who voluntarily takes extraordinary interest in and commitment to the adoption, implementation and success of the project.

- Ongoing **communication of the project approach/vision** (i.e. harm reduction, housing first, supported independence) by the project champion to all partners and stakeholders through informal and formal communication mechanisms.

- Ongoing **communication between project partners** – especially between: the service provider and the property manager; the service provider and the service funder; the Department of Housing and the Department of Health.

- Ensuring the **project approach/vision is front and centre** of planning and decision making.

- **Leadership by the health sector** in coordinating and integrating health services and working with other partners around complex housing/health issues.

- Adequate and stable project **funding.**

- An accountability framework where the **sectors are mutually accountable to one another,** not just to the funder.

- **Flexible and creative policy and service delivery approaches** including an adapted scope of practice specific to the needs of the chronically homeless population.

- **Adopting a culture of learning** whereby the project partners and stakeholders build on achieved successes, are not discouraged by challenges that arise within a unique partnership structure

and are continuously interlinking their knowledge and experience gained around the project into moving the project forward.

- **Significant time commitments** on the part of partners that far exceed initial expectations.

- Having **mental health expertise on site** to facilitate integration and coordination of services across multiple providers.

- Ensuring **staff skills match the project service approach and client needs,** and providing appropriate levels of **staff training and support.**

- Recognizing it takes **time to build trust and relationships** with tenants; having **patience with tenants' progress.**

DISCUSSION

The Bell's first 13 months of data demonstrate that community housing stability in supportive housing can be achieved by long-term chronically homeless adults even among those with high and complex needs. The Bell's retention rate of 81% is comparable to rates for the supportive Pathways to Housing model in the United States (Pathways to Housing) and higher than similar supportive housing projects in other Canadian jurisdictions (Bell Project Team, 2013). It is important to note that, while The Bell provides assertive interventions within a high tolerance environment, a number of the tenancies were not sustainable. Tenants who were unsustainable at The Bell were supported to transition without an eviction on record (supported transitions in place of a recorded eviction aims to result in a rental history that is not a barrier to secure future housing).

Consistent with other studies on how supportive housing impacts the use of health services (Aubry, Ecker & Jette, 2014; Martinez & Burt, 2006), dramatic quantifiable reductions in visits to hospital EDs and ambulance use were experienced by The Bell tenants who had been frequent users of the health system prior to The Bell tenancy. Service arrangements that facilitated reductions included: block-based versus appointment-based Home Care (Home Care available on site during a block of time to tenants who want service, no appointment necessary); linking nearly all tenants to a primary care physician; flexible scheduling of medical appointments at a nearby primary care access centre as supported by the centre's nurse practitioners (tenants are called if they miss an appointment and are rescheduled); twice weekly visits at The Bell by the Health Authority's mobile public health service that promotes healthy sexuality and harm reduction; and weekly in-suite meetings with tenants. That mental health on-site supports connect tenants to appropriate mental health services may also be reflected in decreases in CTAS Levels 4 and 5 (which are the levels often used for triaging mental health presentations). While the reduction of patients leaving the ED without being seen is at least in part reflecting the proportional increase in higher acuity ED visits, it may also be reflecting that on-site supports at The Bell are encouraging tenants to have more trust in and interaction with the health service system. On-site health supports accompany tenants to appointments with health care providers, educate tenants and health care providers on what to expect at appointments to support more positive interactions and use a non-judgmental approach. An embedded on-site clinical support during The Bell's first year (that led to a permanent, full-time on-site nurse in year two) engendered significant trust through relationship building that translated to health service connection. Currently, The Bell nurse provides early identification and intervention so health issues are addressed and resolved.

That stable tenancies are accompanied by decreases in police interactions among persons with former high levels of police contact has been demonstrated in other studies (Dennis, Culhane, Metraux & Hadley, 2002; Somers, Rezansoff, Moniruzzaman, Palepu & Patterson, 2013). However, with respect to *increased* contact with police among some tenants after establishing stable tenancy, at least some of the increase is accounted for by changes in data collection for calls relating to intoxication (during The Bell's first year, calls of this type were included in the Winnipeg Police data; formerly, these data rested with a different Winnipeg organization). Second, as The Bell tenants are supported to self-advocate and report victimization, some of the increases may be due to increased reporting rather than increased incidents. Third, service providers report that as stable tenancies shift tenants' focus away from the securement of basic needs (shelter and food), issues that tenants may be struggling with (e.g. trauma) become more prominent and sometimes manifest in disruptive tenant behavior.

The finding that one quarter of the tenants had no involvement with Winnipeg Police Services before or after their tenancy at The Bell challenges common public perception that all chronically homeless persons are heavy consumers of emergency services. This and other early learnings have facilitated positive discourse around homelessness in Winnipeg. The Bell staff have been asked to speak at events; media attention around The Bell overall has been positive.

Project partners did not always agree on the project's service approach ('supported independence' vs. 'doing for'). While the project model was designed to be independence-based, elements of both approaches were

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beneficial to the success of the project. For example, providing meal support on site was not part of the original project design; however, it became evident that tenants lacked basic food skills and needed support acquiring groceries and preparing meals. Adapting the service approach not only responded to the needs of tenants, it also facilitated staff buy-in to the independence-based approach.

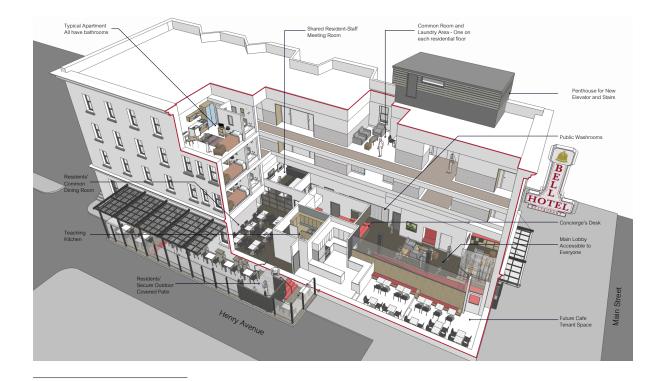A number of the critical success factors noted by The Bell partnership – adequate and stable project funding, robust partnerships with service agencies, a strong match between staff skills and project need and on-site access to nutrition – match those identified by others delivering supportive housing to high-needs chronically homeless in other Canadian jurisdictions (Charette, 2014).

This chapter has outlined the early leanings and outcomes according to the project's first year of operation. Further and deeper investigation is needed to determine the longer-term impact of The Bell's supportive housing environment on tenants' involvement with public services. Additionally needed is a quantifiable measurement of project outcomes according to tenants' health and quality of life (anecdotal evidence from staff suggests that, in addition to experiencing improvements in self-esteem, independent living skills, life and socialization skills and quality of life, tenants are using substances less, are enrolling in courses to improve employability and are reconnecting with family). As well, an analysis of costs and consequences of The Bell in comparison to usual systems of care for the chronically homeless should be undertaken. An additional evaluative framework worthy of consideration is Social Return on Investment, a principles-based approach that values change for people and the environment (Gibson, Jones, Travers & Hunter, 2011; Leck, Upton & Evans, 2014).

CONCLUSION

Solutions involving collaboration, partnership and integration across sectors and systems focused on health, housing and business are powerfully successful in achieving community housing stability among long-term chronically homeless adults even among those with high and complex needs and in reducing use of emergency, health and police services. While The Bell is addressing the needs of a select group, there is a need for more inter-sectoral solutions employing innovative partnerships across multiple sectors to address both the needs of others similar to The Bell's population as well as more specific segments of the Winnipeg's homeless population (e.g. women, families and those committed to a non-addiction lifestyle). The Bell's positive early outcomes have made an impact on project partners who now feel more secure in supporting further inter-sectoral ventures.

Cut away view after transformation

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A Project Partner's Words

The words by one project partner perhaps best sum up the first year outcomes and learnings of The Bell Hotel Supportive Housing Project:

Things really changed for people who needed them to change most importantly. They changed in significant and positive ways and that's what we did, that's what we were able to do. And yes there are ways to do it better in the future. There are ways to do it differently if not better. But you can't ignore the fact that we got a lot of it right. We got a lot of it right because the findings say so. That's because of Winnipeg Housing and because of Main Street Project and because of the Health Authority and because of the Province and because of CentreVenture and every other partner that was involved. It would not have gone the way it did for the tenants if we hadn't done it the way that we did. So at the end of all of it, this is the most important piece, what happened for tenants – and it's the piece we should be holding onto and it should encourage us to continue the work.

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Sharon has a unique role with the Winnipeg Regional Health Authority combining the Director of Housing, Supports and Service Integration with the Community Area Director for Downtown-Point Douglas - focusing on strengthening and integrating health, housing and social service responses to the target population. Working closely with community, agencies, programs, service providers and government sectors, Sharon supports a skilled and dedicated leadership team to build partnerships and practices that prioritize health equity and community capacity.

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Joanne is currently the Senior Director, CEO Implementation & Transformation Unit with the WRHA and has held a series of leadership roles within the provincial government and health region. Her area of focus has been on the development and implementation of innovative health and social policies and programs that impact marginalized populations through strategic engagement and alignment of government, regional health authority and community partners.

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Réal is Vice President and Chief Operating Officer with the Winnipeg Regional Health Authority. He has worked in various leadership roles in the Winnipeg health care system for 28 years. His focus in the health care system in Winnipeg is: to ensure better integration of the Region's health care system; to work closely with other levels of government to improve policy and coordination of services; and to work with community stakeholders to address health equity issues.