Mental Health Commission of Canada

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Turning the Key

Assessing Housing and Related Supports for Persons Living with Mental Health Problems and Illness

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Assessing Housing and Related Supports for Persons Living with Mental Health Problems and Illnesses

Report by the Community Support and Research Unit of the Centre for Addiction and Mental Health and the Canadian Council on Social Development

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A CALL TO ACTION

Over 60 years ago a profound shift took place in the lives of people living with mental illness in Canada. Beginning in Saskatchewan, but soon spreading across the country, the foundations of an old system that had treated people as second class citizens, taken away their rights, and relied on long periods of incarceration began to crumble. Common ideas of the time – that people living with mental illness[1] were violent, or helpless, or a risk to other citizens simply by virtue of their proximity – came into question. Soon the long-stay mental hospitals found across the country appeared anachronistic and in fact actively harmful to their patients.

Other factors came into play, resulting in the process known as deinstitutionalization. **It swept across Canada and by the mid-1970s there were massive closures of inpatient beds and in many cases entire mental hospitals**. Closures eventually topped 80% of all beds, and if we take into account the increasing population of the country, the relative closure rate was much higher.

Along with bed closures came new ideas. Best captured in the Canadian Mental Health Association's seminal work, *More for the Mind* (Tyhurst et al., 1963), the new vision saw mental illness as "an illness like any other" and envisioned moving treatment to general hospitals and outpatient programs. The goal was to have people live in the community, although exactly how was never fully specified. **At its best, the new approach was about the liberation of people from long-term incarceration and the recognition that mental illness was not all encompassing and all defining**. The use of language reflected this – it became more common to hear someone described as a person with a mental illness rather than a mental patient or a schizophrenic. Gradually the notion of capacity crept into clinical language and to the surprise of many it was found that people living with mental illness were often very resourceful in the community and able to take care of themselves in difficult circumstances.

This process of seeing people with fresh eyes was part of a series of fundamental social changes taking place in the second half of the 20th century. Women, racial minorities, Aboriginal people, the physically disabled, and others fought against stereotypes and prejudices. In most cases the struggles still continue, but substantial progress was made. For people living with mental illness the process of being seen as community members and freed from old custodial institutions, or not put in them in the first place, also got off to an optimistic start in most parts of Canada.

For some people this optimism was warranted. **Many thousands of Canadians with mental illness have benefitted from being able to live in the community**. Mental health systems today see comparatively little of them, and their care is often provided by primary healthcare staff. But this is not true for everyone, and for those with the most challenging illnesses, problems emerged. **Disturbing statistics appeared in the public**

[1] The intent of this report is to be consistent with terminology used by the Mental Health Commission of Canada: while there continues to be ongoing dialogue on the use of various terms for people living with mental illness, (i.e., consumers, survivors, people with lived experience, patients), the research team has, in general, used the terminology set forth by the Project Committee for this report: people living with mental illness and/or mental health problems – at various points in the report, we shorten this to people living with mental illness. The use of the term 'mental health problems' reflects the reality that many people may, for a variety of reasons, not have a diagnosis of mental illness per se but whose needs should be captured as part of our ongoing planning for housing and related supports.

debate – life expectancy began to drop, homelessness rose, and jails and prisons became for some a new institutional setting. Eventually it was recognized that very little planning had been done to ensure a successful life in the community. Closing beds turned out to be the easy part – it was much harder to envision how people with ongoing challenges and disabilities could thrive in Canada's cities, towns, and rural and remote areas. With the benefit of hindsight we can see that deinstitutionalization was only the beginning of a much more complex process. The more important goal turned out to be the full inclusion of people living with mental illness in Canadian society, and for many this remains elusive. The revolutionary changes that began with deinstitutionalization are not yet finished.

We now find ourselves at a critical point. **Behind us is an immense amount of learning and experience that has been hard won through many successes and failures**. Whatever one's role and perspective may be on the issue of mental health, there is now a very rich base of knowledge to draw from. Illnesses are better understood, support models are better understood, the idea of recovery has taken hold, and the voices of people living with mental illness and families are more often heard. It can be fairly said that many people involved in mental health have learned from the mistakes of the past.

Looking ahead, there are challenges but also signs of progress. Many provinces and territories are working on or have recently completed mental health reform strategies. This is being done against a backdrop in healthcare that is calling for innovation and new ideas. Thinking creatively and reframing existing problems are now priorities. The Mental Health Commission of Canada is another sign of positive change. After many years of a limited national role, the Commission has created a new focus and energy.

These are powerful ingredients – experience and lessons learned on one hand, and renewed commitment to change on the other. The key players involved – people living with mental health issues, families, professionals, policy makers, and planners – are also committed to change. Although there are naturally many points of debate, the concepts of inclusion and recovery have created an unprecedented degree of alignment about what needs to be done.

Now is the time to complete the job started many years ago. Full lives in the community, characterized by acceptance and dignity, are clearly possible. There are many factors that need to be in place to realize this goal, from good treatment to many kinds of community support. One factor, however, stands out from among the others. People living with mental illness have endorsed its importance, as has report after report for many years. This factor is housing.

Housing, Well-Being, and Health

The importance of housing in everyone's life is clear and obvious. The elements of secure housing include affordability, security of tenure, desirability and safety of location, and the condition of the dwelling unit itself. All of these elements add up to something that is called 'home' and this term has a number of very important meanings. When the elements are positively aligned, 'home' is a foundation, a base, and a key component of our personal lives. A life in the community is built from home, and after facing the daily challenges of community life it is the place to return and recharge. People living with mental illness have repeatedly made this point.

The science supports people living with mental illness in this view. This report will review how a range of research highlights housing as a determinant of health. Canadian scholar James Dunn and his colleagues (2002) state: "**housing, as a central locus of everyday life patterns, is likely to be a crucial component in the ways in which socio-economic factors shape health**." A review of the literature by Dunn (2000) identified critical areas in which housing affects health: (1) people who are homeless have significant detrimental health consequences; (2) poor housing conditions relating to the condition of stock, inadequate space, dampness, and other factors affect health; and (3) spending a large proportion of income on housing affects health. Bryant (2003) expands on these areas and identifies some key findings below, arising from a number of studies:

- Homeless people have a greater incidence of a range of health problems and life expectancy is reduced by 20 years (Hwang, 2001).
- Poor housing conditions damage health. Marsh and colleagues were able to analyze a large sample of people and demonstrate that housing plays an independent role on affecting health (Marsh, Gordon, Pantazis, & Heslop, 1999).
- Spending a disproportionate amount of income on housing leaves people unable to purchase other necessities such as adequate food. Welfare and disability incomes for people living with mental illness are inadequate in this respect. Bryant (2003) describes the result as increased social exclusion.

If having a secure home is important to all of us, it is doubly so to people living with mental illness and this is why they so strongly endorse the importance of housing. Too often they are familiar with not having a secure home, or not having a home at all. Many sections of this report speak to people's personal experiences, and echo many other studies and the writings of many people living with mental illness. The call to arms of a growing number of people living with mental illness is "**a home, a job, a friend**."

The Costs

Health systems in Canada today are under tremendous financial pressures. 'Spending smart' is necessary to control costs and move to models that are effective and allow people to be active in their own care and recovery. Mental health systems are no exception and investments in housing are central to what spending smart means in mental health. In fact it is rare in health care that such a simple solution presents itself. This report documents the rich array of programs, models, innovations, and creative solutions in housing that have been developed across the country. There is no question that we know how to implement solutions and that the infrastructure is in place. **What people are saying in all parts of Canada is that we have not made the full commitment, and that we are paying the price for this**.

One issue that highlights this is alternate level of care (ALC). ALC patients are in hospital when they could be in the community. The costs of this are high – someone who does not need the level of support a hospital provides occupies an expensive bed. The ALC issue was widely mentioned across the country by people who contributed to this report, and in many provinces and territories it is an important priority. Its solution cannot be separated from housing.

Homelessness is another key national issue. Its relationship to the supply of housing and support is obvious, but what about costs? A lot of research has been done resulting in clear conclusions. These will be discussed in the report but two stand out. **First, we can house the homeless**. Research shows that housing is the issue, not mental illness. There is no reason inherent in the illness that leads to homelessness. **Secondly, providing this housing saves money**. The cumulative costs of shelters, increased health services use, and other services outweigh the simple provision of a place to live and support to stay there.

The ALC issue and homelessness examples highlight the fact that dependent people are expensive for any health care system. In some cases, dependence is unavoidable for a variety of medical reasons and high quality inpatient care is the only option. But the clear trend in health care has been to redefine when high-end care really is essential. The evidence shows that in many cases it is not needed and the move to shorter inpatient stays and home care is a testament to this. Strategic investments in housing and support are taken from the same playbook – where we find that the homeless person is not in the emergency room or the police cruiser and the inpatient is in supportive housing in the community.

Supporting People to be Independent

There has been a fundamental change in how disabled people are perceived in Canada. Thanks to the work of many people with a range of disabilities, the nature of disability in society is now seen in a more complex way. In the old view, the idea of why a person was disabled was located firmly within the person. Someone in a

wheelchair could not work or live a normal life because they had a spinal cord injury and could not walk. Someone with a mental illness could not live independently because of their mental situation.

This has now changed. **We can see that many disabled people could not work for reasons that were outside them**. The building was inaccessible, transportation was not available, and employers who were unwilling to be fair were typical external impediments. People living with mental illness also could not get hired, or if they did, faced prejudice and exclusion in the workplace. These were clearly issues in society, not individuals. Ideas about what was disabling and where action needed to occur have opened up new possibilities. As we can see, the fuller inclusion of many disabled people has not had to wait for a cure. People with spinal cord injuries are a good example of this.

Housing is an essential tool of independence for people living with mental illness. Early attempts to develop community housing had serious shortcomings, but a great deal has been learned since. Many early attempts reproduced conditions similar to custodial hospitals where people were seen as objects of care rather than as having capacities that could flourish. Conditions included a lack of privacy and the provision of a one-size-fits-all approach. Criticism emerged of these facilities, as described in the seminal work entitled *Foster Homes: The New Back Wards?* (Murphy**,** Pennee, & Luchins, 1972). Homes of this type still persist and this report identifies the issue and suggests changes.

After initial false starts, new housing models were developed, and continue to be developed. These models are in line with the principles of recovery and typically enable people living with mental illness to live fully in the community and to move onto more independence if they can. The housing settings are varied, from group settings to independent apartments, and support is provided flexibly and individually. Site visits to many programs, and wider contacts with many more were part of developing this report. **The national picture is one of innovation and creativity struggling in the face of inadequate resources**.

Perhaps the most important lesson learned about new housing models is that they enable people living with mental illness to reach their capacities, and by doing this, succeed in two ways: (1) they are what people living with mental illness want, and (2) they are less expensive. By supporting independence they allow people to get on with their lives and move away from a heavy reliance on institutional services.

Moving Forward

Imagine visitors from another world who arrive to study our way of dealing with mental illness. On one hand is a comparatively well-resourced system of treatment services staffed by highly trained professionals. Investments in this system are high, with inpatient costs often between $400 and $800 per day. By international standards, people are getting very good care.

On the other hand is a very different picture, one that comes into focus after discharge, and particularly for people with serious mental illness. The same person struggling with the same illness is now provided for in the $20–35 dollar a day range from a disability pension. Typically, rent for decent housing would eat up 70–90% of this, making good housing an unavailable option unless a special program is available. Life is lived well below the poverty line and all of the stresses and negative health impacts are brought to bear. Trying to recover from illness in these circumstances is overwhelming.

Our visitors would no doubt be left scratching their heads in the face of this contradiction. **Spiralling health care costs are creating a crisis, but strategic investments to address the real causes are in short supply**. In Canada now we have the ingredients in place to finish the job started by pioneering people living with mental illness, professionals and families over 60 years ago. As this report shows, we have a very rich foundation of innovation and experience. **We know how to properly house people and provide enabling support. We know that this works**. What our visitors might tell us most forcefully is that housing is a health issue.

Our study has determined that as many as 520,700 people living with mental illness are inadequately housed in Canada and among them, as many as 119,800 are homeless[2]. There are only 25,000 supportive housing units

[2] The results are composite figures generated from data from reports by the Canada Mortgage and Housing Corporation (2005), Kirby & Keon (2006), Patterson et al. (2008), and Statistics Canada (2009).

dedicated to people living with mental illness available. Respondents told us about long waiting lists, poor quality housing, inaccessible services and supports, lack of transitional housing, adequate income, food security, and choice. They called for a recovery oriented approach to housing and supports over the next 10 years. We can and must do better.

OVERVIEW OF RESEARCH DESIGN AND METHODOLOGY

Goals and Methodology

This project was undertaken to inform the Mental Health Commission of Canada (MHCC) of current housing and community support needs for people living with mental health problems and/or mental illness in Canada. It provides a comprehensive national environmental scan, incorporating multiple dimensions, to support planning and policy work in housing and related supports.

The **project aims** were as follows:

- To conduct a national assessment of the current need for and supply of quality housing and related supports for persons living with mental health problems and illness.
- To identify model programs for the provision of housing options to persons living with mental illness.
- To identify the conditions and actions at the provincial/territorial and civic/municipal levels necessary to develop an adequate supply and range of housing for persons living with mental illness.
- To identify the community services/supports (i.e., the 'basket of services') necessary to support persons living with mental health problems and illnesses in housing.
- To identify the economic, personal and social costs and benefits of providing, or not providing, adequate specialized housing and community support services.

The project involved multiple approaches to reach various stakeholder groups in all provinces and territories. **Gathering input from people living with mental health problems and/or mental illness was a key activity in shaping this report**. For a detailed description of methodology please refer to Appendix One.

MAIN METHODS

Provincial/Territorial and National Reference Groups

Fourteen provincial/territorial and national reference groups were developed, engaging over 150 leaders in the housing and mental health sectors from across the country. The reference groups, e in each province and territory plus one national group, played a critical role in informing all aspects of the project, from planning through data collection and analysis.

Interviews with Key System Stakeholders

Interviews were conducted with over 75 key stakeholders from across the country to obtain current information on housing/support stock in Canada. They included representatives from Regional Health Authorities, provincial housing corporations, municipal housing providers, and government ministries in each province and territory, as well as nationally, who had the necessary expertise to report current information on housing/support models in their respective areas.

International Key Informants

Interviews were conducted with seven international experts knowledgeable about housing models unique to regions outside of Canada. Five informants were from the United States, one was from Portugal, and one was from Ireland.

Webinars

Seven consultations via webinar were held with 70 participants living with mental health problems and/or mental illness (see Appendix Two for findings). Provinces and territories were grouped into six regions, with one webinar conducted in each region: Alberta and British Columbia; Manitoba and Saskatchewan; North West Territories, Nunavut, and the Yukon; New Brunswick, Newfoundland and Labrador, Nova Scotia, and Prince Edward Island; Quebec; and Ontario. A second webinar was held for the Alberta / British Columbia region in response to high levels of interest.

Survey Questionnaires

Surveys were developed and distributed to people living with mental health problems and/or mental illness, family members, community mental health service providers, housing providers, and hospital administrators and clinical leads. Surveys were vetted through databases compiled by the research team, which consisted of mental health service provider networks, social and dedicated housing provider networks, and hospitals with specialized mental health beds, as well as reference group members. Over 850 responses were received (Appendix Three) from 330 people living with mental health problems and/or mental illness, 183 family members, 216 community mental health service providers, 96 housing providers, and 35 hospital administrators and clinical leads.

Literature Search and Review

A comprehensive search and review of grey and published literature was undertaken (Appendices Four, Five, and Six). The key objectives of the review were to: synthesize the history and current status of social housing in Canada; understand housing's effect on health and the "fit" within the social policy context; discuss housing as a basic human right and the implications this has for government; explore how other countries have addressed affordable housing needs; provide additional information on the economic, social, and personal costs of unmet needs; and summarize considerations for policy and long-term strategies for affordable housing.

Mapping Exercise

'Maps' or pictures of existing housing and related supports, structural organization of housing and supports, key policy initiatives, promising practices, challenges, and trends were developed for each of the provinces and territories (Appendix Seven). The maps were generated based on interviews with key informants, most of whom worked in the housing and mental health sectors. Government websites, annual reports, and existing planning reports were also employed.

Site Visits

In an effort to identify innovations in housing and supports that address challenges and/or lead to positive change, site visits were made to more than 30 innovative housing initiatives across Canada (Appendix Eight). Extensive consultation with multiple stakeholders, including hospital representatives, people living with mental illness, housing providers, government ministries, peer support groups, and mental health service providers, were undertaken during these visits.

DATA ANALYSIS

SPSS software was used for entry and analysis of survey data. Analysis of qualitative data involved detailed analysis of transcripts, reference group meeting minutes, notes from the webinars, and field notes from site

visits. This proved to be both an inductive and deductive process, as it broadened the existing knowledge base and also shed light on less explored areas, leading to the emergence of new categories and themes. Triangulation was achieved through using multiple approaches to investigate the research questions. This enhanced confidence in the ensuing findings.

Factors Warranting Consideration

The surveys reached a national audience, and were stratified in terms of stakeholders. The scope and time limitations of the study, however, negated the possibility of random sampling and inadvertently resulted in over/under representation of some groups, provinces, and territories. On the other hand, an unanticipated analytical value was realized in terms of understanding levels of engagement, the concentration or lack of services in different geographic areas, and the need to employ qualitative methodologies to understanding the issues of certain under-represented stakeholders, provinces, and territories. This was particularly true of the Northwest Territories, the Yukon, and Prince Edward Island. Among stakeholder groups, hospitals had the lowest rate of participation in the survey. There was greater participation by people with mental illness living in independent settings than by those living in congregate settings. This may have been due to access issues, though concerted efforts were made to reach out to people living with mental illness in all types of housing settings, both through service providers and by making hard copies of the electronic surveys available for manual completion.

Another consideration is that, while this study focused on housing and supports for people with mental health problems and illnesses, these issues cannot be viewed in a vacuum exclusive of concurrent disorders and addictions. This reality was factored into the questionnaires and other aspects of the research process as warranted, which allowed for the identification of some key issues and overlapping considerations.

The broad range of methods employed in this study mitigated these limitations and reduced many of the drawbacks of any one specific method. It also ensured that a comprehensive picture of housing and supports was captured within the constraints of time and budget.

Knowledge Exchange Strategy

The engagement of a broad range of stakeholders at various levels and through multiple modalities in different aspects of the study created a fertile ground for knowledge exchange in the form of information sharing and consultations through webinars, site visits, reference group teleconferences, and web based information sharing. The Research Team and the Mental Health Commission of Canada also collaborated on a plan for knowledge exchange beyond the life of the project, which will be supported by a Canadian Institutes of Health Research (CIHR) grant.

The knowledge exchange strategy is designed to create meaningful dialogue between multiple stakeholder groups and to share information in creative ways. **The momentum created through such exchange will result in ongoing, nation-wide, proactive collaboration; intervention; and advocacy in the field of housing and related supports**.

The **aims of the Knowledge Exchange Initiative** are to:

- Create an active and sustainable platform for ongoing collaboration and knowledge exchange.
- Develop mechanisms to ensure continued engagement with the MHCC and key players in the areas of governmental policy and strategy development.
- Create user-friendly, target-driven information, available through multiple channels.
- Establish an expert resource base with an interactive, real-time component.

Some strategies for knowledge exchange have already been developed. An online tool to capture the stories of innovative housing initiatives has been developed and piloted with reference group members. Some key areas of common interest were identified through the research process, and reference group members have been invited to participate in cross-cutting groups to share information in their areas of interest with others from across Canada. The knowledge exchange strategy will explore creative ways to present information and project findings to multiple target audiences. Existing websites and portals will also be utilized to share reports and other information. These next steps will be implemented as part of the CIHR knowledge translation project.

HOUSING AND SUPPORTS IN CANADA

Summary of Key Terms

Dedicated Housing is specifically for people living with mental illness and/or mental health problems, or people living with concurrent disorders (co-occurring mental health and substance use issues). Funding originates mainly from municipal, provincial, and/or federal governments, though in some instances, from private sources. Dedicated housing may be divided into two broad categories: housing with supports and residential care options.

Type	Tenancy	Physical organization	Support "Linking" and Description
Housing with Supports: Low-cost housing (25-30% of people's income) combined with some type of support with a focus on empowerment, independence, and recovery in how they provide housing and supports.	People are usually tenants and sign leases with private landlords or mental health or social housing providers – depending on how that particular housing is managed and organized.	Tenants usually have an apartment unit. Housing may be "scattered site" (units are located in social housing, or regular private market owned/ rented housing) or "congregate" (units are located in one building, generally owned or leased in whole by a mental health or housing provider).	Support may be linked in whole, in part, or not at all to the housing setting, and levels of support can range from very low to very high. Supports tend to be flexible and individualized and generally include: **mental health clinical services** such as case management or assertive community treatment and **housing support services** which focus on resources and skills needed to help maintain housing stability and tenure (for example, finances and budgeting, setting life goals, nutrition and food security, addressing issues that are impacting housing stability, helping people to connect to natural supports and activities in their communities). In the case of *Housing First* models, tenants have the choice of whether to utilize available supports – it is not a requirement in order to live in the housing.
Residential Care Options: Generally a board and care model in which a private operator provides a fixed basket of services. Most residential care models (sometimes referred to as custodial models) date from the phase of deinstitutionalization, when longer-term clients were believed to require caretaking.	People are usually not tenants and pay per diems to the private operator.	Rooms are often shared and provided in congregate living settings with shared kitchen and living facilities.	Support **is linked** to the residential care setting with **little flexibility** in the application of the services provided. Services generally include meals, laundry and housekeeping. The fixed basket of services can seriously limit individualized recovery strategies; for example, a client doing his or her own cooking. Some models or operators are adopting new and innovative approaches to increase the flexibility of their model, often working in concert with mental health providers.

Agreeing to access available supports may or may not (i.e., *Housing First*) be required in order to access the housing.

Non-dedicated Housing refers to housing options, funded via government sources, that are not exclusively for people living with mental illness. In general, the goal of such initiatives is to provide housing options where cost does not exceed 25-30% of the household income. While these housing options do not specify people with mental illness as part of their target population, nor is the housing funded specifically for people with mental illness, the reality is that people with mental illness often live in these options, and **without adequate mental health or housing supports in place to assist them in maintaining their tenancy**. This was a common finding across all provinces and territories.

Housing models that may be either dedicated or non-dedicated include social housing units, rent supplement initiatives (tied to units or "portable" and attached to individuals or families), non-profit housing operated by community organizations, affordable housing initiatives, housing co-operatives and public housing programs that target specific groups, et cetera. A more detailed discussion of the range of housing options and definitions is contained Appendix Seven.

Housing First: Appendix Four provides a full description of the *Housing First* approach. **First established in New York City, *Housing First*, at its most basic level, provides low-cost housing without the requirement to participate in substance abuse or psychiatric treatment.** Some interpretations of *Housing First* include a pre-requisite for scattered site settings, or that services not be provided in the housing setting itself – actual implementation, however, usually involves some level of contact with a mental health or housing support worker on an ongoing basis, and physical settings (i.e., scattered site versus congregate) can vary. The overarching philosophy is most important: *Housing First* is defined by its advocates as a "consumer preference supported housing model" (Tsemberis & Asmussen, 1999), in contrast to the "continuum" model that rejects many potential applicants as being "not housing ready" or "treatment resistant" (particularly those individuals with concurrent addiction and mental health issues, and often histories of homelessness and/or involvement with the criminal justice system). This approach has demonstrated successful outcomes in promoting housing stability, reducing homelessness and psychiatric symptoms, and improving quality of life (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Pearson, Locke, Montgomery, & Burton, 2007; Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003).

Core Housing Need (Canada Mortgage and Housing Corporation, 2004a): The Canada Mortgage and Housing Corporation (CMHC) has been analyzing incomes and housing costs for many years to determine the level of "core need." A determination of "core need" is a two-step process, the first of which requires the dwelling to meet three standards: adequacy, suitability and affordability:

- Adequate dwellings: This is a measure of housing condition, to determine whether the dwelling is safe, has basic plumbing, and is in a reasonable and habitable state of repair.
- Suitable dwellings: National occupancy standards are used to determine whether households have a sufficient number of bedrooms based on family composition (a measure of over-crowding).
- Affordable dwellings: This standard is based on a ratio of housing expenditures to total household income; a household spending more than 30 percent of its pre-tax income for housing is considered in need.

The second step determines whether households with one or more of these problems have access to affordable housing alternatives in the same community. If not, they are considered to be in core housing need.

Parameters

The aim of the mapping exercise was to gather and collate existing information about how the housing and support arrangements of people living with mental illness or mental health problems[3] are structured, funded, and operated in provinces and territories across the country. **These provincial and territorial 'pictures' include the range of existing housing and mental health service options for people living with mental illness, approximate figures on current capacity, and information on current policy initiatives, as well as the challenges being faced on the ground**. The maps were generated through interviews with key informants, most of whom worked in the mental health and housing sectors, who were recommended by reference group members. Government websites, annual reports, and existing planning reports were also used to generate the maps, which were further refined in the late fall of 2010 based on feedback from members of the provincial and territorial reference groups, as well as representatives from provincial and territorial governments. Appendix Seven includes the individual maps for all provinces and territories in Canada.

As part of the mapping process, key informants and reference groups were asked to identify "promising practices" related to housing and mental health initiatives – these are summarized within each map and should not be considered exclusive lists, but rather should be cross-referenced with site visit findings.

The challenges to the process were three-fold:

- Delineating between housing that was dedicated for people living with mental health problems and/or mental illness and housing that was non-dedicated but which was recognized as being commonly used or accessed by this population – for example, some social housing initiatives are recognized as serving people living with mental illness but are not funded for this purpose. Further, many people living with mental illness reside in non-dedicated housing models.
- Information to capture housing provided by non-profit organizations was not always readily available. Some organizations that provide housing to people living with mental illness do not receive government or targeted funding to do so.
- While the maps cover a range of housing options, some options are not included. The maps do not include information on private ownership, nor on people living with family members. While information on long-term care and government-funded seniors' residences is included, retirement homes are not. As well, the data generally did not include information on halfway homes and other justice/corrections related transitional housing.

Additionally, housing on Aboriginal[4] reserves was not captured through this exercise. However, Appendix Six discusses housing and supports for First Nations, Métis, and Inuit peoples.

For these reasons, housing stock figures, particularly those for dedicated housing, are likely to be underestimated relative to actual capacity. Nevertheless, **this is the first time that a national picture of housing for people living with mental health problems and/or mental illness has been created, and it represents a reasonable approximation of government-funded housing capacity across Canada as of December 2010**.

[3] Inclusion of the term "mental health problems" has been used since many people with mental illness may not have a diagnosis of mental illness per se (either through personal choice or due to circumstances such as lack of a psychiatrist to formally make a diagnosis).

[4] The research team recognizes that different challenges in housing and mental health supports can face people who are First Nations, Métis, or Inuit and that each of these communities has some unique characteristics that differ from the others. For ease of reading, the report uses "Aboriginal" peoples rather than First Nations, Métis, and Inuit peoples.

The Range of Housing and Supports

Housing is a health issue. The mapping exercise incorporates the range of dedicated housing with support models and residential care options for people living with mental illness and/or mental health problems. The reality, however, is that people with mental illness also live in diverse 'non-dedicated' housing arrangements, as does any person in Canada. **The range of housing for people living with mental illness includes**:

- Owning a home
- Living with parents or with friends
- Renting an apartment in the private rental market
- Living in social housing (including public, non-profit, co-operative, and other affordable housing initiatives)
- Living in dedicated housing[5] (including 'scattered site' housing where a rent supplement or portable housing benefit enables renting in the private rental market, dedicated buildings with self-contained apartments, and dedicated homes with private or shared bedrooms) with a variety of housing and/or clinical supports, ranging from low to high levels of intensity

The reality, too, is that there are also people who, due to lack of appropriate housing and support options, are forced to live in hospital, shelters, or inadequate and unsafe housing situations which have a devastating impact on their ability to move towards recovery. The overarching theme from the mapping process is the tremendous impact of the lack of housing options – whether in the private rental market, in public housing, or in units that are 'dedicated' for people with mental illness. **Various decisions limiting governmental involvement over the last 25 years[6] have culminated in a crisis in affordable housing across Canada** (Falvo, 2003; Hulchanski 2003; Wellesley Institute, 2008; daSilva et al., 2008; Mikkonen & Raphael, 2010)**, the depth of which profoundly impacts the range of housing options available to people living with mental illness and/or mental health problems**.

Adequate social housing stock is central to ensuring adequate, suitable and affordable housing dedicated for people living with mental illness. In many provinces and territories, social housing units and rent supplements are the primary housing options that governments offer for people living with mental illness, with supports provided through regional health authorities or non-profit organizations.

There are a number of ways in which people with mental illness can be assisted in securing affordable housing. Pomeroy (2001) discusses different approaches to achieving affordable housing for the general population:

Supply measures, which seek to reduce or subsidize the cost of housing production in order to make housing more affordable, include:

- Direct support for public/non-profit production
- Incentives for private rental unit development
- Creating a level playing field for rental development

[5] Many dedicated housing options include social housing models – for example, they may have rent supplements attached, they may be located in social housing units, and they may be provided in partnerships between mental health and affordable housing providers.

[6] A brief history of Canadian housing policy is important to understanding the overall context of housing options available to people living with mental illness today and is provided in Appendix Five.

- Reducing development costs
- Encouraging lower cost forms of development (e.g. single-room occupancy, secondary suites)
- Shifting patterns of ownership (e.g. facilitating non-profit ownership).

Demand-side measures, which seek to increase a household's ability to pay for housing by increasing or supplementing income, include:

- Rent supplements
- Shelter allowances
- Reform of welfare shelter benefits

Rent control measures, which divert demand from the rental sector (i.e., through facilitating home ownership options), include:

- Influencing the price of existing rental housing through rent controls
- Securing private, for-profit stock
- Transferring ownership to not-for-profit owners

An analysis of the benefits and challenges of each of these approaches is discussed in Appendix Five. The variety of housing and support models are organized in the following sections to reflect national initiatives, population considerations, and provincial and territorial overviews from the perspectives of policy, structure, and capacity.

Reaching Consensus on Terminology

What follows is a summary of the types of housing and supports captured through the mapping exercise, as well as the terminology used. This expands upon the "key terms" summarized at the beginning of this section.

Dedicated Housing: Housing that is funded specifically for people living with mental illness or a concurrent disorder[7] (co-occurring mental health issues and problematic substance use). Funding sources are generally municipal, provincial and/or federal governments, although in some instances, dedicated housing is funded via private sources. Dedicated housing can include **housing and support models**, as well as **residential care models** (see below for distinction between these two types).

Conversely, **"non-dedicated housing**" includes housing options, funded via government sources, that are not dedicated to people living with mental illness – these can include social housing units, rent supplement initiatives (tied to units or "portable" and attached to individuals or families), non-profit housing operated by community organizations, affordable housing initiatives, housing co-operatives and public housing programs that target specific groups, et cetera. In general, the goal of such initiatives is to provide housing options in which housing costs do not exceed 25-30% of household income. While the maps could have been limited solely to Dedicated Housing options, the reality is that many people living with mental illness or mental health problems, particularly those with lower incomes, reside in non-dedicated, government-subsidized housing options.

The maps include information about "**additional facilities or housing options" –** where readily available, information has been provided on emergency shelters, long-term care, non-dedicated residential care, and

[7] Concurrent disorders include any combination of mental illness and substance use disorders (which includes both substance abuse and substance dependence) and, consistent with best practices, this would include people with a combination of mental illness and problematic gambling.

housing options for people living with intellectual disabilities[8]. While we acknowledge that these options may not be permanent, or may not be appropriate for people with mental health issues, we recognize that people can and do access these facilities or options.

In the context of dedicated mental health housing, many different definitions are in use across the country when it comes to housing and support options – this concern was consistently expressed by reference groups. Terminology can vary nationally, within provinces and territories, and even within regions. Different understandings of what is meant by supportive housing, supported housing, residential care options, et cetera, can create difficulties in having a dialogue about the housing needs of Canadians living with mental illness. This challenge is most prevalent in discussions of "supported" and "supportive" housing. The general elements of supported and supportive housing options are summarized as follows:

Supported housing – there is a delinking of support from the housing in which the person lives, so that if the person moves, the supports follow them.

- The supports the person has access to are most often mental health clinical services, but staff may also provide some aspects of housing support services.
- Apartments are 'scattered site' (i.e., integrated alongside regular private market owned or rented housing).

Supportive housing – some component of support is linked to the housing in which the person lives.

- The supports the person has access to include both housing support services (most often linked to the housing) and mental health clinical services (which may be mobile, community-based services or linked to the housing).
- Housing is more likely to be physically organized in a congregate setting, such as clustered apartments (apartment buildings that are wholly dedicated to people living with mental illness, or a number of dedicated units that are integrated in a private market apartment building) or a home with private bedrooms and baths, but shared common spaces.

The practical reality, however, is that when provinces draw distinctions between supported and supportive housing models, **the characteristics of different housing options do not always fit "neatly" into either supported or supportive descriptions**. Consider, for example:

- Cross-over in functions between mental health clinical services and housing support services can exist, depending on how various organizations or sectors have evolved to meet the needs of their clients or tenants. A person may have a case manager who not only provides mental health services, but also performs a variety of activities that are more closely tied to housing support services, such as teaching household skills like meal preparation, grocery shopping, or budgeting. Conversely, a key task of a housing support worker is linking people to services in the community to help to address issues (such as substance use, mental health issues, or physical health issues) that could impact housing stability, a function similar to that of a case manager.
- While housing support functions may be "linked" to a particular housing option, the mental health services may be "delinked" and thus follow tenants if they relocate, which raises the question, is this supportive or supported in nature?
- There are many examples of housing in which each person has a private bedroom, but there is shared living space. Mental health services are available on-site, but they are delinked and follow the person if they move.

[8] Provinces and territories use different terminology including people with developmental disabilities, developmental delay, intellectual disabilities, and so on – while the individual maps reflect these differences, for the purpose of this report, the term intellectual disabilities is used.

Significant amounts of time and resources can be spent in trying to identify all the exceptions to generally accepted terms.

In developing any type of overarching national housing strategy, a common understanding of terminology and definitions is crucial. The research team adopted **a functional approach to terminology for dedicated mental health housing options: housing with supports, including *Housing First* or low-barrier approaches, and residential care options.**

Housing with supports incorporates attributes common to both supported and supportive housing:

- Low-cost housing combined with some type of support.
- Common population: both models are funded to serve people living with mental illness and/or mental health problems.
- Common philosophy: providers of both options tend to focus on the importance of empowerment, independence, and recovery when providing housing and supports.
- Tenancy: people living in either supported or supportive housing are considered tenants, and sign leases with private landlords or mental health or social housing providers, depending on the organization of the particular housing.
- Support may or may not be linked to the housing setting, and levels of support can range from very low to very high (with staff available on-site 24 hours a day/7 days a week). Supports may include one or both of the following:
    1. Mental health clinical services, including case management, assertive community treatment, or a multi-disciplinary team – these services are generally funded by the relevant provincial health ministry or department via Regional Health Authorities. Service delivery is either directly through the Regional Health Authorities or through contracts with community-based mental health organizations.
    2. Housing support services that focus on skill-building and empowerment to promote housing stability and tenure (for example, finances and budgeting, setting life goals, addressing issues that are impacting housing stability, helping people to connect to natural supports and activities in their communities). These services may be funded by the housing or health departments of provincial or territorial governments and delivered by regional health authorities or community-based mental health or housing organizations. They may also be funded by municipal or federal initiatives, or other provincial ministries, and delivered by providers of social housing or other support services (including providers who serve people living with mental illness, perhaps as part of a broader population, but are not specifically funded to do so).
- Agreeing to access available supports may or may not (i.e., *Housing First*) be required in order to access the housing.
- Support to tenants may be provided through creative approaches and partnerships between housing and mental health organizations.

National Initiatives

Social/Public Housing Programs

Following the devolution of social housing to the provinces in 1996/97, each province and territory entered into a bilateral agreement with the federal government to administer and manage the existing social housing

programs[9]. Annual federal subsidies are paid to the province or territory, and **the agreements identify that these subsidies extend into the 2030s; however, the level of subsidy will decline annually until the agreements expire**. The average annual reduction in subsidies to existing social housing at the national level will be $100 million from 2008 to 2012 and $265 million from 2013 to 2017. These declines will be roughly matched by the provinces, territories, and municipalities. Coupled with declining values of the subsidies, the existing stock is aging, meaning that the costs of ongoing maintenance are increasing every year. An analysis prepared for the Canadian Housing and Renewal Association (Pomeroy, Charles, Gaudreault, & Connelly, 2006) identified that non-profit projects established prior to 1986 are better placed to contend with the expiry of their agreements, as they tend to have a higher level of income mixing and more units close to market rent. More significant difficulty is projected for non-profit providers with post-1985 agreements, and for providers where the 'rent-geared-to-income' proportion of their units is greater than 65% of the total units (as is the case for public housing and urban Aboriginal housing).

Federal and provincial/territorial governments will **reduce expenditures by more than $3.5 billion annually** by the time all the operating agreements expire (Pomeroy et al., 2006). This presents an opportunity, and a funding source to reinvest in existing projects where viability is an issue and to invest in new projects targeted to specific needs.

Homelessness Partnering Strategy

Launched on April 1, 2007 by the federal government, the Homelessness Partnering Strategy (HPS) builds on its predecessor program, the National Homelessness Initiative. Announced in December 2006, the HPS was formed to:

- Build and improve upon the National Homelessness Initiative by focusing on a *Housing First* approach to homelessness.
- Encourage community partnerships to align provincial/territorial social services to help homeless individuals attain self-sufficiency.
- Increase the knowledge base about homelessness.

The HPS is overseen by the federal department of Human Resources and Skills Development Canada (HRSDC). It provides grants to community-based organizations in the private or not-for-profit sectors that provide services and programs intended to promote independence. In general, provincial governments assist in funding ongoing support services. Target populations may include people with mental illness and/or substance use issues. Most organizations funded by the HPS have received funding on a one to three year basis.

In September 2008, the federal government announced $1.9 billion over five years for housing and homelessness investments for low-income Canadians, expiring on March 31, 2014. Specific to homelessness, the government extended HPS funding for two years, until March 31, 2011, and made a five-year commitment to continue to annually fund federal housing and homelessness programs until March 31, 2014.

Affordable Housing Initiative

The Affordable Housing Initiative (AHI), agreed to in November 2001 by federal and provincial/territorial housing ministers, provided the framework for bilateral federal and provincial/territorial affordable housing agreements. Provinces and territories are required to cost-match the federal investment – funding may come from the province or territory, or from other parties (e.g. municipalities, private sector, donations, etc.). These contributions can be in the form of a grant, a stream of ongoing subsidies, or the value of in-kind contributions

[9] The exception is Prince Edward Island, where responsibility still rests with the federal government, via the Canada Mortgage and Housing Corporation.

(e.g., land). Within these conditions, each provincial or territorial housing agency has designed its own housing program and is responsible for program delivery, including the selection of housing projects that receive AHI funding. There have been three phases of AHI funding to date:

- Phase One – announced in 2001, providing $680 million in funding for the creation of new rental housing, major renovation and conversion.
- Phase Two – announced in 2003, providing $320 million in federal funding for housing targeted to low-income households in communities where there is a significant need for affordable housing. Low-income households are defined as those qualified to be on a social housing list.
- Phase Three – announced in 2008, providing $1.9 billion over five years for housing and homelessness programs for low-income Canadians. The third phase of the AHI, the HPS and the RRAP were all extended for a two-year period, to March 31, 2011, during which time the initiatives were to be reviewed and funding allocations for the following three years determined.

Of note, $1.525 billion of the federal government's Economic Action Plan for social housing is being delivered through the AHI.

Residential Rehabilitation Assistance Suite of Programs

These programs, administered by the Canada Mortgage and Housing Corporation (CMHC), focus on preserving existing housing occupied by low-income households and on modifying and adapting homes so that low-income seniors (typically aged 65 and over) and persons with disabilities can live independently in housing that meets minimum health and safety standards. Provinces and territories share the cost of these programs with the federal government. Generally speaking, provinces and territories deliver the programs, although there are exceptions, such as on Prince Edward Island, where CMHC delivers the federal RRAP programs.

Lack of long-term federal commitment to funding (slated to expire in March 2011), the increasing cost of materials and labour, and low program income ceilings are commonly identified issues.

Canada's Economic Action Plan

The Government of Canada's 2008 economic stimulus package includes a series of investments in housing (Chapter 3 of the 2009 budget package), summarized below. In addition to investments to promote home ownership, home renovation, and municipal infrastructure, approximately $2 billion was allocated for social housing.

- A one-time federal investment of $1 billion over two years (fiscal years 2009 and 2010) for renovations and energy retrofits for up to 200,000 social housing units on a 50–50 cost-sharing basis with the provinces. There are approximately 630,000 social housing units in Canada, supported mainly by subsidies from the federal, provincial, and municipal governments. Funding flows through existing federal/provincial/territorial agreements and is administered by the Canada Mortgage and Housing Corporation. This $1 billion investment is in addition to the $1.9 billion over five years announced in September 2008 to extend existing housing and homelessness programs for low-income Canadians (Homelessness Partnering Strategy, Affordable Housing Initiative and the suite of housing renovations programs, i.e., the Residential Rehabilitation Assistance Program).
- $400 million over two years for the construction of social housing units for low-income seniors – delivered through the Affordable Housing Initiative and cost-shared with provincial and territorial governments.
- $75 million over two years for the construction of social housing units for persons with disabilities – delivered through the Affordable Housing Initiative and cost-shared with provincial and territorial governments.

- $400 million over two years to new social housing projects and remediation of existing social housing stock on First Nations reserves. This is in addition to the 2007 budget commitment of $300 million to the First Nations Market Housing Fund, designed to encourage home ownership on reserves. This investment flows through CMHC and Indian and Northern Affairs Canada
- An additional $100 million over two years to support social housing in the North. The Yukon and Northwest Territories are receiving $50 million each, and Nunavut is receiving $100 million. Funding is delivered through CMHC.

Canada Mortgage and Housing Corporation

Canada Mortgage and Housing Corporation is Canada's national housing agency. Its key functions include:

- Supporting access to financing options, including provision of mortgage loan insurance.
- Providing expertise in housing through research on best practices, home buying and renovation, and forecasting and analyzing housing market trends.
- Supporting delivery of the federal government's housing agenda by collaborating with provincial and territorial governments, non-governmental partners, and the private sector. This includes funding for renovations, emergency repairs, and home adaptations for low-income Canadians; support and financial tools for communities to develop their own affordable housing; funding to create affordable housing; and funding to supply and renovate housing for Aboriginal Canadians both on- and off-reserve.
- Promoting Canada's role on the international front by providing support to other countries in building housing systems, facilitating exports, and job creation.

The federal government anticipated spending more than $3 billion on housing in 2010-11 which includes $1.7 billion in CMHC spending on existing social housing (as noted above, this is estimated at roughly 630,000 units across the country). CMHC and Indian and Northern Affairs Canada administer an estimated $277 million annually from the federal government to address on-reserve housing needs, with an additional $151 million provided through CMHC to support the specific needs of off-reserve Aboriginal households. CMHC also administers the $300 million First Nations Market Housing Fund (established in April 2007), which create up to 25,000 housing units on-reserve over a 10-year period.

CMHC reports to Parliament through the Minister of Human Resources and Skills Development.

The Mental Health Commission of Canada: *AT HOME/CHEZ SOI*

The Mental Health Commission of Canada (MHCC) is in the midst of the *At Home/Chez Soi* research project, providing *Housing First* interventions to people who are homeless and living with a mental illness. With an allocation of $110 million from the federal government, the research project is taking place in five sites across Canada and is slated to end in 2013. The project involves 2,285 participants, of whom 1,325 are receiving a *Housing First* model of intervention, while the remaining participants receive the services that are regularly available in each of the cities (for a description of the *Housing First* approach, refer to page 11). The goal of this project is to explore ways to help homeless people who have mental health issues, drawing on knowledge generated from the *Housing First* approach. **The project will generate strong evidence and information to guide the policy and program approaches to ending homelessness in Canada**.

Each of the five sites has a particular population or area of focus: Moncton (the fit of services in smaller urban and rural communities), Montréal (a range of housing options and a unique vocational intervention), Toronto (ethno-cultural diversity, including new immigrants who are non-English speaking), Vancouver (people who are

also experiencing problematic substance use, as well as a unique congregate setting), and Winnipeg (the urban Aboriginal population).

90% of the *At Home/Chez Soi* project's participants have been recruited. Of them, 30% are women. About 10% are under the age of 25, and another 10% are over the age of 55[10]. Other key features of the participant population include:

- A significant proportion of participants have a serious mental illness. Approximately 50% would meet the criteria for a psychotic diagnosis if assessed by a medical examiner, and many of these individuals also have problems with substance dependence.
- 5% have served in the Canadian military forces or its allies.
- Nearly 1 in 5 participants have been homeless for 10 years or more over their lifetime, and 36% have been homeless for over five years.
- More than a third of participants had involvement with the criminal justice system in the past year. Other studies indicate that these are often petty crimes related to living in public spaces.
- There are many indications that participants have faced multiple challenges in their lives that contribute to their disadvantaged status. For example, only 44% have completed high school. Nine out of 10 are unemployed. One in 3 reported ever being married.

The *At Home/Chez Soi* project will generate strong evidence about the cost effectiveness of the *Housing First* approach, as well as further information on the following positive outcomes:

- Increased long-term housing stability
- Reductions in emergency room visits and hospitalizations
- Improved health and addictions outcomes
- Decreased involvement with police and criminal justice systems
- Enhanced quality of life.

Income and Population Considerations

The maps provide more detailed and specific information on population and housing characteristics in each province and territory. As discussed in Section Five, people living with mental illness most often identify income supports as a key challenge in accessing and maintaining their housing. This is consistent with input from providers garnered through **the provincial and territorial reference groups, where particular emphasis was placed on the challenges that people who live with mental illness and receive social assistance face in accessing and maintaining adequate and affordable housing**. The National Council of Welfare (2010) noted that during the period from 1990 to 2009, single persons saw an increase in their welfare incomes in only three provinces and territories: Alberta (6%), Quebec (6%) and the Yukon (48%). **Because inflation increased by 45.9% during the same period, only in the Yukon did increases in social assistance for people with disabilities exceed the cost of living**. Further analysis identified the following important points about social assistance rates (National Council of Welfare, 2010):

- **Welfare incomes for a single person on disability were actually less in 2009 as compared to their "peak year" in 11 of the 13 provinces and territories**[11]. The Yukon and Nunavut had their "peak year" in 2009, thus, the dollar change from peak year to 2009 was $0. The greatest loss ($3,466) was realized in Prince Edward Island, where the peak year was 1992 with an income of $12,533,

[10] "Old age" is defined differently among the homeless because of the complex physical and mental stresses they experience.
[11] This excludes the Assured Income for the Severely Handicapped program recently implemented in Alberta – this is distinct from the Income Supports program.

compared to $9,067 in 2009. In seven provinces, the loss between the peak year and 2009 was greater than $1,000. Most "low years" are in the current decade.

- All 2009 welfare incomes were **below the After-Tax Low-Income Cut-Offs (AT LICO) by at least $4,000**, with the greatest gap, of almost $9,000, in Manitoba.
- The 2009 welfare incomes were more than $6,000 below the Market Basket of Measure (MBM)[12] in Prince Edward Island and Alberta (Income Supports program). Benefits under the Assured Income for the Severely Handicapped program in Alberta were about $1,200 below the MBM.
- Welfare incomes for a single person with a disability in all provinces were below the average after-tax income of all single persons in those provinces by at least $14,000. As a percentage of AT LICO, the lowest welfare income was in Manitoba (51%) and the highest was in Newfoundland and Labrador (71%). As a percentage of the MBM, the lowest income was in Prince Edward Island (57%), and the highest was in Ontario (83%).

Table 1 ranks provinces and territories in relation to the national picture on certain housing and population indicators. Specific population indicators relating to difficulties in accessing and maintaining housing are included. For example, recent new Canadians are at a higher risk of core housing need – if these circumstances are coupled with mental health issues, this group merits particular consideration in the development of future housing strategies.

[12] The Market Basket Measure is sensitive to differences in the cost of the basket of goods and services in different parts of Canada, including transportation, shelter, clothing, and food components.

Table 1. *Comparison of Provinces and Territories by Population Characteristics, 2006*.

Rank (Highest to Lowest)	% Aged 65 and over	# of people reporting Aboriginal identity	% of Pop reporting Aboriginal Identity	% of Total recent immigrant population in Canada	Median annual household income	Median annual shelter cost	% Renter households	% Renter Households spending 30% or more of their income on shelter	% Households in core housing need	2009 Welfare Incomes for single person with a disability*
1.	SK	ON	NU	ON	NT	NT	NU	NS	NU	NU
2.	NS	BC	NT	QC	AB	ON	NT	ON	NT	NT
3.	PEI	AB	YK	BC	YK	AB	QC	BC	YK	YK
4.	NB	MB	MB	AB	ON	BC	YK	NFLD	BC	AB – AISH+
5.	BC	SK	SK	MB	NU	YK	BC	PEI	ON	ON
6.	QC	QC	AB	SK	BC	PEI	ON	SK	NFLD	BC
7.	MB	NU	BC	NS	MB	NS	MB	NB	PEI	NFLD
8.	NFLD	NS	NFLD	NB	SK	QC	NS	AB	NS	SK
9.	ON	NFLD	NS	FLD	NS	MB	AB	QC	SK	QC
10.	AB	NT	NB	PEI	PEI	SK	PEI	MB	MB	MB
11.	YK	NB	ON	NT	QC	NB	SK	YK	QC	NS
12.	NT	YK	QC	YK	NB	NFLD	NB	NT	NB	PEI
13.	NU	PEI	PEI	NU	NFLD	NU	NFLD	NU	AB	NB
Canada	13.70%	1,172,790	3.80%	100%	$53,870	$8,966	31.20%	40.30%	12.70%	$8,665 - $46,066 range

Source: Statistics Canada (2009); *Census Analysis Series* available at http://www12.statcan.ca/census-recensement/2006/as-sa/index-eng.cfm.

* National Council of Welfare (2010); *Welfare Incomes 2009, Chapter 3 – Single Person with a Disability* available at http://www.ncw.gc.ca/ l.3bd.2t.1ilshtml@-eng.jsp?lid=331&fid=26. There is a wide range in welfare levels, reflecting highs of $46,606 in Nunavut, $21,518 in the Northwest Territories, and $18,402 in the Yukon Territory with the majority of incomes falling between $12,905 (Ontario) to $8,665 (New Brunswick).

+ Alberta has two programs and this figure reflects the higher of the two – the Assured Income for the Severely Handicapped at $14,297. The Alberta Income Support rate for 2009 corresponds to $9,433 annually, falling between Quebec and Manitoba.

Provincial and Territorial Overview: Structure, Policy and Capacity

The organization or structuring of housing and associated mental health supports varies by province and territory (see Table 2), but there are some common themes:

- Typically, housing and mental health services policy is set at the provincial or territorial level. Administration of housing and mental health services is through some type of arm's length housing corporation or regional health authority structure, while service delivery is provided through housing corporations (including local or regional offices), non-profit providers, and housing co-operatives. Mental health services are provided either directly by regional health authorities or under contract with non-profit community agencies.
- The **organization of mental health and housing at the policy or strategic level tends to be segregated from the service delivery level**.

Note that Table 2 does not include some non-governmental and governmental 'players,' including non-profit housing associations, co-operative housing associations or federations, regional offices of the CMHC or Homelessness Partnering Strategy, and housing and homelessness networks.

Table 3 presents an overview of key policy initiatives relating to mental health and housing by province and territory, including poverty reduction strategies. Some policy initiatives set out very detailed backgrounds, policy directions, goals, actions, targets, and indicators (for example, New Brunswick's housing strategy).

There is also **an increasing trend by provinces and territories to develop social inclusion, poverty reduction, and/or prosperity promoting strategies, in which housing – including housing for people with mental illness or mental health problems – is one of the main thrusts**. In their work for the Ontario Non-Profit Housing Association, Pomeroy and Evans (2008) explore the role of housing in poverty reduction strategies internationally, and identify three ways in which housing can contribute to poverty reduction:

1. Reducing net housing cost/increasing after-shelter disposable income (through rental assistance for private rental market housing or through social housing units where rent is geared to income – this assistance can be tied to the individual or family or tied to the actual housing unit in a community).
2. Enabling modest-income households to access homeownership and build assets/equity through housing programs.
3. Construction of social housing with associated rent-geared-to-income subsidies (the predominant approach in Canada until the mid-1990s). The authors noted that the right policy can be effective in creating and maintaining mixed-income and mixed-tenure communities, which rental subsidies on their own will not achieve.

In 2004, Québec became the first province to develop a poverty and social exclusion reduction strategy. The strategy flowed from *Bill 112: An Act to Combat Poverty and Social Exclusion*, adopted by the province in 2002. The strategy's primary goal was for Québec, by 2013, to be among the industrialized nations with the least number of people living in poverty. Similarly, in 2006, Newfoundland and Labrador (the second province to adopt a poverty reduction strategy) established a **ten-year goal to transform the province from having the highest level of poverty in the country to the lowest**. Section Four discusses in more detail the concept of integrating housing strategies within broader social policy approaches.

Table 2. *Structure and organization of government-funded housing and related supports by province and territory.*

Province or Territory	Provincial Legislation and Policy		Administration and Management		Housing Delivery		Other
	Housing	***Mental Health***	***Housing***	***Mental Health***	***Non-Dedicated Housing***	***Dedicated Housing and Mental Health Services***	
Alberta	Department of Housing and Urban Affairs	Department of Health and Wellness	Alberta Social Housing Corporation	Alberta Health Services	Housing Management Bodies, municipalities, non-profit housing providers, private housing providers, housing cooperatives	Alberta Health Services, non-profit community-based organizations (housing and mental health)	Alberta Secretariat for Action on Homelessness - facilitating implementation of the provincial ten-year plan to end homelessness
British Columbia	Ministry of Housing and Social Development	Ministry of Health Services	BC Housing	Regional Health Authorities and the Provincial HSA	BC Housing, municipalities, non-profit housing providers, for-profit housing providers, housing cooperatives	Regional Health Authorities and the Provincial Health Services Authority, non-profit and community based organizations (housing and mental health), BC Housing	
Manitoba	Department of Housing and Community Development	Department of Health	Manitoba Housing	Regional Health Authorities	Manitoba Housing, municipalities, non-profit housing providers, for-profit housing providers, housing cooperatives	Regional Health Authorities, non-profit and community based organizations (housing and mental health)	Cross-Departmental Coordination Initiatives Division (partnership of multiple provincial departments) facilitates coordinated approaches to housing and supports for special populations including people with mental health issues
Newfoundland and Labrador	Newfoundland and Labrador Housing*	Department of Health and Community Services	Newfoundland Labrador Housing	Regional Health Authorities	Newfoundland Labrador Housing, municipalities, non-profit housing providers, for-profit housing providers, housing cooperatives	Regional Health Authorities, non-profit and community based organizations (housing and mental health)	
New Brunswick	Department of Social Development	Department of Health	New Brunswick Housing Corporation	Regional Health Authorities	New Brunswick Housing Corporation, municipalities, non-profit housing providers, for-profit housing providers, housing cooperatives	Regional Health Authorities, non-profit and community based organizations (mental health)	Economic and Social Inclusion Corporation monitors progress on the provincial poverty reduction strategy
Northwest Territories	Housing Corporation*	Department of Health and Social Services	Northwest Territories Housing Corporation	Health & Social Services Authorities	Health and Social Services Authorities, non-profit and community based organizations (mental health)	Health and Social Services Authorities, non-profit and community based organizations (mental health)	

Province or Territory	Provincial Legislation and Policy		Administration and Management		Housing Delivery		Other
	Housing	***Mental Health***	***Housing***	***Mental Health***	***Non-Dedicated Housing***	***Dedicated Housing and Mental Health Services***	
Nova Scotia	Department of Community Services	Department of Health	Nova Scotia Housing Development Corporation	District Health Authorities	Local Housing Authorities, municipalities, non-profit housing providers, for-profit housing providers, housing cooperatives	District Health Authorities and non-profit and community based organizations (mental health)	
Nunavut	Housing Corporation*	Health and Social Services Department	Nunavut Housing Corporation	Health and Social Services Department	Local Housing Organizations	Regional Health & Social Services Authorities	
Ontario	Ministry of Municipal Affairs and Housing	Ministry of Health & Long-Term Care[+]	Municipal Service Managers	Local Health Integration Networks	Local housing corporations, municipalities, non-profit housing providers, for-profit housing providers, housing cooperatives	Non-profit and community-based organizations (housing and mental health)	Social Housing Services Corporation provides support to local organizations; Ministry of Community & Social Services – Some homelessness prevention programs
PEI	Department of Community Services, Seniors and Labour	Department of Health and Wellness	Prince Edward Island Housing Corporation	Department of Health and Wellness	Family Housing authorities, municipalities, non-profit housing providers, for-profit housing providers, housing cooperatives	Non-profit and community-based organizations (housing and mental health)	
Quebec	Ministère de Santé et Services Sociaux	Ministère de Santé et Services Sociaux	Regional Authorities	Regional Authorities	Société d'Habitation du Québec (rent supplements) and Regional Authorities	Health and Social Service Centres	
Saskatchewan	Ministry of Social Services	Ministry of Health	Saskatchewan Housing Corporation	Ministry of Health	Saskatchewan Housing Corporation, municipalities, non-profit housing providers, for-profit housing providers, housing cooperatives	Regional Health Authorities and non-profit and community-based organizations (housing and mental health)	
Yukon Territory	Housing Corporation*	Department of Health and Social Services	Yukon Housing Corporation	Department of Health and Social Services	Yukon Housing Corporation and local community housing boards	Department of Health and Social Services	Council of Yukon First Nations - coordinates and addresses issues and activities relating to health and social development within the CYFN; Office of Social Inclusion to oversee social inclusion and poverty reduction strategy

* Housing Corporation reports to the provincial or territorial government via the Minister Responsible for Housing

[+] The Ontario MoHLTC is also the lead on dedicated mental health housing

Table 3. *Policy frameworks relating to mental health and housing by province and territory.*

Province or Territory	Mental Health Strategy	Housing Strategy	Other
Alberta	Provincial Mental Health Plan	*Ending homelessness in ten years*	*Health Promotion, Disease and Injury Prevention Action Plan: 2010-2012 (mental health and addictions are one of five priority areas)*
British Columbia	Integrated Mental Health and Addictions Strategy	*Provincial Homelessness Initiative, Housing Matters BC, Breaking the Cycle of Homelessness*	
Manitoba	Manitoba Health's Vision Statement for Mental Health Renewal	*HOMEWorks! Housing Strategy and Policy Framework for Manitoba; Interdepartmental Homeless Strategy with a Focus on Mental Health Housing*	*All Aboard: Manitoba's Poverty Reduction Strategy*
Newfoundland & Labrador	Provincial policy framework for mental health & addictions	*A Housing Strategy for Newfoundland and Labrador; A Social Housing Plan for Newfoundland and Labrador – Secure Foundations*	*Poverty Reduction Strategy*
New Brunswick	The Action Plan for Mental Health in New Brunswick 2011-18	*Hope is a Home: New Brunswick's Housing Strategy.*	*Overcoming Poverty Together: The New Brunswick Economic and Social Inclusion Plan*
Northwest Territories	Shaping Our Future 2006-2010 (Mental Health & Addictions are one of eight priorities)	*Framework for Action 2008-2011, Northwest Territories Housing Corporation*	
Nova Scotia	*In development*	*Identified as a need in the poverty reduction strategy (which incorporates affordable housing goals)*	*Preventing Poverty: Promoting Prosperity*
Nunavut	Addictions and Mental Health Strategy	*Nunavut Ten-Year Inuit Housing Action Plan*	*Tamapta: Building our future together (vision to 2030, with priorities for 2009-13) - identifies poverty reduction, housing options, and people at risk as priorities for 2009-13.*
Ontario	Open Minds, Healthy Minds	*Long-Term Affordable Housing Strategy*	*Poverty Reduction Strategy*
Prince Edward Island	PEI Youth Substance Use and Addiction Strategy		
Quebec	Plan d'Action en Santé Mentale	*Incorporated in poverty reduction/social exclusion strategy*	*Bill 112 - An Act to Combat Poverty and Social Exclusion; Action Plan - Reconciling Freedom and Social Justice: A Challenge for the Future.*
Saskatchewan	Mental Health Strategic Plan		*Report from Task Force on Affordability*
Yukon Territory			*Cross-departmental social inclusion and poverty reduction strategy in development*

The summary tables in Appendix Five provide an overview of various models in the categories of dedicated mental health, non-dedicated affordable housing, and additional facilities or housing options. In addition, individual maps provide information about available home ownership and renovation programs. **Most, but not all, provinces and territories have some form of dedicated mental health housing, but generally, the majority of government-funded housing resources are in the form of non-dedicated housing**. These programs, including social or public housing, rent supplements (attached to units or individuals), and housing co-operatives, generally provide housing only. Reference groups from across the country emphasized the significant challenges in accessing existing supports and the lack of available new funding to enhance capacity. Table 4 summarizes the approximate capacity of dedicated mental health housing stock – **the breakdown of population per unit or bed for various housing options demonstrates a wide range in capacity across provinces and territories, but capacity remains a tremendous challenge across the country**. As noted in the parameters section, this exercise is intended to present a higher-level overview of housing stock as reported by provincial and territorial governments and reviewed by reference group members.

The intention of this mapping process was to present provincial and territorial "pictures" of available housing models together with reasonable estimates of existing capacity. We recommend that this practical approach be used to further refine and update these maps on an annual basis. This is an important component in building national capacity in ongoing planning, needs assessment, and priority setting to assist in, and monitor, the development of future housing and related supports.

Table 4. Dedicated mental health housing in Canada, December 2010.

Province or Territory	Population (Aged 15+)	Dedicated Mental Health Housing		
		Housing with Supports (Number of Units)	Residential Care (Number of Units)	Population (Per Unit/Bed)
Alberta	2,658,835	657	591	2,130
British Columbia	3,433,885	5,834	1,666	458
Manitoba	923,230	1,182	36*	758
New Brunswick	611,745		97	
Newfoundland and Labrador	427,240	85	55	3,052
Northwest Territories	31,545	0	0	0
Nova Scotia	767,025	118		6,500
Nunavut	19,470	0	13	1,498
Ontario	9,949,480	7,900	2,476	959
PEI	111,870	69	*	1,621
Quebec	6,293,620	9,231	*	682
Saskatchewan	780,460	291	817	704
Yukon	24,655	0	0	0
CANADA	26,033,060	25,367	5,654	839

* Additional dedicated beds in residential care settings are available through the Regional Health Authorities throughout the province.

Challenges

While Section Five speaks in greater detail about the range of challenges identified through the various methods employed in this project, a number of common challenges and planning considerations emerged through the mapping process and are summarized here.

Housing Stock and Affordability: The overall housing stock in the regular and social housing markets must be considered when planning for housing for people living with mental illness and/or mental health problems. Lengthy wait lists and affordability issues in social housing impact overall housing and support options. Lack of sufficient housing stock and true housing affordability are the most significant barriers to the provision of housing and supports for people with mental illness.

Quality of Housing: Housing stock is aging. This presents significant challenges for providers who own and operate housing for people living with mental illness, as well as for individuals who are attempting to secure housing through the private or social rental markets. Existing models do not incorporate sufficient funds for owners to properly maintain housing without sacrificing in other budget areas.

Income Security: As discussed under the Income and Population section, income security was of central importance to the key informants who participated in the mapping process, as well as to provincial and territorial reference group members.

The Range of Housing and Support Options: Key informants identified gaps relating to the inadequacy of the models available (i.e., requiring people need to "fit" the model rather than the model "fitting" the person), the insufficient range of supports available to people living in non-dedicated housing models, and tremendous capacity issues in existing dedicated housing models.

Differentiating Clinical and Housing Supports: The mapping and reference group processes clearly identified that differentiating between housing supports and clinical supports is a part of the "needs" equation that has not been adequately addressed in the policy context. Some key observations included:

- Consideration needs to be given to shared care models of support (i.e., housing support workers and clinical supports).
- There is a need to better understand of the role of housing providers in service delivery, and their interface with health and mental health providers.
- Understanding the concept of *Housing First* can be challenging for some providers – there has been considerable discussion about how this model is operationalized.
- From a recovery perspective, options around 'delinked' support need to be provided so that people do not have to fear losing support if they change residences. Employment supports and non-punitive policies related to earned income for people on social assistance could play important roles in this process.
- One group of people requiring attention are those who do not have a mental health diagnosis but may have fetal alcohol syndrome or cognitive issues coupled with mental health issues; no real options exist for this group.
- The vulnerability of the client population makes on-site supports very important, particularly from a safety perspective.

Residential Care and Recovery: Mapping informants and reference group members also discussed the "residential care" component of the range of housing and supports, and the challenges of integrating recovery-oriented approaches within these models. Across Canada, the residential care systems were developed mainly in the 1970s (with some variation by province and territory). A recovery-oriented approach is not prevalent in some of these residential settings - there can be subtle disincentives associated with what people see as their mandate and mission, and with the approach to people. For example, people may be subject to limitations on whom they can live with, when they can access their living space, whether they are able to cook their own meals, and the extent to which their goals can be self-directed. Maps and focus group feedback focus on the need to "shift" these models rather than replace them. Ultimately, people end up living in places that they can afford, including residential care facilities, single room occupancy hotels, and rooming homes. As well, residents may have primary care needs that warrant on-site supports that are available in residential settings. Our focus needs to be on how we **support these existing housing options to be safe, healthy, and empowering environments.**

Individual provinces and territories should consider evaluating existing residential settings with the view to development of longer-term strategies on how these homes can best be used, and services best delivered, in the future. This evaluation would include standards' development that support recovery orientation of these homes.

In addition to residential facilities, most provinces and territories have "Single Room Occupancy" (SRO) hotel and rooming house markets. While this mapping process did not include this type of privately funded housing, many people live in SROs and rooming houses, and they constitute part of the affordable housing market. In addition, a large proportion of people who use SROs and rooming houses receive some form of income assistance and/or shelter benefit, so these facilities are, in effect, a form of publicly-funded option.

SROs are located in buildings that were previously regular hotels and, over the past century or so, have become a form of affordable rental housing. A 2005 analysis of SROs in Winnipeg found about 1,000 people living in SROs, the majority of which are located downtown (Distasio & Mulligan, 2005). Residents pay an average of $250/month for a furnished room (which generally includes minimal kitchen facilities such as a bar fridge and hotplate) and shared bathroom. Rooming houses are usually defined as houses with several private bedrooms but a shared bathroom. Residents are considered tenants in rooming houses, but not in SROs. **SROs and rooming houses are vitally important as a housing option in places that have few other available and affordable options.** The question is how to ensure that these models can be tailored and supported to support the people who live in them.

To date, planning for housing and supports has failed to recognize that people living with mental illness do not all reside in some form of government-subsidized housing. **People live in their own homes, where they may encounter challenges in making mortgage payments, paying property taxes, and keeping up with maintenance when they're not feeling well – the integration of this living situation with supports must form part of any future range of housing and supports.**

Movement in the System: Participants from many provinces discussed the challenges inherent in a system that lacks capacity. There is an inability, and sometimes an unwillingness, to identify ways in which people can move to various housing and support options. Undoubtedly, people have the right to remain in their current housing arrangement; however, one of the unintended consequences of the principle of permanent housing is that people are often locked into a level of support that is different from the level that they want or need. At the present time, insufficient private rental market options, inadequate income assistance programs with respect to shelter costs, and insufficient mental health housing options 'blocks' people at different points on the housing range (i.e., people may be ready and wanting to move to more independent options, but **there is nowhere for them to go**). This reality, combined with insufficient capacity in affordable housing options, has serious consequences from both a health outcomes and cost efficiency perspective; in particular because of the impact on people awaiting discharge from hospital settings. A national strategy relating to mental health services and housing options needs to include strategies that promote systems flow and empower people in finding and maintaining housing and supports options that are a good fit to their needs and wants.

Rural, Remote, and Northern Communities: Findings from multiple data sources identified significant issues in rural and remote communities, including very limited housing stock, lack of a range of housing options, limited

funding, inadequate staffing, staff training and staff retention, and limited resources in terms of housing supports.

Planning and Coordination: Reference group consultations and provincial and territorial maps repeatedly cite the lack of coordination between key stakeholders including funders, policy makers, and housing and service providers as a challenge in developing an efficient and operational housing and support strategy for people living with mental illness. Key messages include:

- People's problems can be complex (e.g., homelessness, behavioral issues, involvement with the criminal justice system); viable solutions require interdepartmental collaboration with creative solutions. Coordination across ministries and agencies to address housing and support needs for people with mental health issues requires continued improvement. **Specific expectations at the interdepartmental, interagency, and front-line worker level are often lacking.** There are opportunities to look at how funding could be tied to partnership and innovation. Similarly, coordination across mental health and addictions services must be strengthened.
- **Cabinet shuffles and associated changes in leadership can create confusion and change at the service delivery level**. Stable and consistent leadership is needed to foster collaboration and partnership.
- **Real mechanisms to foster coordination are needed** – good will is not sufficient. For example, in the Yukon, four levels of government and over 100 non-governmental organizations serve a population of just under 33,000 people. This creates unique challenges in virtually all aspects of organizational administration.
- **Coordination across municipal, provincial/territorial, and federal governments** is critical to affordable housing planning, investment, and maintenance, and to streamlining the administrative and reporting burdens on agencies.

Ongoing Needs Assessment and System Planning: Informants to the mapping process and members of the reference groups identified a number of challenges in estimating the true need of people living with mental illness with respect to housing and support options. These included:

- A disconnect between existing estimates of housing and support needs versus the reality on the ground. Many people without a formal diagnosis of mental illness have significant mental health issues together with affordable housing needs. **The absence of comprehensive, sufficient and reliable data to accurately assess the degree of housing, homelessness, and mental health issues, and to evaluate existing interventions, remains a large systemic gap.**
- The **limited supply and demand data** specific to mental health housing and limited monitoring of quality and adequacy of housing.
- The level of demand for housing and supports at the front-line level, coupled with inadequate levels of resources, promotes a **"crisis reaction" approach to planning** rather than a proactive one.
- To support planning of new construction, there needs to be more information on what the **right housing "mix"** should be (i.e., number of units dedicated for people with mental health issues versus non-dedicated in the same building).
- **Demographic shifts** must be incorporated into future estimates of housing and support needs in the future (i.e., Canada's aging population, the growing Aboriginal population).

Trends

The individual maps incorporate information on the current and anticipated future trends in housing and supports for each of the provinces and territories. Some highlights include:

Alberta
There is a focus on, and buy-in to, moving from the management of homelessness to the implementation of creative solutions through the Ten-Year Plan to End Homelessness. Prevention is identified as part of the solution, and there are opportunities to see how prevention might align with mental health promotion and early intervention. There has been a significant shift towards a *Housing First* approach including harm reduction practices. There has also been a growing movement for integrating housing, and more specifically stable housing, in key principles of the Alberta Health Act.

British Columbia
There has been considerable policy focus on housing and homelessness issues, together with significant resource allocations (although resources for supports have been smaller than anticipated). The general trend has moved towards more client-centered housing options, including low-barrier or *Housing First* models. The bulk of new funding for housing focuses on congregate options for people with multiple, complex needs, usually with histories of homelessness. Although significant progress has been made towards developing the supports needed for the single room occupancy model, funding for the full range of recommended supports was not realized. Future work should incorporate models that provide greater flexibility (i.e., current trends focus significantly on bricks and mortar, but the future population may not need congregate models to the extent that they are being created today). A major area of present and future focus now is building much closer partnerships and linkages between the housing and health sectors at the governmental, organizational, and service delivery levels.

Newfoundland and Labrador
The philosophy of both government and community organizations has leaned toward a *Housing First* model, offering more permanent, rapid housing. Historically, funding has been allocated to congregate housing; however, this has been due to a lack of housing development rather than a preference for the model, and currently, more *Housing First* models are being funded. The Ministry of Health and Community Services has downsized the boarding home stock by approximately 20-30% and placed priority on getting people into housing from institutions with a provincial government commitment to fund dedicated housing, both clustered and scattered sites. There is a strategic commitment to better serve those with involvement in the criminal justice system. The new Supportive Housing Initiative is expected to assist in breaking down barriers across sectors.

Manitoba
There is an increased focus on supported housing models and *Housing First* approaches that serve people with mental health issues (a broader application than people with serious mental illness). There is an overall revival within the housing sector, including new projects and revitalization of existing stock. People with complex needs are increasingly a priority and government has recognized that housing is a key part of the solution. There is also a growing recognition that there is a difference between housing supports and mental health supports and the two need to work together effectively. There is greater interest in exploring avenues for providing appropriate supports in settings previously viewed as inappropriate (e.g., single room occupancy hotels and rooming houses) – there is potential to work within these systems to improve existing housing options.

New Brunswick
There is currently a significant focus on homelessness and poverty reduction, which is very promising from a housing development perspective, though the end of federal funding for a number of programs poses much concern. The government, through its provincial frameworks, has emphasized the linkages across housing, self-sufficiency, and poverty reduction. There is increasing interest by aging parents in the development of secondary suites for their children (young adults) with mental illness or intellectual disabilities. As parents are

aging, they want to offer their children opportunities to live independently, but require financial assistance to do so.

Northwest Territories
Historically, supportive housing services were in the form of emergency beds and temporary shelter. The last five years has seen an increase in transitional housing to address the support gaps between the emergency shelters and permanent housing. Historically, in order to receive mental health services in the Northwest Territories, individuals had to have an addictions issue; however, there has been a recent shift whereby mental illness and addictions are now in the same service provision portfolio. The application of this shift on the ground is still in progress. There are no significant resources available for people with mental illness – people are most often discharged from the hospital into community services for people with addictions or Fetal Alcohol Spectrum Disorder.

Nova Scotia
The province's poverty reduction/prosperity promoting strategy identifies clear targets for funding affordable housing – specifically, the government has committed to $59 million over the next three years to affordable housing for people who have difficulties in accessing housing – single adults, often with disabilities. The strategy further identifies the need to adjust income assistance personal allowances, review existing provincial housing policies in the context of poverty reduction, and develop a long-term housing strategy linked to the goals of the poverty reduction strategy. In March 2011, the government of Nova Scotia committed to the development of a mental health strategy, and a Mental Health Strategy Advisory Committee has been formed to make recommendations for mental health and addictions services in the province. This committee includes researchers, clinicians, and people living with or affected by mental illness.

Nunavut
The Nunavut Housing Corporation is in the process of identifying a greater variety of housing and support options, particularly to meet the needs of young families. Another priority is addressing the growing infrastructure requirements of the local housing offices. Mental health priorities for 2010–2012 include development and implementation of the Addictions and Mental Health Framework, including land-based and facility-based treatment programs and services, and implementation of a territorial suicide prevention strategy in partnership with Nunavut Tunngavik, Inc. and the Embrace Life Council.

Ontario
Housing First approaches are commonplace in Ontario, however, discussions continue regarding how the province's "Homes for Special Care" residential care program 'fits' or might fit within a future range of housing options. Two recent mental health and addictions planning processes, initiated by the provincial government, have the province poised for a new mental health and addictions policy framework: the Select Committee on Mental Health and Addictions, who tabled their report in August 2010, and the Minister's Advisory Group on Mental Health and Addictions, tasked with developing a new 10-year strategy for mental health and addictions. The recently released provincial affordable housing strategy emphasizes collaboration and advocacy. The level of new stock development that will result from this strategy is less clear.

Prince Edward Island
Several populations are emerging priorities for housing and supports. Housing and support needs for youth are a significant priority. The increasing New Canadian population in P.E.I. is creating new needs for cultural diversity in services, and new and enhanced options are needed for the aging population. There is currently concern about the range and capacity of existing housing and support models, wherein people are often housed in Community Care Facilities due to a lack of more appropriate options.

Québec
The *Plan d'Action en santé mentale* (2005-2010) highlights the need to move from the current residential mental health system towards a system of independent housing options with supports. A transformed service model must consider and balance the need for independence, the safety of the individual, individual choice in regards to living options, and the individual's own capacity. A significant development is that the role of the

peer support worker is being formalized in legislation. A service quality improvement initiative in the supervised residential housing sector is presently being implemented provincially.

Saskatchewan
The tendency has been to focus on supporting home ownership initiatives that, though creating space in other parts of the affordable housing range, does not address critical capacity issues. There is increasing emphasis on cross-sectoral collaboration between housing and health, with a provincial forum and regional committees to encourage this collaboration. Housing and supports for people with mental illness are receiving less attention, although there is some discussion of this population; however, the majority of the focus is on families, seniors and youth.

Yukon
The creation of a social inclusion policy, incorporating housing stock and mental health services, is a very promising direction for the future. The focus in planning housing and supports is to consider the size of the communities in rural and remote areas – for example, the Abbeyfield model (sized for 6-12 people) is a good fit in terms of critical mass. There is a growing emphasis on planning for high-density, multi-unit buildings.

CHALLENGES RELATED TO HOUSING AND SUPPORTS

This section addresses the question: "**What are some of the pressing challenges identified through this project?**" This section is informed by multiple data sources which include provincial and territorial surveys, survey analysis, literature review, site visits, webinars, international key informant interviews, and provincial and territorial reference groups.
The data from the project outlined several high level challenges in housing and related supports and also succeeded in exploring some innovations that helped address some of these challenges which are highlighted throughout the section.

Housing Stock, Housing Options, and Quality of Housing

> "We lack low income housing. This is the biggest need. If they don't have housing, they don't have the energy to do anything else."
> -webinar participant

The mapping exercise and discussions with provincial/territorial reference groups revealed that affordable housing stock is severely limited in provinces and territories across Canada. Housing options are curtailed both by inadequacy in the range of available options and because options are often far from optimal in terms of factors such as safety and accessibility. Substandard quality of affordable housing options along with the general stress associated with finding and keeping affordable housing significantly affects recovery and well-being. **Insufficient housing stock and true housing affordability are two of the most significant barriers to the provision of housing and supports for people with mental illness**.
Nearly one quarter of Canadians (approximately three million households) spend 30% or more of their income on shelter (Statistics Canada, 2009), some by choice, while others are forced to do so due to inaffordable housing. While the proportion of households in core housing need declined from 13.6% to 12.7% between 1991 and 2006, the total number of households in need increased to nearly 1.5 million households, a 15% increase (Canada Mortgage and Housing Corporation, 2009), the highest among low-income households. Overall, the number of households with serious affordability problems rose from 4.7% to 5.3% between 1991 and 2001 (Canada Mortgage and Housing Corporation, 2006).

The Canadian Mental Health Association (2004) notes that people with serious mental illness are more likely than the general population to live in poverty, which puts them at increased risk of living in core housing need and homelessness:

- As many as 30% of people without housing live with a mental illness[13].
- An estimated 75% of homeless single women live with a mental illness.
- Those with mental illness who are housed often live in substandard conditions without the needed supports.

The importance of having high quality housing options resonated in findings from the multiple data sources. Survey data from 330 people living with mental illness revealed that lack of affordability, quality, safety, accessibility to essential services, and the necessary supports were cited most frequently as challenges to appropriate housing. Responses to open ended items revealed additional challenges such as lack of house cleaning assistance, long waiting lists to access housing, and inadequate financial assistance to afford good quality housing.

Survey data from 183 family member questionnaires were in agreement with data from people living with mental illness that the lack of affordable housing, supports needed to stay in a home, safety concerns, quality of housing, and access to transportation and shopping were major challenges. Responses to open ended items revealed other challenges that included long waitlists for low-income/subsidized housing, access to high support housing, and permanent stable housing to prevent relocation. The reports from survey participants of long waiting lists for low-income housing is not a new revelation; **in a recent affordable housing action plan for Toronto, it was noted that more than 66,000 people wait up to 12 years for rent-geared-to-income accommodation** (Housing Opportunities Toronto, 2009).

Challenge Faced	People living with Mental Illness (*n* = 330)	Family Members (*n* = 183)
Lack of affordable housing	68%	57%
Lack of quality of housing	45%	40%
Low sense of safety	42%	42%
Inaccessible to essential services	39%	28%
Lack of supports needed to stay in a home	26%	48%

Survey data from 216 mental health service providers and 96 housing providers showed a significant proportion of respondents who identified insufficiencies in the following areas of safe and affordable housing: funding, transitional housing, staff availability to support individuals in their homes, and outreach teams/off-site services, stock, and available options.

Housing Concerns	Mental Health Service Providers (*n* = 216)	Housing Providers (*n* = 96)
Lack of safe, affordable housing	83%	74%
Insufficient funding	72%	79%
Lack of transitional housing	59%	35%
Insufficient staff available to support individuals in their homes	50%	43%
Insufficient outreach teams/off-site services	48%	42%
Lack of supports in place for individuals aging	47%	63%

Housing stock is not keeping pace with demand where affordability and development of new housing is further impacted by higher construction and land costs, challenges that are also faced by private developers. From the mapping exercise, the lack of incentives for developers to generate housing for people living with mental illness

[13] Some researchers propose higher prevalence rates with ranges beginning at 30% and ending at 40% (Kirby & Keon, 2006) while even newer research suggests that the prevalence of mental health issues among the vulnerably housed and homeless populations could be even higher than 50% (Research Alliance for Canadian Homelessness, Housing, and Health, 2010).

and/or affordable housing options was observed. Complex administrative rules in some provinces hinder the ability of some municipalities to take advantage of opportunities in neighbourhood redevelopments.

Half of the 96 housing provider survey respondents reported inadequate funding to maintain the housing they provide. There were several reasons for this:

- Funding models do not incorporate sufficient dollars for maintenance (58%).
- Maintenance costs exceed budget availability (54%).
- Buildings are run-down and capital dollars for repairs are inadequate (44%).

While it is generally acknowledged that strategies around systems integration and collaboration, portable housing benefits, and innovative support models are key elements in improving housing and supports options, the significant deficits in affordable housing render these strategies virtually meaningless in some communities.

Findings from site visits and the mapping process supported the importance of these concerns. Many housing providers, who were leaders in innovative housing and supports, reported the constant struggle to find the monies for maintenance and upkeep as it was rarely factored into the funder's agenda. The mapping process observed that while options to secure capital funding for housing stock development exists, there are few opportunities to secure new, annualized funding to support tenants, subsidize rental costs and sustain the operational costs of buildings. Deteriorating stock was a major concern voiced by housing and service providers during one-to-one conversations across the different provinces. Exploitation in rooming houses was highlighted by service providers in the Atlantic Provinces. Webinar participants stressed the issue of predatory landlords.

While high support housing with 24-hour on-site support scored the highest as an unmet need, 35% of the 96 housing providers also supported the need for more transitional housing options. In comparison to housing providers, however, mental health service providers more acutely felt the lack of transitional housing, with 59% of the 216 service providers reporting this as a challenge.

The 35 survey respondents representing hospitals also echoed the challenges of available housing options, with 61% of respondents reiterating the need for high support housing. 63% cited exclusionary criteria that also limit housing options. 43% of housing providers saw inadequate supports for complex mental health and acute care issues as crucial and associated with difficulties in discharging clients from hospital; 91% of hospital respondents viewed existing service capacity as inadequate to meet demand and limited housing options and supports responsible for ALC clients in hospitals, which in turn hugely impacts cost efficiency and service delivery in meeting the needs of people with mental illness. 80% of the 330 respondents living with mental illness and 74% of 183 family members agreed that more housing for single people was required.

From the survey data, while both the family members and people living with mental illness reported the need for supports as significant in expanding the range of housing options, family members reported it as a challenge nearly twice the rate of people with mental illness, 48% and 26% respectively. Of note, almost one third of the 183 family member respondents had their relatives with mental illness living with them or with other family members. These living arrangements may be necessitated by inadequate supports in other housing situations, articulating a pronounced need for supports geared to this population.

Survey data revealed that affordability was a major issue in all provinces; more than 68% of the 330 respondents living with mental illness in Quebec, British Columbia, Saskatchewan, Ontario, Nova Scotia, and Alberta cited this as a significant challenge. This finding is a prevalent issue across Canada where over 500,000 households spend 50% or more of their income on housing (Canadian Mortgage and Housing Corporation, 2004).

Lack of safe and affordable housing including a shortage of housing stock and vulnerability to slum lords were prominent themes in the webinars and the former was echoed in all of the regional webinars.

Lack of safe and affordable housing, including a shortage of housing stock and vulnerability to "slumlords," were prominent themes in the webinars, with the former echoed in all regional webinars. The situation is more dire in some regions than others. In the webinar for the North (North West Territories, Nunavut, and Yukon), participants reported huge housing gaps and shortage of affordable housing. In the territories, there was an abnormally high use of the shelter system. For example, **in Yellowknife, 936 people (5% of the city's population) stayed in a shelter in 2008 while shelter beds were used a total of 67,340 times** (Yellowknife Homeless Coalition, 2009). In Brandon, Manitoba, the advantages of portable housing benefits for people living with mental illness are limited by the vacancy rate which is often as low as 0.1%.

In the regional webinar for Newfoundland and Labrador, New Brunswick, and Prince Edward Island, people living with mental illness noted that lack of housing stock and options has given rise to "slum"-type living situations, where social services make rent payments directly to "slumlords" without consideration for the living conditions for which payment is being made. Decrease in housing options and lack of affordable housing further compromises the quality of housing available to a vulnerable population. The issue of "slumlords" preying on this population was also raised in the Ontario webinar. Participants from Quebec emphasized the lack of housing stock in general, and housing stock that is affordable and clean. For further findings from the webinars, please see Appendix Two.

International key informants spoke to the challenges of transitioning housing and supports from custodial models to recovery-oriented models. In the United States, the focus over the last five years has turned to supportive housing initiatives and adopted as policy in almost all states. Although there has been a rapid increase in the popularity of the supportive housing model, there remain formal and informal systems in which people with psychiatric disabilities live. The formal system is maintained and supported by municipal, state and federal funding, whereas informal systems range in degrees of substandard housing and support services; in some cases, individuals are housed in unlicensed, uncounted and unsupervised residences. A prime example is New York State where though supported housing stock has been on the rise, traditional board and care homes running in deplorable conditions remain prevalent.

INNOVATIONS

HIGH SUPPORT HOUSING INNOVATION: LOWER UNION STREET PROJECT, FRONTENAC COMMUNITY MENTAL HEALTH SERVICES (KINGSTON, ONTARIO)

Over the last decade, in response to issues such as ALC clients and bed blocking, the focus across Ontario has been to develop high support housing options for people following lengthy hospital inpatient stays. Frontenac Community Mental Health Services (FCMHS), in collaboration with the Providence Continuing Care Centre (PCCC), has developed an innovative recovery-oriented model to assist in the transition of these people. This high support transitional housing option is one component of the broad array of community mental health and addictions services provided by FCMHS including housing, assertive community treatment, intensive case management, crisis services, vocational supports and family supports.

The 'Lower Union' project is comprised of 18 bedrooms, with shared bathrooms and a common kitchen and living area for tenants. The key elements of the model were developed in partnership with PCCC, based on the needs of people with long inpatient stays at the hospital site:

- PCCC identifies individuals who are ready to transition to the community; staff from FCMHS and PCCC then complete a joint shared care checklist with the referred tenant.
- The FCMHS team meets monthly with social workers from PCCC to discuss potential new tenants, bridging support as they move from PCCC to Lower Union, and other elements of the partnership.
- Transition planning includes day visits and short stays.
- FCMHS owns and operates the Lower Union project and supports the tenants with day-to-day assistance in building life skills (from on-site residential mental health workers and a key worker), medication management (from on-site registered nurse), and community clinical services (from assertive community treatment team or through a high intensity team).
- Clinical services follow tenants when they move to other housing (based on their needs).

There is strong emphasis on the principles of recovery in program delivery and supporting tenants in reaching their goals. Tenants share responsibility for dinner preparation, with support from staff as needed, but are individually responsible for breakfast and lunch.

Since its inception, the model has evolved to focus on a transitional model of housing (rather than permanent) where people would move on to a less intensive model, recognizing that each person is different, with varying needs and goals, thus necessitating flexibility in length of stay. Lower Union residents are tenants who sign one year leases which can be extended as required.

This project also provides an option for respite and brief stabilization for tenants of other, lower supports FCMHS housing options.

Based on tenant feedback, FCMHS is exploring expansion of existing supports to include more group options to address vocational, social/recreational and peer support needs.

Capacity Issues in the Range of Housing and Support Options

In addition to the challenge of accessing affordable housing, access to a range of housing options with established appropriate supports is a major challenge for Canadians living with mental illness. Supports are significant in expanding the range of housing options available to people.

Informants to the mapping process clearly identified the **major service capacity issues that exist in mental health and housing support services**. Significant concern was expressed that while various initiatives are underway that may positively impact housing stock, few if any initiatives address the supports people need and want to maintain their housing tenure. For example, as the Province of Alberta rolls out its 10-year plan to end homelessness, thousands of people may wish to access services once they are housed. Also of significant concern was how existing client bases are being served on account of high caseloads.

Other capacity related issues reflected in the mapping process include:

- Gaps in mental health services with respect to **capacity, consistency in the availability of services and coordination with health services**.
- The increasingly limited resources available to social housing agencies to maintain their aging housing structures, remunerate staff, and invest in their organizations (Hulchanski, 2002) leaves little, if any, resources to provide housing support for tenants. Juxtaposed against this challenge is an increasingly pressured mental health service system and lack of consistency in who plays which roles in the provision of housing and related supports to people with mental health issues.
- **Support models need to transcend clinical services** to include food banks, recreation, education and income supports, and promotion of natural support networks.
- There is a wide range within social housing providers in how they meet people's mental health needs. While some providers have developed true expertise, others have very few ties to, or are unable to access, existing mental health services.
- Similarly, a high percentage of people with mental illness living in seniors' care facilities have minimal access to mental health services.
- An agreed upon **funding formula** is needed for mental health services and housing where specific investments are tied to specific models of housing and support.

There was consistent feedback through the mapping and reference group processes that differentiating between housing supports and clinical supports is part of the "needs" equation and has not been adequately addressed in the policy context. Some observations relating to this differentiation included:

- Consideration for **shared care models of support** (i.e. housing support workers and clinical supports).
- Better understanding of **the role of housing providers** in service delivery and the **interface with health and mental health** providers.
- The concept of *Housing First* can be challenging for some providers to understand.
- From a recovery perspective, there needs to be a shift in existing models and **options around 'delinked' support**.[14] Employment supports and non-punitive policies on earned income for people on social assistance could play an important role in this process.
- No real options are available for people who, though not diagnosed with a mental illness, may have fetal alcohol syndrome or cognitive issues coupled with mental health issues.
- The vulnerability of client groups makes on-site support important from a safety perspective.

[14] 'Delinked' supports are support services that are provided from outside the home, often by an agency other than the housing provider, and are portable, in that they stay with the client if he/she moves residences (Centre for Addiction and Mental Health, 2002).

Individual provinces and territories should consider evaluating existing residential settings with the aim to develop **longer-term strategies** on how these homes can best be utilized, and services best delivered in the future, including the development of standards that support recovery orientation within these homes.

The **challenges of integrating recovery-oriented approaches into "residential care" models** were frequently mentioned as cause for concern. Many residential settings have structural features that impede recovery. These can include rules about whom people may live with, when they can access the living space, whether they can cook their own meals, and the extent to which their goals can be self-directed.

In addition to residential care facilities, most provinces and territories have Single Room Occupancy (SRO) hotel and rooming house markets. Data from Winnipeg identified that about 1,000 people lived in SROs in 2005 (Distasio et al., 2005). The majority of SROs are located in the downtown core, and cost an average of $250/month for a furnished room (generally with minimal kitchen facilities such as a bar fridge and hotplate) and shared bathroom. Rooming houses are usually defined as a house with private bedrooms and a common bathroom. Residents are considered tenants in rooming houses, but *not* in SROs. While the focus of this mapping process was not on this type of privately funded housing option, many people live in SROs and rooming houses, and they are part of the affordable housing market.

Since ultimately, people end up living where they can afford to live, in settings that may include residential care facilities, SROs, and rooming houses, reference group members recommended not seeking to replace these models, but rather, on **adapting residential care, SRO, and rooming house models so that they can be safe, healthy, and empowering environments**.

The mapping process also highlighted the fact that **many people living with mental illness do not live in government-subsidized housing**. But living in one's own home can create its own challenges if people do not have access to necessary supports. People living in their own homes may encounter challenges in making mortgage payments, paying property taxes, and keeping up with home maintenance when they're not feeling well – any future range of housing and related supports should **consider supports for all housing situations, not just those that are subsidized by the government**.

INNOVATIONS

Condominium Program – Canadian Mental Health Association, Ottawa Branch (Ottawa, Ontario)

One way in which CMHA Ottawa provides a range of housing to people with serious mental illness is through its Condominium Program. Capital funding from the Ministry of Health allowed CMHA to purchase 22 condominiums in 2005 and subsequent funding allowed expansion to 31 units. The city provides rent supplements up to market value and the Ministry of Health provides a small annual stipend for maintenance. Some condominiums are designated for specific groups (e.g., women, homeless persons).

All tenants sign a lease with CMHA Ottawa. The housing model emphasizes mental health clinical supports and building community connections. Services include peer support, volunteer matching program and mentoring opportunities. Matching the individual's wants with what the housing can provide is the key to success.

On moving in, each person is assigned a CMHA case manager who provides housing and mental health supports; people's needs may lessen over time and if they no longer require a case manager, CMHA has structured supports in a way that allows them to access transitional or ongoing case management supports as needed.

As with all of the sites visited, there is no 'one size fits all' option that works for everyone; the Condominium Project presents one way to expand housing stock that is timely, cost-efficient and reflective of the type of housing model desired by many people living with mental health issues.

Phoenix Residential Society (Regina, Saskatchewan)

The Phoenix Residential Society in Regina provides psychosocial residential services to people with psychiatric disorders, concurrent disorder (dual diagnoses) and acquired brain injury. The first psychiatric rehabilitation group home was established by the Phoenix Society in 1979, followed by the successful conversion of the group home model to independent apartment living models. The provision of a range of housing models and support services to enable individualized and recovery-oriented care is the basis of their innovation and enhanced by a successful partnership with the Saskatchewan Health Authority.

Cluster Model with Supports
The conversion of the group home led to the establishment of Phoenix Oak, a 16-unit apartment building operating as a residential facility based on a 24-hour onsite staffing model. Eight units house clients with higher level support needs and eight who are transitioning to independent living in scattered apartments and receiving reduced level of supports offered by the Phoenix Supported Apartment Living Services. All 16 residents have a case manager from the Health Authority. CMHA and the Abilities Council partner with Phoenix Society to provide employment related supports in addition to the health and skill development activities offered throughout the week.

Scattered Model with Supports
Through the Phoenix Supported Apartment Living Services, supports are provided to 60 clients in scattered apartments throughout Regina. Clients from Phoenix Oak also transition into this living arrangement when ready. A case manager and a worker from Phoenix is attached to each client. There is regular communication between the case manager and the psychosocial rehabilitation worker.

Integrated Provision of Supports
All skill and wellness related groups provided at Phoenix Oak are open to other clients in the scattered housing and other housing programs of the Phoenix Residential Society. The West View Dual Diagnosis Program is a housing and support program of Phoenix, for people with dual diagnosis (concurrent disorders), which operates from a cluster apartment model. The services offered for substance use and recovery through this program may also be accessed by residents in other housing programs of Phoenix, resulting in the integration, cross-pollination and avoidance of duplication of services.

Peer Support
Through the Peer Support Specialist Program, former residents are hired to support the clients of the Phoenix Residential Society. Plans are to create a peer support model exclusive to the housing programs.

Financial and Income Support Issues

Lack of income security and the resulting issues related to housing and food security create dependence on the system and negatively impact health. Many provinces and territories have discussed housing strategies within the broader context of poverty reduction strategies that incorporate timelines, targets and resources. The premise of this strategy is that people's most basic needs must be addressed for mental health services to be most effective. For example, despite Yukon's booming economy in recent years, 22% of Yukoners reported having financial difficulties to secure food (Yukon Health Status Report, 2003).

Survey data from 330 people living with mental illness revealed that income supports was cited most frequently (68%) as one of the most important supports that should be offered by housing programs. It was similarly rated by the 183 family members (69%).

81% of the people living with mental illness who were surveyed concurred with the recommendation for more housing options that subsidized rent or mortgage based on one's income. 75% of family member respondents also favoured this recommendation.

In response to an open ended item, data from 216 mental health service providers identified lack of adequate income and financial support as a significant barrier. **Subsidized housing stock was a significant need that emerged in all stakeholder surveys**.

While there was clear articulation of need in terms of financial and income supports in the survey data, the webinars clearly portrayed the systemic challenges:

- Lack of financial supports and subsidies, and disabling social assistance structures were raised by webinar participants as significant barriers to accessing appropriate housing and supports.
- A dearth of recovery-oriented practices in the form of disincentives to working were noted; people living with mental illness who work beyond a certain threshold risk termination from the income support program and jeopardize needed supports, benefits, etc. They are forced to maintain their "illness" and function "below capacity" in order to keep the income and disability support channels open and flowing.

> "I have to make sure I only work a certain amount of hours so they don't take money back and I get kicked off the program, and I need a career so I can afford to keep housing in the future. I need government support to finish school."
> -webinar participant

From the mapping process, it was observed that low ceilings for earned income are built-in systemic mechanisms that promote poverty. Prince Edward Island has the lowest ceiling for earned income for people on social assistance at $75 on a monthly basis, plus 10% of the excess as a wage exemption. This is by far the lowest rate in Canada and does not recognize the additional costs related to employment, which creates a financial disincentive for individuals to leave the social assistance system.

> "There's another issue, the change in people's situation. If you're living on ODSP or Canadian Pension, you may have drug coverage so you get your meds. But, if you go back to work, your rent goes up and you risk losing your coverage. There's a rotating door effect. Every time you get a little better, you lose support and it drags you back down."
> -webinar participant

Research corroborates the importance of financial support for successful community integration for people living with mental illness (Carling & Tanzman, 1996; Forchuk, Nelson, & Hall, 2006; Tanzman, 1993). In a 1993 study, Carling found that the people with mental illness were spending up to 80% of their income on rent, and concluded that poverty was the major issue for people with mental illness. As disability income programs

across Canada and internationally provide incomes that are below the poverty line and fail to coincide with the costs of living, few people with significant mental health challenges are able to access affordable housing (Forchuk et al., 2006).

Moving Through the Range of Housing and Supports

From the mapping exercise, numerous provinces discussed the challenges inherent in a system that lacks capacity. There is an inability, and sometimes an unwillingness, to identify ways in which people can move to various housing and support options. More precisely, while there is no doubt that people have the right to remain in whatever housing arrangement they currently have, one of the unintended consequences of the principle of permanent housing, is the 'blocking' of higher supports options, sometimes by people who do not necessarily want or need this level of support. At the present time, insufficient private rental market options, inadequate income assistance programs with respect to shelter costs, and insufficient mental health housing options 'block' people at different points in the range of housing. For example, people may be ready and wanting to move to more independent options, but there is nowhere for them to go. This reality, combined with little capacity in affordable housing options, has serious consequences from both a health outcomes and cost efficiency perspective, especially because of the impact it has on people awaiting discharge from hospital settings. **A national strategy related to mental health services and housing options needs to carefully consider and integrate strategies that promote systems flow and empower people in finding and maintaining housing and support options that are a good fit to their needs and wants**.

Barriers in Transitioning Clients from Hospitals to Housing

In its simplest form, Alternate Level of Care (ALC) refers to patients who are staying in hospital when they are able to live in the community. Ultimately, people who require access to inpatient beds cannot do so because appropriate housing and/or supports are unavailable for ALC patients awaiting discharge. This results in inefficient use of system resources, inappropriate care and support, and poor outcomes.

Survey results from 35 respondents representing hospitals identified the issues as **barriers to discharge**. The ten most prevalent barriers reported based on frequency are as follows:

- Existing service capacity is inadequate to meet demand (91%).
- Funding levels do not support the provision of additional supports (83%).
- Lack of integrated mental health and housing services (69%).
- Existing service models do not meet criminal justice sector support needs (63%).
- Existing service models do not meet youth-specific support needs (63%).
- Staff skill level and/or staff training is not sufficient to meet all support needs (63%).
- Exclusionary criteria prevents meeting needs (63%).
- Staff skill level in private accommodations (e.g., lodging homes) is insufficient to meet people's needs (63%).
- Fragmented/uncoordinated service delivery systems (57%).

Maintaining strong networks with community providers was identified by hospital respondents as crucial to overcoming barriers when discharging clients; **almost 86% agreed that a good relationship between hospitals and community providers was a key element in enhancing access to housing and supports on discharge, thereby facilitating appropriate discharge into the community**.

INNOVATIONS

Hamilton House: Post-Discharge Transition Program – Canadian Mental Health Association (Calgary, Alberta)

Hamilton House is a partnership between the Calgary Region of the Canadian Mental Health Association (CMHA) and Alberta Health Services (AHS). It is an eight bed transitional housing program which offers an alternate level of support to individuals with a sever and persistent mental illness that puts them at risk for repeated of prolonged hospitalization and who have been unsuccessful in attempts to live independently or access other housing supports. Clients must have a primary Axis I diagnosis, but may have concurrent Axis II and substance abuse disorders. Referrals are only accepted from the inpatient mental health units within the AHS Calgary Zone, thus making it an exclusive hospital discharge program. This is one of the few housing programs in Calgary that operates from a harm reduction philosophy.

Hamilton House provides 24-hour intensive support within a group living environment to facilitate transition within six months to a long-term living arrangement, while focusing on each client's highest level of independence. Each client works with his/her supportive living coordinator to establish and individualized service plan that facilitates skill development and the establishment of a collaborative support network including mental health, housing, recreational, employment and other community resources. In-house groups that promote wellness and recovery are conducted on a regular basis.

This unique partnership between AHS and CMHA provides a number of benefits to clients in the program. The home is run by CMHA staff, including a program manager and supportive living coordinators. A full-time nurse employed by AHS works out of the home to monitor symptoms and medications, and a dedicated psychiatrist provides follow up for clients who do not have a community psychiatrist. These features allow for community stabilization of mental health symptoms and reduce hospitalization of clients. The partnership further facilitates access to a greater range of supports; community resources are provided through CMHA staff, in conjunction with Alberta Health Services supports, and accessed through the AHS nurse.

As a new initiative, an extensive evaluation was completed on the program. Highlights include increase in scores on the Global Assessment of Functioning, the Goal Attainment Scale and the Life Skills Profile, as well as a decrease in symptom severity as reflected by reduced scores on the Brief Psychotic Rating Scale. Anecdotal reports from clients indicated a significant reduction in isolation and increased feelings of self-esteem, self worth, safety and security. While no other program exists in Alberta to allow outcome comparisons, the finding that over 50% transitioned to some form of supportive living is viewed as positive given the high needs and housing history of this client population.

INNOVATIONS

Transitional Rehabilitation Housing Project (Ottawa and Toronto, Ontario)

In 2007, the provincial Ministry of Health & Long-Term Care funded the Transitional Rehabilitation Housing Project (TRHP) through the Service Enhancement funding initiative, targeting people with mental illness in the criminal justice system. TRHP sites were funded in both Ottawa and Toronto. New and smaller TRHPs have been implemented in St. Thomas/London, North Bay and Whitby.

In Ottawa, three organizations deliver the project through a co-operative partnership: two are community mental health providers, Ottawa Salus and CMHA Ottawa, while the other is a regional specialized mental health hospital, Royal Ottawa Health Care Group (ROHCG). TRHP includes two components for people being discharged/transitioned from the forensic inpatient units at the ROHCG: (1) a 4-bedroom transitional home called "Grove" and (2) six satellite apartments. Both components include ongoing case management and housing support.

The Toronto TRHP involves collaboration between the Centre for Addiction and Mental Health (CAMH) and CMHA Toronto. Clients are discharged from CAMH's Law and Mental Health Program to an apartment building owned and managed by CMHA Toronto. The housing stock includes one-bedroom and two-bedroom apartments. The building is occupied by TRHP and other CMHA clients with criminal justice sector involvement. Like Ottawa, the TRHP program offers ongoing case management and housing support. Key features of the TRHP programs in Ottawa and Toronto include: flexibility to respond to the changing needs of participants; a range of providers to allow for rapid, preventative measures to be implemented in serving people; and recovery orientation (the key is empowering clients and promoting a sense of normalcy).

As far back as the mid-90's,, the impetus for the development of transitional housing included the need for recovery-oriented hosing and support options for this population, and the pressure to discharge patients from inpatient beds.

Anecdotally, all organizations involved agree that though the program is relatively new, it has had a major impact on discharge rates and timelines. Furthermore, a larger number of inpatients at the regional mental health hospitals would be able to transition to the community more effectively if program capacity was increased.

Gaps in Serving Sub-Populations

CONCURRENT DISORDERS

Survey data from 330 people living with mental illness identifies trends which suggest that individuals with concurrent disorders face greater challenges in finding and keeping housing than do individuals with a mental illness only. Greater discrimination and financial difficulty was reported by this sub-population.

Amongst the 96 housing providers, support for people with concurrent disorders rated within the top five support needs reported as not being met. Amongst service gaps for populations, concurrent disorders figured as one of the most prominent, both at the agency and regional levels, 35% and 65% respectively. **The prevalent gap between support needs for people with concurrent disorders and available services from both agencies and regions clearly illustrates the need for greater supports**.

Supports for concurrent disorders also figured amongst the top five new and emerging needs in the data from mental health service providers, and hospital administrators and clinical leads. 52% of the 216 mental health

service provider respondents and 42% of the 35 respondents representing hospitals cited this as a need that warranted immediate consideration.

In addition to the survey data, webinar participants identified people with concurrent disorders as a population particularly lacking in adequate supports, services and housing options.

Site visits also evidenced this existing gap. While there were some innovative models were low barrier options, the majority of programs did not cater to people with concurrent disorders. Some innovations, such as Bolivar Court in British Columbia, arose in response to this challenge (highlighted in Section Eight).

DUAL DIAGNOSIS

Survey data from housing providers also illustrates a gap between available supports for people with dual diagnoses and the needs of this population. 32% of the 96 respondents reported a gap existed in their agency and 45% reported a gap at the regional level.

Treatment and support for people with dual diagnoses was identified by hospital administrators and clinical leads (27%) and mental health service providers (21%) as one of the five most important supports not being met. 9% of the 35 hospital respondents believed it was, in fact, the most important.

As one of the new and emerging housing and related mental health related support needs, people with dual diagnoses were viewed as requiring immediate consideration by surveyed housing providers, mental health service providers, and hospital administrators and clinical leads. It was ranked the second most important new and emerging need by housing providers, third by mental health service providers, and fourth by hospital administrators and clinical leads.

YOUTH AND YOUNG ADULTS

Young Adults

Youth under 24 years of age is considered the fastest growing segment of the homeless population in Canada (Koeller, 2008). The lack of supports for young adults was widely identified by survey respondents. Amongst the 96 housing providers, social providers were most concerned with the lack of services; 75% of respondents stated that support needs for young adults was a critical need. The need for housing and supports for this population group was also significant in rural and remote communities; for more details, see the upcoming section on rural-remote challenges.

In data from 216 mental health service providers, the largest gap between services available and the needs of young adults was reported in Nova Scotia and Ontario.

Webinar participants highlighted the lack of system planning and housing options, as well as **the need to address systemic issues and gaps in service for young adults, particularly those between the ages of 18 and 19 years**.

INNOVATIONS

"RÉSIDENCE PAUL-PAUL" HOUSING AND SUPPORT MODEL IN RESPONSE TO AN EMERGING TREND OF YOUTH CLIENTS (MONTREAL, QUEBEC)

A unique Montreal model is "Résidence Paul-Paul" managed by the "Direction des services de réadaptation et d'hébergement dans la communauté" of Montreal's Louis-H. Lafontaine Hospital. This innovative resource offers services to meet the recovery needs of more recent and younger cohorts of youth and young adults experiencing mental health problems.

Paul-Paul residence is a housing and support model that specifically targets transitional needs. Tyically, residents are youth in care who are about to turn 18 and leaving the care of youth protection services. A collaborative partnership was formed between the Rivière-des-Prairies Hospital and the "Centre Jeunesse de Montréal – Institut Universitaire" and Louis-H. Lafontaine Hospital to offer an integrated housing and support model to transitional youth.

The "Résidence Paul-Paul" is a group home that houses and counsels up to 9 young adults aged 16 to 20 years old. It offers highly individualized psychosocial rehabilitation and recovery services which allows youth to adapt at their own pace to their young adult freedom and independence, and also meet the challenges of their mental health issues while transition to adult services.

Services for these young adults include housing, employment and educational supports, psycho affective services and psychiatric follow-up by professionals including special educators, residential practitioners, nurses and a part-time sex therapist. The team supports the development of independence, motivation, social integration and interpersonal skills.

Youth

Gaps in services for youth were cited as a significant challenge in many of the discussions with reference group members as well as in the site visits. In Prince Edward Island, there was specific reference to inadequate housing available to youth and inappropriate stock where young women were housed in seniors' housing. Reference group members in Manitoba mentioned it was challenging to find housing for youth due to their intensive needs and sometimes the preferable option, in the context of limited housing and support options, was to house them in a single room occupancy (SRO) type of environment where meals and some supports are provided as they sometimes lack the skills to live alone in an apartment. For example, at the site visits to "Pathways to Housing" in Calgary, one of the greatest challenges cited was housing youth in independent living as many of them had a co-occurring disorder and lacked independent living skills.

Survey data from 96 housing providers reflected that youth specific housing and support challenges were significantly greater in remote communities. **Of the 35 respondents representing hospitals, around 63% felt that existing service models do not meet youth-specific support needs, which poses a barrier to discharging clients to the community**.

INNOVATIONS

TRANSITIONING FROM A GROUP HOME MODEL TO SUPPORTED INDEPENDENT LIVING: WATSON HOUSE – A GROUP HOME MODEL (VANCOUVER, B.C.)

Watson House is an eight-bedroom restored heritage home for young adults living with a mental illness. The Watson House project is a two-year transitional program in partnership between the federal, provincial, and municipal governments, the Mole Hill Community Housing Society, and the Coast Foundation Society, to provide housing and support to young people as they establish themselves within the community. Vancouver Coastal Health provides annual operating funding.

Young clients recovering from mental illness have their own rooms with shared bathrooms and common living and kitchen space. On-site staff support is provided by Coast Mental Health during the day. Staff act as referral sources to other agencies and services, especially for education and employment. They also work with assigned clients to set specific personal goals and move them towards goal achievement. The group home provides an opportunity to develop life skills in a supportive environment that is crucial for young clients who have not previously experienced independent living. Residents take turns to cook group meals once daily. Individual clients are responsible for cleaning and other chores. As medication compliance is an issue with young clients there are regular symptom management groups, as well as recreational and leisure groups. Clients generate much of the group activity.

The Transition to Supported Independent Living

During the two years at Watson House, the clients are supported in meeting their housing goals with the majority transitioning to market rent units. Coast Mental Health tries to arrange supported independent living for these clients. Market rent housing is facilitated through the Supported Independent Living (SIL) subsidies which top up the welfare amount to match the rent. Through the SIL staff, supports and rent supplements are made available for an additional two years during which time many of the clients reach a level of recovery to enable them move out of the SIL. Some move onto SIL provided by another agency. Moving out of the SIL means that while the support is withdrawn, tenants can continue to live in the same setting.

This model facilitates a shift in the range of housing and related supports with a seamless support network, helps young adults move towards independence and develops their skills to assist them in maintaining their housing.

The Aging Population

Our aging population requires serious consideration to ensure their needs are met through housing and support models and future policy frameworks. The marginalization of people living with mental illness within the housing market will be compounded with aging (Beer & Faulkner, 2009). Survey data from 96 housing providers highlighted the growing concerns of this population:

- 83% of housing providers from Ontario reported challenges to aging as a concern and this was also an issue in Saskatchewan, Manitoba, and Alberta.
- 52% endorsed the recommendation for better supports for the aging population.
- Just under half felt that supports for aging individuals was a current challenge and endorsed the recommendation for the development of supports.

In the survey data from 35 hospital representatives, all participants from Alberta, British Columbia, Newfoundland and Labrador, and Quebec, as well as 84% of participants from Ontario stated that supports for the aging population was a significant need.

Seniors in Canada who need mental health supports are becoming homeless more rapidly than in the past.

A key observation from the mapping process was that as the population ages, there will be increasing pressure on ensuring that long-term care options are well supported by mental health services. Currently, either the existing capacity is insufficient in some provinces such as Newfoundland and Labrador, or there is no capacity, such as in Manitoba. Concurrent planning is also needed to address how seniors with mental illness and co-occurring physical health issues are best served within the range of housing and supports.

Webinar participants further emphasized **stigma among some nursing homes as evidenced in their reluctance to accept persons with mental illness, making it even more problematic for this population to access housing**.

CULTURALLY DIVERSE POPULATIONS

The reference group in Ontario underscored the need for housing and supports for culturally diverse populations and recent immigrants and refugee claimants. This was not surprising considering that Ontario received the largest number of immigrants to Canada, with more than 75% settling in Toronto. Another dimension raised was the government policy which denies social housing for migrants with no status. This could be an additional risk factor for some newcomers who are at a greater mental health risk due to pre-migration trauma and post-migration settlement stressors. Reference group and site visit consultations acknowledged the growing diversity of demographic populations as an issue to be considered; there has not been much thought around addressing the needs of these diverse populations. and the lack of planning may well have long-term implications.

Survey data indicated that only 26% of the 96 housing providers were able to meet the cultural needs of their clients, 61% partially meet the needs and 8% reported an inability to meet these cultural needs. **An even lesser percentage of mental health service providers (15%) indicated that they were fully able to meeting the cultural needs of the clients**, 74% were partially able and 7% reported an inability to meet cultural needs. The primary reasons why providers are unable to meet their clients' cultural needs are listed below.

Reason for Being Unable to Meet Clients' Cultural Needs	Mental Health Service Providers (*n* = 216)	Housing Providers (*n* = 96)
Inadequate staff training and/or skill level in providing culturally competent services	22%	**34%**
Unable to meet language needs	21%	**23%**
Insufficient staffing levels	**18%**	**19%**

The report, *Best Practices in Developing Anti-Oppressive, Culturally Competent Supportive Housing* (Warner et al., 2008), reflects some of these gaps in its recommendations. A key recommendation in the report emphasized the need for governments to increase funding and support for capacity building and cultural competence training for housing and support services.

Findings from the mapping process identified a tremendous unmet need for new Canadians with histories of trauma, abuse, torture and illness. Coupled with significant stigma issues, new Canadians are more likely to be part of the 'hidden homeless' population as they double up housing arrangements with other families. These challenges are strikingly similar to those faced by Aboriginal persons.

THE ABORIGINAL POPULATION

Roundtable discussions with Aboriginal[15] leaders, site visits and webinar data yielded rich insights into the challenges faced by the Aboriginal population. Almost all of the site visits to the various provinces identified a dearth of services for this population. It was frequently mentioned that mistrust ran so deep in the cities that the homeless Aboriginal population, and those otherwise marginalized due to mental health and addiction issues, preferred shelters or to sleep under bridges rather than avail themselves of the housing and supports offered by mainstream agencies. Reference group consultations revealed major issues including racism, lack of understanding of cultural differences, lack of trust and inherent tensions as barriers to providing needed supports to this population. Lack of culturally specific programming and failure to provide an environment of cultural safety were byproducts of these barriers. The roundtable discussion noted that because the Aboriginal population is growing exponentially, issues around housing and co-morbid health problems is becoming a challenge.

An increasing percentage of the Aboriginal population is migrating from the reserves and the larger Canadian society is not equipped to deal with the challenges this poses. For example, there is a phenomenal in-migration of Aboriginal persons into Northwestern Ontario. In many cities, there is a much higher representation of the Aboriginal population amongst the homeless and impoverished. The National Aboriginal Housing Association's action plan (2009), *A Time for Action: A National Plan to Address Aboriginal Housing*, highlights some key considerations related to housing need among the non-reserve Aboriginal population:

- A funding mechanism is needed to respond to the disproportionally large level of housing need among the non-reserve Aboriginal population, which is much higher than among non-Aboriginal people.
- High rates of homelessness exist not only in large but also small, urban centres.
- Overall housing stock is at risk due to imminent expiration of operating and subsidy agreements.
- Current housing funding frameworks are competitive and have disadvantaged proposals to address the housing needs of the Aboriginal population.
- Access to dedicated funding to address homelessness has been burdened with excessive process.

There are also housing problems on the reserves; the rates of housing need among Aboriginal persons on-reserve is twice that of the general non-Aboriginal population in Canada (Hay, 2005). Additional challenges which are critical and of imminent concern include:

- Infrastructure problems (e.g., inadequate water and sewage systems).
- Overcrowding.

Participants in the webinar for the North discussed the issues specific to the Aboriginal communities in that region including: lack of housing options; the need for self-governance and ownership or involvement in program planning for their community; the need to evaluate Euro-based versus traditional Aboriginal approaches to mental health; and, the need to address the inherent racism that surrounds the Aboriginal people, specifically the assumption of high drug and alcohol abuse within this population and the tailoring of services exclusively around these parameters. Also identified was the lack of cultural awareness and the variety of cultures within Aboriginal communities, and its influence on the needs of people living with mental illness.

> "When we go to the hospitals, hospitals always put it down to drug and alcohol abuse. If doesn't address mental health issues at all. It's an automatic assumption. Sometimes it is [drugs and alcohol above], and sometimes it isn't, but it's pure racism."
> -webinar participant

[15] The research team recognizes that different challenges in housing and mental health supports can face people who are First Nations, Métis, or Inuit and that each of these communities has some unique characteristics that differ from the others. For ease of reading, the report uses "Aboriginal" peoples rather than First Nations, Métis, and Inuit peoples.

Lack of housing and supports for the Aboriginal populations is prevalent across provinces. Of the existing housing projects in some regions, few are specifically targeted to those with mental health and addictions. Housing and supports offered through mainstream organizations are rarely accessed.

Appendix Six provides a more in-depth analysis of the housing and related support challenges faced by First Nations, Inuit, and Métis people.

INNOVATIONS

AT HOME/CHEZ SOI PROJECT (WINNIPEG, MANITOBA)

In Winnipeg, the national demonstration project concentrates on the inner city which has a disproportionately high Aboriginal population and hence the specific focus on the Aboriginal group in this site of the project. The team, which includes MHCC national staff, provincial departments, and the site coordinator spent a considerable amount of time and effort building trust in the Aboriginal population; numerous community meetings and information sessions were hosted to build knowledge and awareness of the Housing First framework which had not been used in Winnipeg. This was greatly facilitated by having two community based organizations (CBOs) come aboard the project. One of the partners of the project, the Institute of Urban Studies of the University of Winnipeg, had previously worked with the CBOs and this helped the process. It also necessitated additional training and capacity building for the CBOs in case management and other support services related to mental health as it was new territory for them. One of the CBOs was not a health centre, but more of a community based training and life skills enhancing centre. However, this investment was worthwhile as the Aboriginal community is more amenable to accessing services through these CBOs in comparison to services offered through mainstream organizations. Also, the intensive case management model for this community is a hybrid model which incorporates Aboriginal health and wellness practices.

While this initiative is just underway and the results are yet to be seen, reaching out to the community by working with and creating capacity in organizations trusted by them, and using these organizations as vehicles of change is an innovative and significant step in the right direction.

Challenges in the Context of People Living with Family Members

Research demonstrates that people with mental illness share the same preferences for the place they call home as those without mental illness. People with mental illness want to live independent lives, whether on their own or with whom they choose (partners, family, friends, chosen roommates), in affordable and regular homes in livable neighborhoods with nearby amenities such as transportation, shops, community services, and other desirable features (Browne & Courtney, 2005; Carling & Tanzman, 2006; Forchuk, Nelson, & Hall, 2006; Parkinson & Nelson, 2003; Rogers, Danley, Anthony, Martin, & Walsh, 1994; Seilheimer & Doyal, 1996; Tanzman, 1993; Warren & Bell, 2000).

An Australian review of important housing characteristics identified six main themes also supported by other recent research, including Canadian sources (O'Brien, Inglis, Herbert, & Reynolds, 2002). Independence and choice rated the highest, followed by convenient location, safety and comfort, affordability, privacy and social opportunity.

Survey data clearly reflected it is challenging when people with mental illness live with family members. The fact that more than 31% of the respondents amongst the 183 family member stakeholders had a family member with mental illness living with them, or with other family members, is reflective of a group that wants to be heard.

Of the 330 people living with mental illness who completed the survey, one of the highest rates of dissatisfaction with current living arrangements was expressed by those living with their families (22%). Half of the respondents stated they would move to new housing if they had the option and identified the following motivators:

- More independence (42%).
- Less distance to family and friends (34%).
- More mental health services (33%).
- More physical health supports (25%).
- Less distance to public transportation (21%).

While proximity to family is desired, independence is highly valued. **Living arrangements that promote independence while also helping maintain social and familial connections are important to recovery**.

Among the 183 family members who completed the survey, more mental health services was indicated as most needed by respondents whose family members were living in a place not meant for people with mental health problems (40%) and by respondents whose family members were living with them (28%). By extension, lack of adequate mental health supports is seen as a key challenge to people living with mental illness and their families when residing together.

Respondents who had family members living with them (38%) or with other family members (44%) reported independence as a greater need as well as the need for on-site support workers. Lack of adequate housing options with on-site supports may force families to take care of their loved ones in less than optimal arrangements.

> "Family is support I can count on. But at one time my parents weren't able to any longer, I felt guilty. We tend to depend on family around the person but not all families have the ability."
> -webinar participant

Reference group consultations and webinar participants also spoke to issues faced by aging caregivers to family members with mental health problems who live with them. The perspective of reference group members was largely around caregivers' long-term options and a looming predicament that needs to be addressed. Webinar participants highlighted the lack of planning for this population group. Consultations with the *Turning the Key* project steering committee around initial findings revealed this as a largely hidden need now being vocalized through this research process. Meeting this challenge will necessitate factoring into calculations and cost additional housing stock and supports required to meet the needs of this specific population group.

Rural, Remote, and Northern Challenges

Findings from multiple date sources pointed to very limited housing stock, lack of a range of housing options, limited funding, inadequate staffing, staff training and retention, and limited resources in terms of housing supports as significant issues in rural and remote communities.

Discussions with reference groups and key informants from the mapping exercise highlighted a number of considerations for planning exercises for housing and supports:

- What works well in urban areas will not necessarily transfer as successfully to rural areas; in fact, some community context factors will be reversed.
- There is often insufficient 'critical mass' to support the creation of certain housing and support options (i.e., the small size of the population has not yet generated a large enough need; in the absence of options, people will be forced to leave their home communities to access appropriate housing).
- Geographic centralization of services and housing options, and the lack of transportation to these services.

- Smaller, more rural regions tend to have very limited or no options for mental health oriented housing, particularly in the area of support, which forces residents to move to larger communities where they are more isolated.
- The tremendous stigma often attached to mental illness in rural communities makes people reluctant to seek help.
- Resources for the identification of mental illness are very limited.

These concerns were echoed in the webinar discussions where participants spoke to the challenges of living in rural and remote areas, including the negative effects of having to leave one's community to travel to large urban centers to access needed care or supports. One example is the very limited mental health services in the territories, necessitating out of territory referrals. Lack of housing options, supports and services, issues with transportation (also evident in urban areas with respect to lack of choice), and the high costs of building housing stock and expanding limited road access were also touched upon. The issues faced by those in rural/remote areas were identified as being unique and needed to be addressed as such.

Survey data showed that for the 17 housing providers serving remote communities, transition aged youth services was an unmet significant support need. Another prevalent issue in remote communities was that of youth-specific needs (not met by existing service models); 83% of remote providers reported this as a barrier that prevents people from retaining their housing as opposed to the 36% of non-remote providers.

Consistent with reports from housing providers, a divide existed between the need for transition aged youth services among remote and non-remote mental health service providers. Of the 87 remote providers, 48% believed there was a dire need for services for transitional aged youths, much higher than non-remote providers (28%). Many of the crisis services (i.e., crisis beds, telephone crisis lines, and mobile crisis services) were also reported as not being met at a higher rate among remote providers than among non-remote providers.

The 17 housing providers serving remote communities were more accepting of two recommendations than were non-remote providers: **(1) the need for adequate training of staff** and **(2) identification of lead agencies to address housing and support needs**. Both garnered support from more than 80% of remote providers, while less than 40% of non-remote providers backed the recommendations.

The recommendations reflected the challenges that rural and remote communities face. In the site visits to rural communities in Manitoba, British Columbia, and Saskatchewan, staff training and staff retention came up as significant issues. This was also found during the visits to the Atlantic Provinces; difficulty in recruiting and retaining mental health professionals was a specific challenge in Newfoundland. Prince Edward Island reported no resident psychiatrists in rural areas.

Remote areas experience significant challenges in building new housing. For example, a review of the Nunavut Housing Trust by Deloitte and Touche (2010) identified a $60 million shortfall that is required to complete construction on 725 new units. Challenges in building new housing in remote and Northern communities include:

- Material logistics and shipment
- Limited construction season
- Labour availability and retention
- Storage and protection of materials
- Ability to replace material in remote locations
- Access issues across vast geographic areas
- Continuity of management

Providers in these areas report a sense of professional isolation (Housing Assistance Council, 2001) which is attributed to lack of continuing educational opportunities, financial incentives, and Survey data showed that in the assessment of barriers that prevent people from meeting their support needs that assist in the retention of housing, nearly half the listed barriers were rated significantly higher by the 87 remote mental health service providers than by the 129 non-remote providers. Remote providers more frequently identified the following as barriers: existing service models do not meet aging needs, criminal justice support needs, culture-specific needs

and gender-specific needs; the non-existence of inter-agency partnerships; insufficient staff training and/or skill level; and, the fragmentation of service delivery systems.

Analyses also showed that housing providers serving remote areas reported greater difficulty in transitioning tenants to new housing than those serving non-remote areas.

In addition to the challenge of recruiting and retaining professional staff (Housing Assistance Council, 2001; Rajkumar & Hoolahan, 2004; Sawyer, Gale, & Lambert, 2006; Turpin, Bartlett, Kavanagh, & Gallois, 2007), rural, northern and remote regions in Canada particularly stressed severe shortages of health care workers (Pong & Russell, 2003). Generally, the number of doctors per 1,000 rural residents is much lower than for urban residents, and on average, the distance to a doctor is much greater (Ryan-Nicholls, 2004).

Site visits also underscored the importance of partnerships with a lead agency model to address housing and support needs in an under resourced environment. A case in point is Eden Health Services in Winkler, Manitoba which follows this lead agency model.

INNOVATIONS

A CENTRALIZED COMMUNITY HUB MODEL – EDEN HEALTH CARE SERVICES (WINKLER, MANITOBA)

Eden Health Care Services is a 43-year-old community based organization run by the Mennonite Faith Community and is the primary provider of health care, housing, and support services in Winkler, which is a predominantly Mennonite community. Eden Health Care Services works in close coordination with multiple health authorities, to provide services to many parts of rural/remote Manitoba. It is an example of a well established and accepted community base expanded to meet the needs of the population.

The organization moved from a long-term care approach to mental health to an acute care approach. They run a 30-bed, acute mental health unit, primarily funded by the Central Regional Health Authority through a Service Purchase Agreement. In addition, Eden operates a range of community based mental health recovery programs spanning the generations from child and adolescent to adult to psycho geriatric services. Other programs include supported housing, employment and a professional counseling service.

There is a close partnership between Eden Health Services, the Regional Health Authority, and the Ministry of Family Services and Housing. As the communities around Winkler are small and remote, there is a tendency to gravitate towards Winkler for services. Thus, there is a higher concentration of people with mental health issues in this community. Eden Health Care Services administers the Portable Housing Benefits for the region. They also function as both the housing provider and landlord in providing housing for people with mental health and addictions. Subsidies are received from Manitoba Housing. They provide a range of housing, from transitional group homes to permanent, independent apartments. As with many housing providers, sustaining the quality of housing proves to be a challenge as there is limited funding available. Various supports are made available to tenants in the housing. They have access to a tenant service relations coordinator, community mental health workers, case managers, and proctors. Employment supports and vocational rehabilitation services are also made available to the tenants as well as the larger community. Some of the services are provided by the health authority in collaboration with Eden Health Care Services. Employees of the health authorities working in this collaboration report to Eden Health Care Services.

Landlord and Tenancy Issues

The mapping and webinars showed that **many provinces and territories identify stigma and discrimination as major barriers for people trying to access private, market rent housing**. The maps highlight the importance of

developing educational strategies for landlords to reduce bias and provide ongoing supports to both tenants and landlords to promote maintaining tenancies.

Survey data revealed that assistance in dealing with landlords was a support that was significantly correlated to housing arrangements; 16 people with mental illness who were renting a subsidized apartment identified this as a significant support need (94%). One of the highest rates of dissatisfaction with current housing arrangement was expressed by those renting a place not dedicated to people with mental health problems. This suggests that landlords of non-dedicated housing stock may not be supportive of or sensitive to the needs of those with mental health problems or illnesses. Fear of eviction was also a primary cause of concern regarding current living arrangement.

80% of the 183 family respondents agreed to the statement that **supports are needed to help prevent eviction**. They also noted discrimination as a significant challenge when trying to find and maintain housing.

Eight of the twelve social housing providers indicated that orientation to better practice models was a significant training need, revealing that social housing providers themselves lacked knowledge in dealing with people living with mental illness. In response to this challenge, several provinces like Manitoba, British Columbia, and Ontario have developed successful partnerships with social housing providers to enhance landlord support in social housing. Stigma reduction that specifically targets landlords was seen as a significant support need by the 96 housing providers. This was also highlighted by mental health service providers, however, received greater support from housing providers. Around 48% of the 216 mental health service providers confirmed they were involved in developing relationships with landlords.

> "When my roommate was in the hospital, her rent check decreased, but we had an understanding landlord so all three of us didn't have to become homeless."
> -webinar participant

Throughout the webinars, participants reported the stigma variously experienced in interactions with landlords, employers, the community, police, etc., and voiced the need for public education to change society's views of individuals with mental illness. **Additionally, people reported their experiences of losing housing on admission to hospital**. This directs attention to housing maintenance policies and supports during periods of hospitalization.

Planning, Coordination, and Integration Challenges

In earlier sections of this chapter, there are many pointers to lack of coordination and integration between housing and supports which lead to gaps in services for certain sub-populations and the creation and maintenance of less than optimal living arrangements. Gaps between housing providers and mental health service providers, between service providers and landlords, between housing needs and funding priorities are but a few examples.

Survey data reveals that the 12 social housing providers reported the least integration between mental health services and housing providers. The 26 mixed model providers (i.e., housing models where some degree of stock is allocated for people living with mental illness) reported slightly more integration while the 55 dedicated providers indicated the most integration. This disjunct will make it more difficult for social housing providers to accept people with mental health problems and illnesses because of the lack of support in dealing with this population group.

Integrated mental health and housing services was amongst the top five support needs reported as not being met by the 96 housing providers, the 35 hospital respondents and the 216 mental health service providers.

The need for cross-ministerial partnerships for planning and funding purposes was endorsed by 53% of the 216 mental health service providers. This was endorsed by 54% of the 96 housing providers while development of partnerships with funders was endorsed by 41%.

Reference group consultations and provincial and territorial maps strongly echoed the lack of coordination between key stakeholders including funders, policy makers, housing and service providers as a challenge in developing efficient and operational housing and support strategies for people with mental illnesses. Key messages include:

- **Needed coordination**: viable solutions require interdepartmental collaboration with creative solutions. Coordination across ministries and agencies to address housing and support needs for people living with mental illness as well as across various levels of government needs to continue to improve. Specific expectations at the interdepartmental, interagency, and front-line worker level are often lacking.
- **Lack of stability in leadership**: cabinet shuffles and changes in leadership for the relevant departments or ministries can create confusion and change at the service delivery level.
- **Mechanisms in place for service delivery**: good will is not sufficient. For example, that Yukon has four levels of government and over 100 non-governmental organizations serving a population of just under 33,000 people; this creates unique challenges in virtually all aspects of organizational administrations.

Reference group members also cited some innovative partnerships, such as the Cross Departmental Coordination Initiative in Manitoba, that have been highlighted in Section Eight of this report.

Ongoing Needs Assessment and System Planning

Informants to the mapping process and reference group members identified a number of challenges in terms of estimating the true need of people living with mental illness with respect to housing and support options. One such problem is the disconnect between existing exercises in estimating need for housing and support versus the reality on the ground. Many people living with mental illness do not have a diagnosis per se, but they have significant mental health issues together with affordable housing needs as well as emerging physical health needs. **Having comprehensive, sufficient, and reliable data available to do accurate assessments of housing and homelessness issues, mental health issues, and to evaluate existing interventions is a systemic gap**.

The level of demand for housing and supports at the front-line level, coupled with inadequate levels of resources, promotes a "crisis reaction" approach to planning rather than a proactive one. Planning and funding of housing and support needs for people living with mental illness must determine potential future needs and incorporate flexibility to allow change or shifts in models in response to systemic demands.

Many people who fall through the cracks are people with complex mental health and addictions issues that often stem from long histories of trauma and marginalization and do not always fit clearly into the categories of the mental health system.

D**emographic shifts** need to be considered when estimating housing and support needs in the future (e.g., significant increases in aging population and a growing Aboriginal population).

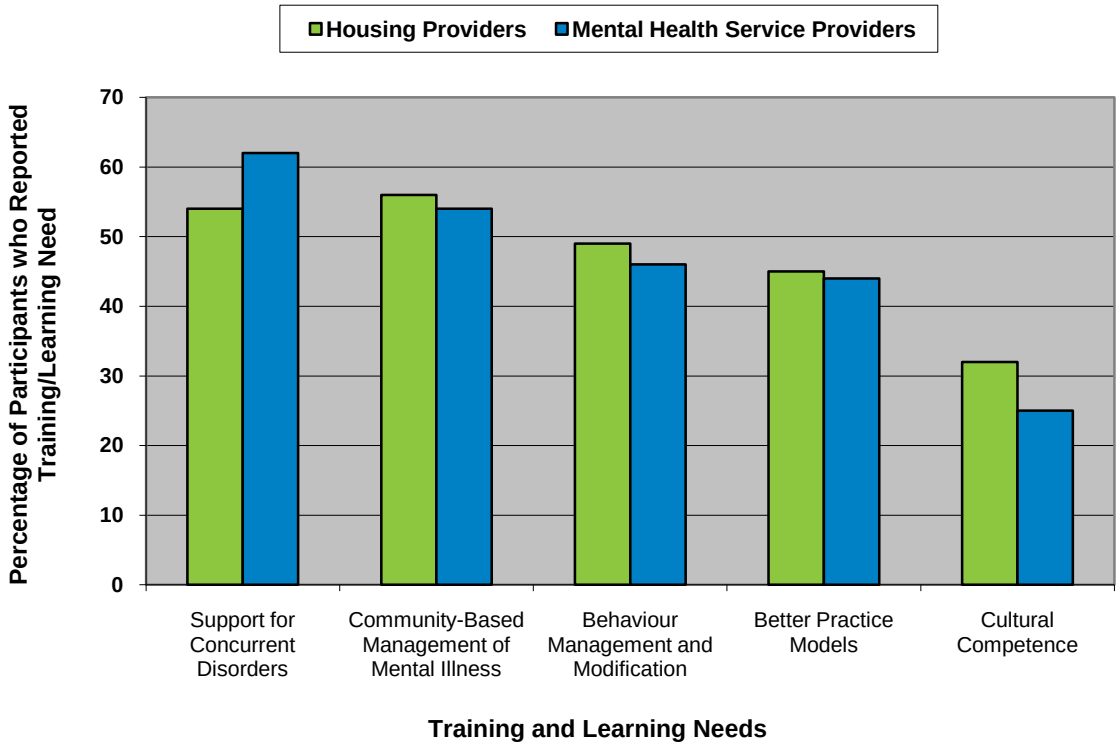
Inadequate Staff Supports and Training

"…They also check up on me, make sure my place is okay, and if I like it. They have been a wonderful support for me and have made my days easier, both physically and mentally."
-tenant housed through a Portable Housing Benefit Program

In reference to both mental health and housing support service, the importance of adequate staff, staff sensitivity, support and skill was underscored as basic to all supports provided. This was highlighted in interactions with people living with mental illness during site visits. The lack of funding for adequate staff training, and the lack of opportunities for staff training in the context of housing and related supports was highlighted by service providers, especially within the housing sector and in rural/remote areas. The lack of funding to invite qualified people to offer in-service training and or send existing staff for additional training was noted in the Atlantic Provinces.

Survey data from 96 housing providers and 216 mental health service providers highlighted the need for major training and learning within their agencies. The difficulty of recruiting and retaining mental health professionals was an issue in rural/remote communities in Prince Edward Island and Newfoundland and Labrador. Support for concurrent disorders arose as a major need for both types of providers. Figure 1 summarizes the training and learning needs that were identified.

Figure 1. *Survey data from housing providers and mental health service providers of their agency's training and learning needs.*



HOW DO WE MEASURE UP? HEALTH, HUMAN RIGHTS, AND HOUSING POLICY

The Broader Social Policy Context of Mental Health and Housing: Housing as a Social Determinant of Health

"Housing is an absolute necessity for living a healthy life and living in unsafe, unaffordable or insecure housing increases the risk of many health problems. Lack of economic resources is the prime reason many Canadians experience housing problems. Housing is a public policy issue because governments have a responsibility to provide citizens with the prerequisites of health. Canada is signatory to numerous international human rights agreements that guarantee the provision of shelter" (Mikkonen & Raphael, 2010).

The greatest influences on our health status are not addressed through our traditional health care system. Traditional health care is only one of twelve key determinants of health as indentified by Health Canada. **The single most important determinant of our health is income and social status, due in no small part to the impact this has on the type and quality of housing that can be secured** (housing is one component of our physical environment, another determinant of health). By extension, income and social status also impact and interact with other determinants of health, such as social support networks, personal health practices and coping skills, and healthy child development (Mikkonen & Raphael, 2010; Bryant 2003).

A recent analysis of changes in income inequality across thirty developed countries concluded that income inequality has increased since the mid-1980s in most, if not all, of the countries (Organisation for Economic Co-operation and Development, 2008). **Canada was identified as one of a small group of countries that have had significant increases in income inequality since the mid-1990s**.

In 1980, a family at the 90th percentile of the income distribution earned 15 times the income of a family at the 10th percentile. By 2000, a 90th percentile family earned 32 times as much as a 10th percentile family. Although the median family income in Canada increased by 19.3% between 2000 and 2005, 20.6% of Canada's families lived in poverty in 2005. Between 1980 and 2005, the poverty rate as measured by the 'Low Income Cut-Off' measure has dipped below 20% only once; this occurred in 1989 (Community Foundations of Canada, 2008).

Mikkonen and Raphael (2010) provide the following summary with respect to Organisation for Economic Co-operation and Development (OECD) nations and disability:

- As compared to the other wealthy, developed nations of the OECD, Canada's levels of benefits to persons with disabilities are very low, and **its support for integration of persons with disabilities into society (including the workforce) is below the OECD average**.
- The percentage of Canadians reporting a disability is 14.3% with over 40% of Canadians with disabilities not in the labour force (i.e., many rely upon social assistance benefits which are very low compared to other OECD nations). **Canada ranks 27th of 29 in public spending on disability-related issues**.
- In looking at measures of the extent to which governments provide benefits and supports to people with disabilities, Canada provides the second to lowest compensation and benefit levels and **has some of the strongest restrictions on receiving benefits**.

The United Nations Convention on the Rights of Persons with

Disabilities

> The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.
>
> Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.
>
> Article 1 (Purpose) of the Convention on the Rights of Persons with Disabilities

The United Nations Convention on the Rights of Persons with Disabilities endeavours to ensure that the existing rights which apply to all people are fully guaranteed for people with disabilities (United Nations General Assembly, 2011). This includes, but is not limited to, ensuring that the rights of people with disabilities are upheld in the contexts of health, work and employment, adequate living conditions, living independently and being a part of the community, access to public transportation and buildings, and freedom from exploitation. It also recognizes the right of people with disabilities to make their own decisions.

Canada originally signed the Convention in 2007 and ratified it in March 2011. Under Article 35 of the Convention, once a country has acceded to ratification, it is confirming that it will protect the legal rights and obligations detailed in the document as well as report to the Committee on the Rights of Persons with Disabilities on measures taken to meet its obligations. Thus, **Canada will be required to report its progress in working to improve this situation**. Ratification of the Convention marks significant progress in the work toward equality for people with disabilities in Canada.

Impact of Housing on Health

The following are key findings related to the impact of housing on health, together with examples from recent research.

- There is a **strong relationship between housing quality and perceived health**: the better the dwelling, the better the health status (World Health Organization, 2007). Poor treatment retention and higher mortality are associated with substandard housing.
- **Stable housing is associated with reduced use of expensive hospital health care services** (Culhane, Metraux, & Hadley, 2002).
- **Improving access to acute care and health care does not address housing**: health care interventions pay little attention to social determinants of health such as housing.
- The context of neighbourhood is an important determinant of mental health (Braubach, 2007) as the risk of substance-related mental disorders increases with neighbourhood deprivation and neighbourhood disorganization (Chaix et al., 2006).
- Recovery – social role satisfaction and positive sense of community (social support networks): **resilient functioning is associated with social role satisfaction, social supports, and being part of a positive community context** (Banyard & Williams, 2007).
- **Poor housing and community environments prevent many adults from adopting health-promoting behaviour** (World Health Organization, 2007).

Level of educational attainment and living arrangement: among the elderly, low educational attainment is associated with risk of poor health. **Poor mental health is associated with the type of one's living arrangement** (Rueda, Artazcos, & Navarro, 2008). Age, combined with low income and living arrangements (living alone or without access to social support networks) are directly related to problems in housing.

Interplay of Health, Housing and Income

Poverty and mental illness are often co-occurring conditions (Health Canada, 2002; Raphael, 2007). The dire living conditions that low-income children and their families experience daily have a powerful influence on their physical and mental health. There is often a chicken and egg syndrome with respect to poverty and mental illness with the labelling of a mental illness leading to loss of employment, support networks, and housing. There is also a link between income and mental illness due to the fact that a disproportionate number of people living with mental illness are using income support systems. These supports can be inadequate and often create inherent disincentives to finding gainful employment, such as loss or reduction of health benefits if employment is found, often leaving individuals with a choice between continuing medication and therapy or getting employment (Centre for Addiction and Mental Health, 2003).

Like poverty, homelessness is a sad part of the journey for many people living with mental illness (Canadian Institute for Health Information, 2007; Wellesley Institute, 2010). **The pathways leading to homelessness are complex and varied, with mental illness being a precipitating factor in some cases and a result of homelessness in others** (Canadian Institute for Health Information, 2007). Mental illness in and of itself, however, is rarely a sufficient explanation for homelessness. Other factors, such as alienation and marginalization, poverty, and a lack of adequate support, are equally, if not more, important explanations. In a recent report, Lightman, Mitchell, and Wilson (2008) found that the poorest 20% of Canadians, when compared to the wealthiest 20%, have:

- More than double the rate of diabetes and heart disease
- A 60% greater rate of two or more chronic health conditions
- More than 3 times the rate of bronchitis
- Nearly double the rate of arthritis or rheumatism

The poorest fifth of Canada's population face a staggering 358% higher rate of disability compared to the wealthiest fifth. The poor experience major health inequality in many other areas as well, including having **128% more mental and behavioural disorders**; 95% more ulcers; 63% more chronic conditions; and 33% more circulatory conditions.

There are as many faces to homelessness and mental illness as there are unique situations of individuals. While there are multiple stories that can be told, they invariably all tell the tale of a breakdown in the ability to function within mainstream society that comes with a lack of income and access to affordable housing. The stigma and discrimination faced by persons with mental illness, and the assumption that they are not as capable of work as those without mental illness, act as a major barrier to obtaining and sustaining employment (Dewa, Burke, Hardaker, Caveen, & Baynton, 2006; Mizzoni & Kirsh, 2006). Keeping a job is an even greater challenge when there are few workplace accommodations for those with mental illness (Gates, 2000; McAlphine & Warner, 2002; Shankar, 2005). Imagine the situation even further worsened by not having an address or a place to store belongings. **Being work ready requires some basics like being properly rested, fed, clothed, sober and clean – things that may be an ongoing struggle for individuals with mental illness who are inadequately housed**.

For people on social assistance or with low paying jobs, finding affordable housing is difficult in most parts of the country. Many people are paying over 30% of their income for housing, and some are spending more than 50%, which puts them at imminent risk of becoming homeless (Research Alliance for Canadian Homelessness, Housing, and Health, 2010). There are many precarious household situations in which individuals and families are 'one pay cheque away from being homeless.' Rents have increased in Canada every year since 1992 while household incomes have been stagnant. It is not surprising that waiting lists for affordable housing are on the rise. For example, the Ontario Non-Profit Housing Association (ONPHA; 2011) reported that in the past year, waiting lists across the province have increased by an additional 10,442 households for a total of 152,077 households, an increase of 7.4% in one year and a 17.7% increase since 2009. The Wellesley Institute (2010)

suggests extrapolating from ONPHA's estimates to a national level as a crude measure of need. This would equate to roughly 3.4 million households nationwide[16].

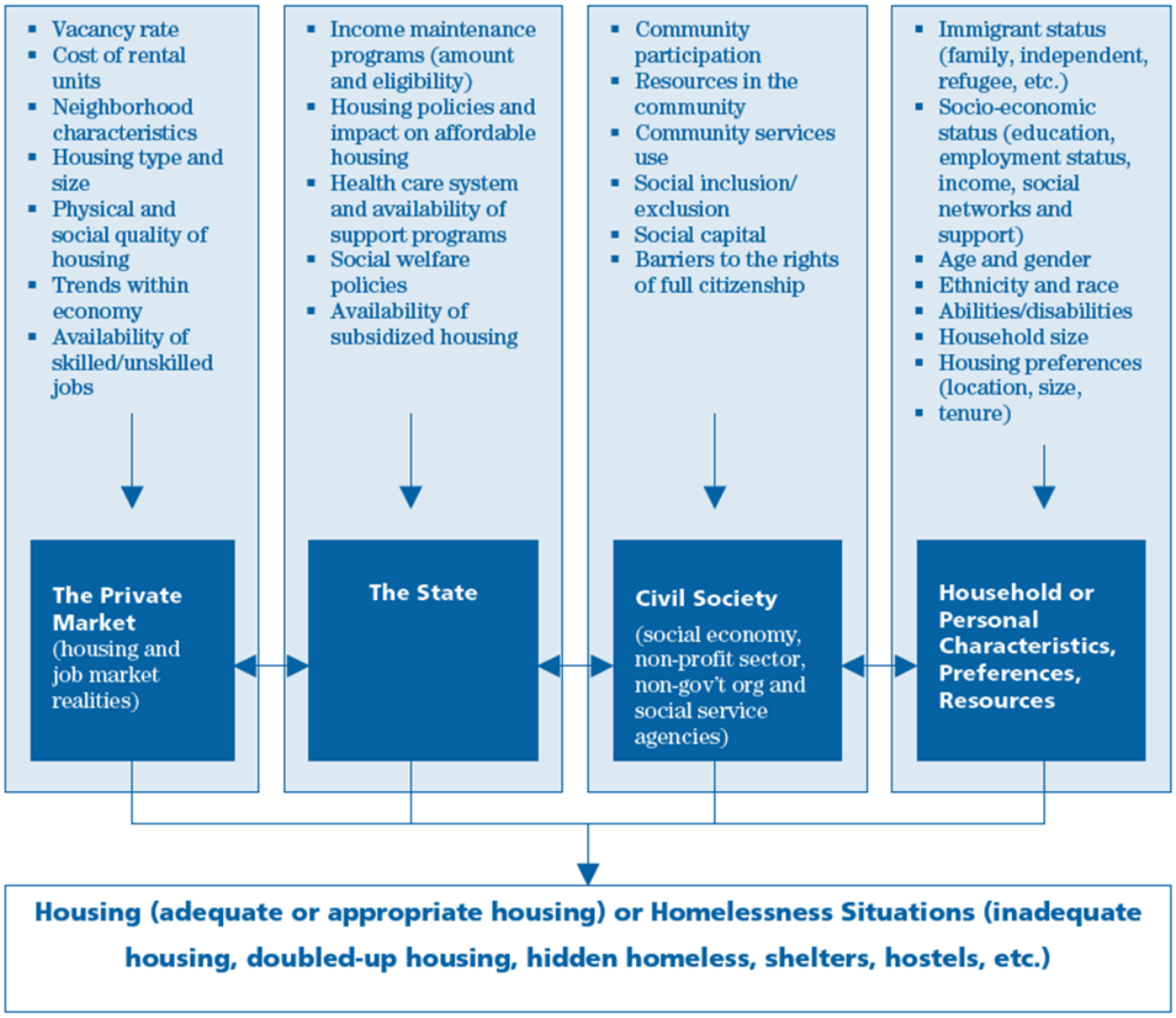
Difficulties in accessing housing can also be compounded by the stigma that comes with the label of mental illness and other kinds of discrimination related to new immigrants, language, culture, sexual orientation, families with children, etc.

A Multidimensional Model of Housing and Homelessness

The Policy Research Initiative (PRI) of the Government of Canada has existed since 1996 and provides leadership in carrying out research projects that cross-cut various departmental mandates. In a 2005 analysis of housing, poverty, and social exclusion, the PRI noted that the disconnect between housing policy and broader social policy development "can reduce the effectiveness of individual housing policies, miss opportunities to address broader socio-economic priorities, and complicate efforts to increase coordination or determine appropriate investments in this policy area" (Policy Research Initiative, 2005). Historically, the Canada Mortgage and Housing Corporation (CMHC) and the National Secretariat on Homelessness have collaborated on policy activities, but generally operated their programs separately. Although both housing issues and homelessness are now consolidated under Human Resources and Skills Development Canada, the PRI notes that "an administrative divide remains" (Policy Research Initiative, 2005). From a poverty and exclusion perspective, homelessness and/or inadequate housing is an exclusion - a product of persistent poverty and one that "accentuates the negative effects of that socio-economic situation" (Policy Research Initiative, 2005). Figure 2 provides a framework that identifies factors and their interactions that are associated with housing stress.

[16] The *Precarious Housing in Canada* report by the Wellesley Institute (2010) extrapolates using ONPHA data from 2009. Taking into account the 9.6% increase, an updated estimate would be roughly 3.7 million households.

Figure 2. *Factors that impact housing.*



Sources: Policy Research Initiative (2005); reproduced from Anucha (2005a).

Using this model, we can see how social and economic forces can disproportionally affect certain groups, and that these groups can often face multiple social and economic integration challenges. **To be fully effective, housing policy cannot be isolated from other social and economic policies targeting long-term poverty**. As the connections among issues are self-reinforcing in nature, housing policy can be made more effective by having social supports incorporated into policies (Policy Research Initiative, 2005).

Inadequate housing circumstances cluster with other indicators of disadvantage. A lack of adequate, affordable housing can aggravate other problems associated with low income. For example, households that must spend a disproportionate amount of income on rent often face problems of food insecurity and possible malnutrition, and are unable to participate in healthy community activities such as active recreation and social programs (Bryant, Chrisholm, & Crowe, 2002).

The province of Québec provides a powerful case study of the impact social environment and social policies can have on addressing health inequities, improving health outcomes, and preventing chronic disease (Fang, Kmetic, Millar, & Drasic, 2009).

The province of Québec provides some insight as to the impact of social environment and social policies on health inequities. A recent study by Fang, Kmetic, Millar, and Drasic (2009) compared major chronic disease

risks and prevalence across provinces' low-income populations. They found that, while British Columbia is the healthiest province overall, when looking at low-income populations, Québec's low-income residents had the least risk of major chronic diseases. Until recently, Québec, which in 2002 passed an act to combat poverty and social exclusion, was the only province in Canada to have a comprehensive poverty reduction strategy in place. The authors conclude that this strategy "has led to social and health care policies that appear to give its low-income residents advantages in chronic disease prevention … [and that] chronic disease prevalence is associated with investment in social supports to vulnerable populations" (Fang et al., 2009).

Implications of a Social Policy Approach to Housing and Supports for People with Mental Illness

Because of the complex interactions among the social determinants of health and because housing intersects with so many areas of social and economic policy, our ability to fully address the challenge of achieving adequate, affordable, and supportive housing for people with mental illness cannot be addressed in isolation (Bradford, 2005; Jenson, 2004; Hay, 2004). Hay (2005) identified the following considerations in social policy development, specifically in relation to housing policy:

- Effective policy development encompasses multiple dimensions including housing, income, and health services together with multiple players such as departments within government, multiple levels of government, community members, and the private market.
- Effective social policy also reflects a place-based understanding – this means that local community knowledge and capacity are harnessed in the implementation of local programs, rather than hampered by a one-size-fits-all approach to housing for people with mental illness. The Homelessness Partnering Strategy is one example in which there was strong community engagement in translating social policy into action at the ground level.
- Horizontal collaboration occurs across government departments to facilitate seamless service delivery, between governments (municipal, provincial/territorial, and federal) and other players such as private developers to share investment and risk, and at the regional level to leverage different initiatives.
- Vertical collaboration across community, business, the public, and through to the most senior levels of government ensures there is the right balance between local solutions (place-based approaches) and national goals. It also facilitates sharing of resources, lessons learned, and infrastructure resources.
- Effective social policy reflects goals and priorities that are rooted in consensus and is supported by coordinating mechanisms that channel energy and expertise. Investments should focus on building self-reliance in local communities.

Housing policy, then, forms one part of a broader social policy approach. This has been evidenced in recent national work; in particular, the report on poverty, housing and homelessness by the Senate Standing Committee, chaired by Art Eggleton (The Standing Senate Committee on Social Affairs, Science and Technology, 2009).

In developing effective housing policy (including housing policy for people living with mental illness) in the context of a social policy approach that doesn't have unintended consequences of "concentrating" poverty in particular neighbourhoods, a variety of approaches need to be considered (Pomeroy & Evans, 2008):

- Rehabilitation programs to improve neighbourhood appearance and help market the area to a better mix of incomes.
- Community-based social housing construction programs based on non-profit and co-op forms of tenure.
- Ownership programs to reduce issues of absentee landlords who neglect physical upkeep.

- Mobile or portable housing allowances to enable poor households to relocate to areas of lower poverty; thus diluting the original neighboured concentration of poverty – a practice extensively used in the US (i.e., Moving to Opportunities for Fair Housing demonstration program).
- Portable housing allowance programs that can be used for emergency housing by street homeless, abused women, and other priority households.
- Tax-based incentives to encourage private sector construction or rehabilitation of rental housing.

Housing and Human Rights

> The daily conditions in which people live have a strong influence on health equity. Access to quality housing and shelter and clean water and sanitation are human rights and basic needs for healthy living (United Nations, Educational, Scientific and Cultural Organization, 2006; Shaw, 2004).

This holistic understanding of the social determinants of health and the social policy environment is inextricably tied with the principle of housing as a basic human right. "Housing" is explicitly described as a human right in the United Nations Universal Declaration on Human Rights (UDHR):

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."
> Article 25(a) of the United Nations Universal Declaration on Human Rights (1948)

In Article 25(1), the UDHR specifically mentions the socio-economic rights of people with disabilities: the right to an adequate standard of living, including food, clothing, housing, medical care, and social services, as well as the right to security in the event of unemployment, sickness, disability, widowhood, or old age. Article 7 guarantees equality before the law and equal protection by the law for all people, including against discrimination.

The UN Declaration of Indigenous Peoples, recently passed by the UN Human Rights Council, also identifies housing in as a right:

> "Indigenous People have the right to, special measures for immediate and continuing improvement of their economic and social conditions, including in the areas of employment, vocational training and retraining, housing, sanitation, health and social security.
>
> Indigenous People have the right to determine and develop all health, housing and other economic and social programs affecting them and, as far as possible, to administer such programs through their own institutions."
>
> Commission of Social Determinants of Health (2008)

Practically all states that have ratified or acceded to an international treaty must issue decrees, change existing laws, or introduce new legislation in order for the treaty to be fully effective. **The United Nations has identified three immediate steps that a country must take to meet its international obligations under the Declaration of Human Rights** (and numerous agreements since):

1. **Determining the extent of homelessness**.

2. **Adopting a national housing strategy which should reflect extensive genuine consultation with the homeless**.
3. **Ensure that forced evictions do not result in individuals being made homeless**.

> "There are clear links between a 'rights' approach to health and the social determinants of health approach to health equity. The Universal Declaration of Human Rights points to the interdependence of civil, cultural, economic, political, and social rights – dimensions of social exclusion highlighted in the social determinants of health framework" (Commission on Social Determinants of Health, 2008).

Many nations have embedded the concepts of health, housing, and human rights in their policy and legislative frameworks. Our own Canadian Charter of Rights and Freedom (1982) was intended to unify Canadian society under a common framework of legal rights. However, access to specific provisions, such as housing, are not identified in the Charter.

The United Nations makes the following observations with respect to people who are homeless and people with disabilities, in the context of the right to adequate housing:

- The most common definitions of homelessness recognize that social exclusion is part of the person's experience - "homelessness implies belonging nowhere rather than simply having nowhere to sleep" (United Nations Human Rights Council, 2009).
- Poverty is the common denominator for people who are homeless – other factors that increase people's risks of homelessness include unemployment, lack of social security systems, lack of affordable housing, forced evictions, non-availability of social housing, conflicts and natural disasters, as well as a lack of attention to the needs of the most vulnerable.
- Following the "deinstitutionalization" of the mental health system, which began in many countries during the 1960s and 1970s, homelessness was almost certain for persons with disabilities who required support but could not access necessary services in the community.

The United Nations Committee on Economic, Social and Cultural Rights reaffirmed that the right to adequate housing includes accessibility for persons with disabilities. The Special Rapporteur on adequate housing has also underlined that not only should housing be physically and economically accessible to persons with disabilities, but also that these individuals should be able to effectively participate in the community in which they live. Appendix Five provides an overview of what the right to housing includes.

United Nations' Evaluation of Canada's Obligations to the Right to Housing

> The violation of the right to adequate housing may affect the enjoyment of a wide range of other human rights and vice versa. Access to adequate housing can be a precondition for the enjoyment of several human rights, including the rights to work, health, social security, vote, privacy or education. The possibility of earning a living can be seriously impaired when a person has been relocated following a forced eviction to a place removed from employment opportunities. Without proof of residency, homeless persons may not be able to vote, enjoy social services or receive health care.
>
> Fact Sheet 21 of the United Nations Rights to Adequate Housing (2009)

Over 15 years ago, the United Nations Committee of Economic, Social, and Cultural Rights (CESCR) expressed concern in its report to the Government of Canada that "social and economic rights have been described as

mere 'policy objectives' of governments rather than as fundamental human rights" (1993). The Committee also expressed concern about "the persistence of poverty in Canada." In 1998, CESCR maintained that Canada's failure to implement poverty reduction policies between 1993 and 1998 had further exacerbated homelessness among vulnerable groups in the population. In 2006, most of the 1993 and 1998 recommendations by the CESCR had still not been implemented (Kothari, 2009).

Homelessness in one of the most visible and most severe signs of the lack of respect for the right to adequate housing, which is even more **shocking to see in a developed and wealthy country as Canada** (Kothari, 2007).

The United Nations appoints "special rapporteurs" who provide recommendations on specific countries and themes; one such position is the Special Rapporteur on the Right to Adequate Housing. In 2007, Rapporteur Miloon Kothari was invited to Canada by the federal government to review four areas: homelessness, women and their right to adequate housing, Aboriginal populations, and adequate housing and the possible impact. In a news release shortly after this mission, The Special Rapporteur announced "**the deep and devastating impact of this national crisis on the lives of Canadians**" which has resulted in many deaths. The Special Rapporteur also noted that the lack of a properly funded national poverty reduction strategy was a cause of this national crisis" (Kothari, 2007).

Appendix Five contains a more detailed review of Kothari's report to the United Nations Human Rights Council, *Report of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context* (2009); In brief, his recommendations were to:

1. Recognize, at all levels of government, the right to adequate housing, and adopt or amend legislation to protect the right to adequate housing. **Denial of the right to adequate housing to marginalized, disadvantaged groups in Canada clearly assaults fundamental rights in the Canadian Charter of Rights and Freedoms**, even if the Charter does not explicitly refer to the right to adequate housing. As the definition of core housing need is more restrictive than the human rights definition of adequate housing, the number of people living in inadequate housing may be higher than the available figures.
2. **Commit to a comprehensive national housing strategy with stable and long-term funding**.
3. Adopt a comprehensive and coordinated national strategy for the reduction of homelessness and poverty. **The Special Rapporteur was concerned by the significant number of homeless people in all parts of the country and by the fact that the government could not provide reliable statistics on the number of homeless**. During the mission, he came across particularly severe situations such as in Downtown Eastside in Vancouver.
4. **Address the situation of the Aboriginal population in and off reserves through a comprehensive and coordinated housing strategy**. The 2009 federal budget contained a one-time-only allocation of $400 million for on-reserve Aboriginal housing. The federal government provides an annual subsidy of $272 million for on-reserve Aboriginal housing. Overcrowded and inadequate housing conditions, as well as difficulties accessing basic services, including water and sanitation, are major problems for the Aboriginal population. These challenges have been identified for many years, but progress has been very slow, leaving entire communities in poor living conditions for decades.

"Canada **is one of the few countries in the world without a national housing strategy**. The federal, provincial, territorial, and municipal governments, along with civil society organizations (including the charitable sector) have introduced a series of one-time, short-term funding initiatives … Canada has a significant number of programs relating to housing that are funded by the authorities at federal, provincial and municipal levels. Due to funding, program and legislative differences in various parts of the country, the overall effect seems uneven and disorganized" (Kothari, 2009).

Finally, the March 2009 Universal Periodic Review of Canada again reinforced the importance of the right to adequate housing, and the necessity of strategies and investments to ensure this right.
While some progress in addressing housing problems has been made through provincial and territorial policy and legislative initiatives, as well as some limited federal initiatives, successive reports and recommendations of the UN Human Rights Council identify ongoing, serious concerns about Canada's progress since 1998.

Bill C-304: Creating a National Housing Plan

Bill C-304, a private member's bill introduced by Vancouver East MP Libby Davies, began third reading debate in October 2010. With the support of three of the four political parties, this bill calls on the federal government, in partnership with the provinces, the territories, First Nations, municipalities and stakeholders, to develop a national housing strategy. The bill, entitled *An act to ensure secure, adequate, accessible and affordable housing for Canadians*, cites Canada's obligations under the United Nations to provide adequate housing for all citizens. **It calls on the minister responsible for the Canada Mortgage and Housing Corporation (CMHC) to establish a national housing strategy in consultation with provincial and territorial ministers of municipal and housing affairs, municipalities, Aboriginal communities, and other non-profit and private sector organizations**. Specific funding investments and targets would be tied to the plan. This bill is consistent with recommendations from a recently adopted Senate Report, *In from the Margins* (The Standing Senate Committee on Social Affairs, Science and Technology, 2009), by Senators Art Eggleton and Hugh Segal, calling for a National Housing Plan.

International Context

The policy context for housing in other countries, and Europe in particular, is increasingly seen as a broader social inclusion issue. The European Union (EU) has agreed to a core set of poverty and social exclusion indicators (the Laeken indicators), which are regularly produced for every EU country on a comparable basis. Housing indicators are under development and are seen as connected to social exclusion. Housing plays a central role in national poverty reduction strategies in France, Ireland, and Sweden. In the Netherlands and the United Kingdom, housing is integrated into broader social strategies. Pomeroy and Evans (2008) provide a brief review of international examples of the integration of housing into overall poverty reduction strategies. This information, together with a review of poverty reduction strategies conducted by the National Council on Welfare (2007), is summarized in Table 5. In Canada, we have a number of examples of such strategies at a provincial level, often referred to as 'prosperity promoting' or 'social inclusion' strategies; these are discussed in Appendix Seven.

Canada **is lagging behind many other developed nations** by lacking a national framework to address affordable housing.

For purposes of comparison in Table 5, about 5% of Canadian households live in social housing, which is far lower than in many other developed countries. The Canadian rate of social renting is less than half the Organisation for Economic Co-operation and Development (OECD) average (Falvo, 2003). Home ownership in Canada stood at about 68% of total households according to the latest census (Statistics Canada, 2006). Appendix Five provides further information comparing specific housing policies among G8 countries, as well as a more detailed discussion of social housing, the broader determinants of health, and human rights.

Table 5. *Interplay of housing and poverty reduction strategies in a section of developed countries.*

Country	Description of Housing and/or Poverty Reduction Strategy
European Union	▪ Member countries share a common framework with three main objectives: 1. Social cohesion, equality between men and women, and equal opportunities for all through adequate, accessible, financially sustainable, adaptable and efficient social protection systems and social inclusion policies 2. Effective and mutual interaction among policies for greater economic growth, more and better jobs and greater social cohesion, as well as sustainable development 3. Good governance, transparency, and the involvement of stakeholders in the design, implementation and monitoring of policy ▪ EU Countries develop plans to further these objectives and report progress publicly on the EU website
France	▪ The third priority of the poverty reduction strategy is to develop the supply of subsidized housing and quality accommodation ▪ Universal housing allowance system: paid directly to individuals and allows for freedom of choice between social and private renting ▪ Universal housing benefits extended to all low-income households
Ireland	▪ Launched a 10-year National Anti-Poverty Strategy in 1997 ▪ Utilizes a broad number of measures to assess progress towards poverty reduction, including development of a national integration policy based on equality principles and social inclusion ▪ Rate of people experiencing consistent poverty dropped from 15.1% in 1994 to 5.2% in 2001 (National Council on Welfare, 2007) ▪ Comprehensive poverty reduction strategy integrated into the 2007-2013 National Development Plan, targeting a reduction in consistent poverty to 2-4% by 2012 and elimination of consistent poverty by 2016 ▪ Housing is the fourth priority in the poverty reduction strategy ▪ Two national housing programs are: (1) Social Housing Provision and Renewal and (2) Affordable Housing and Targeted Private Housing Supports; funding is equivalent to approximately $30 billion annually –substantively more than is allocated to similar programs in Canada
Netherlands	▪ Affordable housing programs are primarily funded by the national government, but operated by municipal housing corporations (together with a small number of co-operative and non-profits) ▪ Prior to 1990, the national government's primary housing strategy was to subsidize the purchase and development of social housing stock ▪ In 1991, the national government stopped subsidizing low-income housing providers, replacing them with a housing allowance (calculated using a rent-geared-to-income model). About 30% of renter households receive the national rent allowance (a universal program; given out on the basis of income to rent ratio) ▪ Found that the rent-geared-to-income model acted as a work disincentive, as rent subsidy was reduced if earnings increased. Adopted a net income index in 2003 in an effort to reduce work disincentive – based on net residual income after payment of housing expenses
New Zealand	▪ Adopted a social development approach in 2003, focused on social protection and social investment ▪ Strong focus on use of consultation and the use of indicators for monitoring progress (e.g., development of the Agenda for Children involved contributions from community experts and government officials, as well as nationwide consultations with children, young people, and adults) ▪ Indicators of social well-being have been released yearly since 2001 to monitor trends over time and to make comparisons with other countries ▪

Sweden	▪ Universal welfare policy, active labour-market policy ▪ Welfare system includes health care, social care, and social insurance that provides financial security in illness, disability and old age and for families with young children ▪ Basic supplementary protection in the form of financial assistance ▪ Sets priorities within a long-term vision: for 2006-2008, these included job creation, reducing ill-health at work, improving long term care, increasing accessibility for people with disabilities, tackling homelessness, and increasing social inclusion ▪ Creation of a commission focused on vulnerable service users and collaboration across multiple levels of government
United Kingdom	▪ Social housing sector peaked at over 30% – various policies have decreased this, most notably that some tenants are able to purchase their dwellings at deep discounts ▪ Eligibility for social housing increasingly restricted to low-income ▪ National initiatives have focused on targeted estate regeneration; focus on a "place-based" policy lens ▪ Separation of the basic income support from the housing benefit allowance has created disincentives for work; careful thought needed on how benefits are withdrawn/scaled down as people enter work ▪ Child poverty reduction strategy: set the target of halving child poverty by 2010, eradicating it by 2020. Similarly, a poverty reduction strategy has been devised for pensioners. Specific program targets are linked to this strategy and there is a focus on targeted support for people who need it most: single parents, people with disabilities, older workers, and members of ethnic minorities. ▪ UK determined that no one measure on its own could sufficiently capture measurement of poverty, so has identified a small set of measures that are being tracked. ▪ Child poverty decreased from 27% in 1997 to 22% in 2004. One million pensioners and 800,000 children moved out of relative poverty since 1999 (National Council on Welfare, 2007)

REDEFINING THE BASKETS OF SERVICES

The Implications of a Recovery-Oriented Approach

A central part of our information gathering process was hearing directly from people living with mental illness, together with families and providers, to better capture the range of services and supports that foster success in housing tenure. Again and again, we heard about the importance of being recovery-oriented in any range of housing and support models.

Since the mid-1980s, a great focus of mental health recovery has been from the perspective of the person living with mental illness, the family member, and the mental health professional. The amount of research of various aspects of recovery continues to grow. Early research by Courtney Harding (1987) and others challenged the belief that severe mental illness is chronic and that stability is the best for which one could hope. They discovered multiple outcomes associated with severe mental illness and that many people did progress beyond a state of mere stability. As such, the concept of recovery began to obtain legitimacy (Sullivan, 1997).

Recovery is a highly personal process that is defined by the individual experiencing the illness and, at a fundamental level, is a journey in finding meaning in one's life, and on one's own terms. **A recovery-oriented approach needs to emphasize self-determination and self-management to attain personal fulfillment, meaningful social and occupational roles and relationships within the community, and measuring outcomes in terms of housing, education, employment, and participation – not only by reducing symptoms** (Davidson, Chinman, & Sells, 2006). To this end, an overview of recovery is as follows (Eastern Regional Network, 2006):

- Recovery is not a single model, it permeates the system.

- Recovery is not synonymous with cure; however, there is always opportunity for a person to improve their sense of meaning in their lives, making recovery accessible to everyone.
- Recovery thrives in hope-filled environments that nurture dignity and respect.
- Recovery is made possible by people who stand by and believe in the person battling with an addiction and/or mental illness.
- This journey involves recovery from the secondary consequences of being ill and the experience of discrimination as well as from the illness itself.
- Recovery can occur with or without professional intervention.
- Recovery involves taking risks to try new things, and having the courage to do so.

Recovery makes sense for the person and for the system. Commitment to this common understanding of recovery entails specific practical details at the service and system levels:

- People in recovery are meaningfully involved in the community at all levels of system and service planning, delivery, and evaluation.
- Demonstration of people in recovery having the power to shift their community and the health care system.
- Services can be closely tied to improved outcomes at a person's level, based on the social determinants of health, rather than on symptom reduction alone.
- Services that focus on community reconnection.
- Respect, inclusion, and authenticity form the basis for relationships.
- Peer support services are an important ingredient of our recovery-oriented system – they cross all 'levels of need,' and have been proven to be highly effective, both as a stand-alone service, or when accessed in combination with other mental health services.

The basket of mental health services has typically referred to crisis services, case management, and Assertive Community Treatment. The work of this project, and feedback from Canadians across the country and from many different perspectives, identifies the importance of housing support that is recovery-oriented – as such, the basket of services becomes more holistic, and encompasses the range of the determinants of health. This section deals with the key question: **how should the mental health basket of services be defined to reflect an inclusive and recovery oriented array of supports that help people to find and maintain housing?**

Housing Support Services

The survey to stakeholders broadly defined 'housing support' as a variety of flexible, on-site supports that assist individuals in maintaining their housing tenure (may include assistance with running a household, finances and budgeting, interpersonal relationships, and referrals to other clinical and non-clinical services). The findings from the questionnaire spoke to an array of recovery oriented housing support services.

INCOME SUPPORTS

Among survey respondents, income support was the most frequently identified support need by people living with mental illness (*n* = 330) and their families (*n* = 183) to find and maintain housing. It was interesting to see that this trumped all other support needs, including mental health services, and thus **it is essential to incorporate dimensions of anti-poverty strategies into the recommendations for an effective housing strategy**. This approach is also consistent with the social determinants of health framework that is integral to a recovery oriented model of care. As members of the research team carried out the mapping exercise, it became clear that income supports are an integral part of the "related supports" context that warranted focused exploration.

International key informants also spoke to the importance of income supports. In the U.S.A., the significant role of the Department of Housing and Urban Development by providing Section 8 subsidies, which allow a tenant to pay only 30% of his or her income towards rent, was underscored.

FOOD SECURITY

Close on the heels of income support was the need for healthy, affordable food; this ranked by frequency as the second most essential support service by the 330 people living with mental illness and fourth in importance by the 183 family members who completed the surveys. This relates to inadequate income supports and poverty as disabling and problematic in the maintenance of housing as cost is a key barrier to healthy eating. Access to healthy, affordable food was cited as a significant need by survey respondents in the provinces of Nova Scotia, Manitoba, and British Columbia.

These results are corroborated by findings from the report, *Housing Vulnerability and Health: Canada's Hidden Emergency* (Research Alliance for Canadian Homelessness, Housing, and Health, 2010), which found that **among people who are vulnerably housed or homeless, 33% reported difficulty obtaining enough to eat, 27% reported inability to obtain food of good quality, and 22% reported their diet was not nutritious**.

LIFE SKILLS TRAINING, EMPLOYMENT SUPPORTS, AND EDUCATIONAL SUPPORTS

The goal of life skills training is promote self-sufficiency; it can include the education and fostering of core or basic skills (e.g., literacy, information technology), independent living skills (e.g., managing a household, budgeting), and social skills (e.g., interpersonal skills, avoiding or dealing with neighbour disputes; Power, 2008). Life skills training followed by employment supports were fifth and sixth respectively in the order of essential support services by frequency listed by the 183 family member survey respondents. For the 330 people living with mental illness, this order was reversed, with employment supports coming fifth and life skills training sixth. Income, employment, and education services garnered high support in the webinar data as well.

Webinar participants spoke specifically to the need for support in the activities of daily living and **housekeeping support**. This was reflected in the webinar data from Newfoundland and Labrador, New Brunswick, Prince Edward Island, and Quebec. Reference group members also spoke to the lack of support with regards to housekeeping. For example, in Alberta, there is no house cleaning support for those under the age of 65, hindering transition to independent living; a program previously available in 1993-94 was cut. This need was also stressed by service providers during site visits.

International key informants also spoke to **the need of creating partnerships with other organizations to provide educational and employment supports that would complement successful housing programs**.

MEAL PREPARATION SERVICES AND MEDICATION MANAGEMENT

Family member survey respondents placed greater emphasis on meal preparation services and medication management than did people living with mental illness. This relates to the fact that one third of the family members who participated in the survey had a family member who had mental health problems living with them or with other members of the family. A reason for people living with mental illness to stay with their families could well include inability to prepare their own meals and manage medications. There was a significant association by province with regards to the need for meal preparation services; family members from New Brunswick and Manitoba reported this as a significant need, but not so in Newfoundland and Labrador and Quebec.

Housing supports were among the top five unmet support needs in the survey data from the 96 housing providers as well as from the 216 mental health service providers. The 35 participants representing hospitals also identified housing supports as an important need that was not being met.

INNOVATIONS

HOUSELINK (TORONTO, ONTARIO)

Houselink has been in operation in the Toronto area for over 32 years and has provided housing to over 2000 people. The organization owns 22 properties in the Toronto area and manages over 100 units through partnerships with private market landlords. Over 460 people have been permanently housed through Houselink.

The model of housing is both supportive and supported housing. Houselink provides long-term, permanent housing; however, through its model orientation, transitional needs are also addressed. The funding model employed at Houselink is geared toward providing a range of service delivery combinations to meet specific client needs. Furthermore, services are geared toward promoting housing retention. Support is focused on behaviours to assist members to stay housed; individual diagnoses are not the focus of support.

One of the most exemplary features of this organization is its governance. Houselink views its success as grounded in its member leadership at each level. Approximately half of the Board of Directors at Houselink consists of members living with mental illness. Program decisions and policies are overseen by an elected volunteer committee comprised of people with mental illness. Houselink's 'Members Guild' consists of over one hundred resident and non-resident members (members currently living in Houselink housing, have lived in Houselink housing in the past, and those who would like to live in Houselink housing) who address any issues and themes from the perspective of members.

Services at Houselink are provided to a diverse client population with a full range of needs. The approach is rooted in a service delivery model that is community-based, client-centered, and non-clinical. The services offered through Houselink include informal counselling, crisis support, and life skills training. As the organization views the needs of its members as changing through various living experiences, the support offered to clients is flexible to address the changing needs of individuals.

Houselink operates within a non-clinical, non-professional approach. Through this orientation, labeling is minimized. Houselink views staff as 'Supportive Housing Workers.' Supportive Housing Workers use a strengths-based, empowerment approach to teach members to become self-advocates. Programs are peer-driven, accessible, and sensitive to the complex health needs of members.

Various committees comprised of both staff and members help strength the sense of community. For example, *Houselink 101* is a committee designed to provide new members with educational information sessions about Houselink's operations, member employment, and the role of the support worker.

The Social Recreation Program at Houselink offers two drop-in centres, community meals, and affordable activities. The drop-in centres are open to both resident and non-resident members. The Food Program at Houselink is oriented towards the nutritional needs of members. Community kitchens offer members and non-members nutritious meals each day of the week. Other nutritional needs are put in reach of members through Good Food Boxes (e.g., fruits and vegetables at affordable prices); group grocery shopping expeditions; and education, training, and counselling on healthy eating.

A program tremendously valued by members of Houselink is the Work Program, which offers members supported work within Houselink and employment external to the organization. The organization employs over 100 of its members each year through various work programs, including its employment support program. A key characteristic within Houselink's Work Program is its flexible nature. The flexible work environment makes it possible for members' individual needs to be accommodated. The work offered to members includes property maintenance services (i.e., landscaping, cleaning, painting), administrative services (i.e., reception relief), and program support (i.e., peer support workers, community kitchen cooks). The training component of jobs assists members to develop transferable skills. Upon visiting the organization, it was obvious that the work program, particularly its flexible nature, was deeply valued by members. Members view the employment program as an opportunity to develop skills at their own pace and consistently working towards their full potential. It also is a way of providing much needed income and financial supports.

The strengths of the organization are embedded within its recovery orientation at every level of service delivery. As a case in point, board members participate in regular training in recovery and reflective practices. Houselink's commitment to the promotion of mental health recovery is also evidenced in its focus in enhancing members' voice through opportunities for meaningful organizational involvement, both in its operations and governance, and the development and implementation of policies and practices supportive of recovery goals. An exemplary practice includes the organization's distribution of a survey tool, *Developing Recovery Enhancing Environment Measure*, to review members' personal experiences of recovery and the supports available to them.

The basket of services provided by Houselink is based on the psychosocial determinants of health model and thereby is highly recovery oriented.

Health and Mental Health Services

Survey data from 330 people living with mental illness showed that mental health services (33%) was third amongst the top factors that motivated people to move from their current housing arrangement. The need for this service was also significantly higher amongst the 45 individuals who owned their own home (77%), the 27 who rented a room (73%), and the 60 who rented an apartment dedicated specifically for people with mental illnesses (68%). The gravitation to dedicated housing could be indicative of the availability of mental health supports in such living arrangements.

In terms of other health services, people living with mental illness placed more value on having access to a family doctor (fourth on the list) than did family members.

Of the essential support services ranked by frequency, mental health services rated third in terms of needs by people living with mental illness. Responses to an open-ended survey question highlighted **case management** and the **availability of onsite counselling** as needed supports.

The 183 family members reported that the need for more mental health services (36%) was the topmost factor for why they wished their family member who lived with mental illness would move to new housing. More mental health services was indicated as most needed by respondents whose family members were living in a place not meant for people with mental illness and by respondents whose family members were living with them.

According to family member survey respondents, those whose relatives living with mental illness were currently utilizing mental health services, had access to a community nurse, and access to housing support services were in greater agreement that the services their family members had access to helped them maintain their housing than those whose family members did not have access to or utilization of these services. Survey data from participants living with mental illness also supported these findings. Further analyses found that housing support services was the strongest predictor of success in maintaining housing tenure.
Survey data revealed that a crucial new and emerging support need identified by housing providers (*n* = 96) was **supports for complex mental health and acute care issues**. **Crisis beds/safe beds/respite beds** that can be accessed by persons requiring short-term support and Intensive Case Management (ICM) were reported among the most important support needs that were not being met within the mental health housing context. Crisis beds and integrated mental health and housing services were among the top five most important support needs that were not being met according to 216 mental health service providers, while ACT and ICM featured amongst the top ten most important unmet needs. Crisis services (i.e., crisis beds, telephone crisis lines, and mobile crisis services) were reported as inadequate at a higher rate by the 87 service providers serving remote communities than the non-remote providers. In contrast, data from 35 hospital providers found that ACT was the third most important unmet need with short-term case management, crisis beds, and mobile crisis services much lower down the list of the top ten unmet support needs. International key informants also spoke to the need for ACT to be flexible depending upon needs. For example, ACT teams for individuals with concurrent disorders need to be staffed differently than ACT teams for those without an addiction.

For a brief overview of literature pertaining to the array of mental health services, please refer to the review of literature section on mental health services in Appendix Four.

Peer Support

"I also have a peer support counselor, who has been helping with the trauma and tribulation of the move as well as with other matters. She is caring and competent in her dealings with me and I would love to see more of these kinds of people available with increased funding for salaries."
-Person living with mental illness' comment during a site visit in Manitoba

Data from webinars, surveys, site visits, and reference group consultations yielded the strongest backing for peer support as a much needed service. In survey data, it was found that 73% of the 330 people living with mental illness concurred with the recommendation that people need access to peer support, while 68% of the 183 family respondents concurred with this recommendation.

In the survey data from mental health service providers (*n* = 216), the need for peer support, which was ranked 16th from the 60-item support need list, differed between the provinces and territories. The majority of respondents from New Brunswick, Quebec, Nova Scotia, and Saskatchewan reported that the need for peer support was not being met. Service providers from British Columbia and Ontario reported the gap existed at a lesser rate with approximately 25% of respondents from each province indicating a gap. This is supported by the fact that there are more peer support initiatives in these two provinces in comparison to the others.

Feedback from webinar participants identified peer support as well as the role of peers and peer organizations in aiding people living with mental illness to access and navigate the system as important and beneficial. In the Quebec webinar, informal peer support was mentioned by many as being important and aiding in recovery. **Supports noted as beneficial included both tangible supports, such as help with housing or financial assistance, as well as emotional supports, such as promoting self-confidence and serving as a confidante**. This resonated in the site visit to Potential Place in Calgary which offered very strong elements of informal peer support among tenants with mental illness.

INNOVATIONS

A PEER RUN AND SUPPORTED MODEL: POTENTIAL PLACE (CALGARY, ALBERTA)

A Clubhouse Model with Cluster Apartments
The focus of Potential Place Society is to contribute to the recovery of persons suffering from a mental illness by creating a supportive and restorative environment where individuals who have been socially and vocationally disabled by a mental illness can attain or regain their self-esteem, confidence, and the skills necessary to lead vocationally productive and socially satisfying lives. It is a strengths-based model. As in other clubhouse models, the member is central to the clubhouse and its operations.

According to the Executive Director, Gordon Young, the housing model of Potential Place seeks to create an "intentional community," with peers living adjacent to each other and providing the much needed support and therapeutic environment crucial to recovery. The sense of community and ownership is further underscored by the fact that all members of the clubhouse are the landlords and the tenants act as their own property managers.

There are two apartment buildings owned by Potential Place – one with 11 apartments and another with 16 apartments. Alberta Works and CMHA assisted in renovations of the two buildings. Calgary Housing also assists this project by providing assistance on a case-by-case basis. Tenants are members of the two local community associations and this has helped address any Not In My Backyard (NIMBY) issues within the community. Also, partnerships with the police force (Community Liaison Officer) and PACT (Police and Crisis Team; a partnership between Calgary Policy and Alberta Health Services) are helpful in preventing any escalating situations and being proactive with community supports. Thus, effective collaborations have helped facilitate the realization of this housing model.

Three staff members along with a number of residents support this program and manage orientation, intake, and any financial and clerical work needed to run the operation. All member tenants in each apartment with one liaison from the other apartment partake in the weekly house meetings. There is no on-site support staff; the model is very independent with peer support playing a crucial role. In addition, all clubhouse staff and clubhouse program supports are available to the tenants.

Members in the housing assume complete responsibility for building maintenance and are involved in cleaning, vacuuming, grass cutting, and general upkeep of the property. According to members, this "intentional community" is an incredible source of support for all of them when needed. For instance, when one neighbour fixes a fuse in another's apartment, she bakes him cookies in return. Once when the sewer backed up and flooded the basement, those living in the basement apartments were offered a home by their neighbours upstairs.

Detractors sometimes call this type of program "warehousing" but tenants say this could not be further from the truth. The active positive peer support and the sense of responsibility regarding ownership elements of the model make it recovery oriented.

Lack of startup funding and housing stock to expand this model continues to be a challenge.

A definite theme that arose in the Ontario webinar was the important role of peer support in the lives of people with mental illness. Peer run initiatives located throughout Ontario were viewed as providing various supports, including navigating the system, advocacy, and employment as well as being important to recovery.

Reference group consultations pointed to the Clubhouse model as enhancing accessibility to peer support. Prince Edward Island is one of the few provinces where there is a Clubhouse model also available to the rural community. In this example, the operator is the CMHA. Calgary and Toronto also have clubhouse models. Consultations with Nova Scotians mirrored the survey data, namely, the necessity for peer support but lack of funding and mandate. The reference group stated it was imperative to start more peer support initiatives, and also discussed cost-efficiency of the model.

The need for peer support was also echoed in the international key informant interviews. Discussing recent innovations in the area of housing and related supports, Dr. Sam Tsemberis, from the United States, that **peer support as an individual support service or within an ACT team was among the most important innovations to date**.

For a brief overview of literature pertaining to peer support in housing, please refer to the review of literature section on peer support in Appendix Four.

SUMMARY

Although our research focused primarily on tangible supports that can be offered in a basket of services, there are certain concepts or factors that are common to recovery and should be reflected in any given basket. Some of these themes include:

- Fostering a sense of hope
- Medication/treatment
- Empowerment
- Spirituality
- Support from peers, family, friends, and mental health professionals
- Self-help
- Knowledge/education about mental illness
- Peer support
- Employment/meaningful activity

A basket of services needs to be eclectic and based on the needs of people living with mental illness and their families in order to be helpful for recovery. The assembled basket for housing goes well beyond traditional mental health services and includes services such as housing support, with a focus on services that are linked to the social determinants of health such as income, food security, employment, and education. The basket must also include mental health services that are critical to recovery. The basket also includes formal and informal peer supports that are crucial to engagement, intervention, and recovery. In summary, what is suggested is a wraparound model of supports that can then be tailored to the individual needs of the clients and their specific contexts.

INNOVATIONS

AN EXTENSIVE BASKET OF SERVICES MODEL: CMHA (NANAIMO, BRITISH COLUMBIA)

An Enhanced Model in a Rural Community
With the initiation of the closure of the psychiatric facility, Woodlands, in the 1980s, and the subsequent relocation of Riverview patients to other communities, such as Nanaimo, just three years ago, many people with mental illness and addictions were at high risk of becoming homeless or being under-housed in very low quality housing in an under-resourced rural environment. CMHA took on the challenge of integrating these individuals back into the community by providing them with support and quality housing.

This is the only low barrier, long-term housing available in Nanaimo, operated and staffed by CMHA, Nanaimo. It is a 19-unit single room occupancy (SRO) model where an old hotel was converted into an SRO and is currently undergoing major renovations. Most tenants have to share bathrooms.

The units represent an effective partnership between CMHA, the Vancouver Island Health Authority, and the Ministry of Housing and Social Assistance. When CMHA acquired the property, there were 19 people with mental health and/or addictions issues who were living there under very poor conditions, and who had no connections to any mental health or support services. By virtue of the partnership, all but three clients are now connected to mental health and support services. These three clients are attached to building support workers, while all other are either connected to an ACT team or an outreach service.

Service access to the tenants of the building is also facilitated through their proximity. For example, income assistance services from the Ministry of Housing and Social Assistance that are crucial to maintaining housing are provided on-site. Apart from the building support workers, CMHA has outreach workers serving people who are homeless operating out of this office space. Vancouver Island Health Authority provides on-site mental health and addiction services. The ACT team has integrated a truly psychosocial approach to working with clients in the buildings. It was a pleasant surprise to note that the ACT team in Nanaimo helped residents with the activities of daily living and had posted a laundry schedule to assist clients with this basic activity. All three teams work together and have a strong focus on community engagement, and all contribute to engaging clients in such activities as the community garden and general upkeep of the building. Social clubs in the evenings, movie nights, spaghetti nights, and laundry nights are some of the activities that tenants engage in as a community.

The innovation of this program is the range of services made available through equitable partnerships, and the fact that a marginalized, high-need group is supported in retaining existing housing, enhancing their quality of life, and moving towards recovery. A transformation has been initiated in a familiar setting.

BEYOND THE MORAL IMPERATIVE – THE ECONOMICS OF ACTION AND THE COSTS OF INACTION

"People should be pushed to do something simply out of humanity, but if you want to talk about money…"
Kim Kerr, In from the Margins (The Standing Senate Committee on Social Affairs, Science and Technology, 2009)

Health systems across Canada are wasting money by not investing in housing for people with mental illness. We have a clear case of false economy – paying a lot of money for emergency room use, inpatient stays, police services and jails, and lost productivity, instead of paying a small amount of money to house people properly. The reality is that investments in housing are the most effective means to control costs and allow people with mental health issues to move towards recovery. Unfortunately, housing for people living with mental illness is often

regarded as a cost burden with little return, not as an investment. In fact, it is an investment that pays off downstream, as well as providing safety and dignity.

By providing an insufficient number of housing units and inadequate supports for people living with mental illness, we have created grounds for dependency on the health care system. People become stuck in an endless cycle through costly systems that are often ineffective for individual recovery and an expensive financial burden for society. It is clearly time for decision makers across Canada to move beyond the idea of health as doctors, nurses, and hospitals. Housing is a health issue, and by not responding to this we are wasting money and lives.

> A recent study from the United Kingdom found that "supported housing for people with moderate mental health needs, after discharge from hospital, **estimated savings of £22 000 ($35,000 CDN) for each client per year** across the wider health and social care system"
> (Department of Health, 2011).

Further, "**housing-based support services for people with mental health problems could deliver cost savings to health and social care of £10 000–£20 000 ($16,000–$32,000 CDN) per year per client**" (Department of Health, 2011).

As Michael Shapcott of the Wellesley Institute states in his recent report, "precarious housing in Canada, whether defined by the level of inadequate or affordable housing, homelessness, or under-housing, can be solved in this decade; the mechanisms already exist, but the will to do so must be nurtured" (Wellesley Institute, 2010).

Understanding the Costs of Inaction

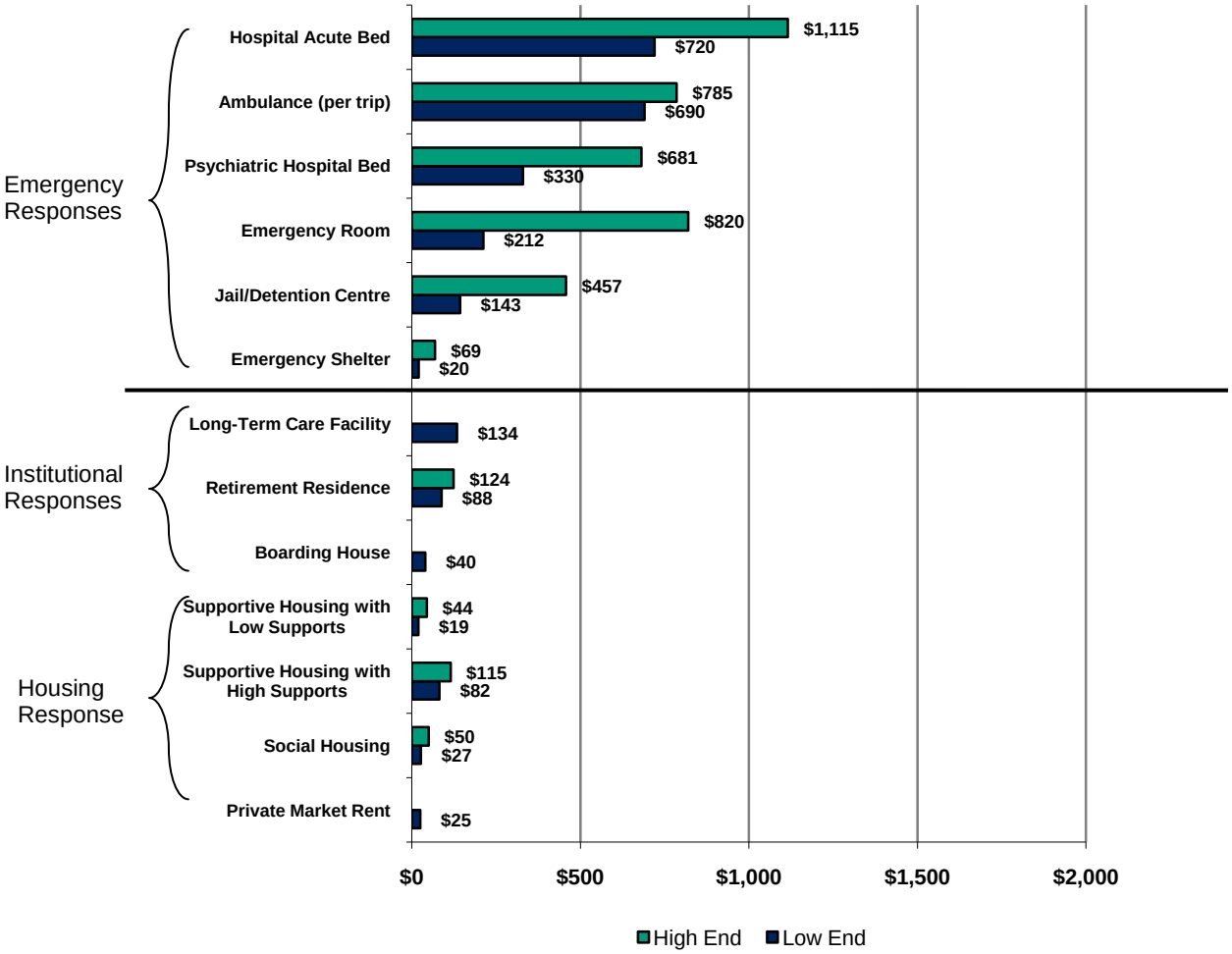
> **"Doing nothing is not free."**
> US Department of Housing and Urban Development's Strategies for Reducing Chronic Street Homelessness (2004)

There is a huge cost to society resulting from inadequately housed people living with mental illness re-circulating through a range of emergency and institutional services such as emergency rooms, psychiatric hospitals, general hospitals, emergency shelters, domestic violence shelters, foster care, detoxification centres, and jails.

> A well-known example is the article that appeared in the *New Yorker* about "Million-Dollar Murray," a homeless person with a serious alcohol addiction in Reno, Nevada (Gladwell, 2006). **The cost to the system of not doing something about Murray mounted to an estimated $100,000 per year over a ten year period resulting from his repeated cycling through a range of social services.**

The following figure presents various forms of shelter in Canada, falling into three general areas: emergency, institutional, and housing. A typical, or in some cases, a range of costs is depicted. Keeping in mind that the categories vary in what is included (e.g., accommodation, meals, supports for daily living, and medical supports. A crude comparison of the costs of operating/providing a particular service for a single day, not taking into account frequency or duration of service utilization, shows that **various institutional and emergency shelters are about 10 times more expensive than supportive housing**.

Figure 3. *Daily or Per Use Costs of Housing, Institutional, and Emergency Services.*



Sources: City of Toronto (2009); The Conference Board of Canada (2010); Jacobs et al. (2010); Pomeroy (2005); and Vincent and Morin (2010).

A Simple Equation

A study of state hospital patients living in Chicago found that when poor persons with mental illness seek psychiatric hospitalization, they often do so **more as a short-term housing arrangement than for psychiatric reasons** (Lewis & Lurigio, 1994).

A Toronto-based program, *Streets to Homes*, which helps homeless people find long-term housing with necessary supports, demonstrates that once individuals are housed, they use fewer emergency services and begin accessing more appropriate ongoing health and community services. An evaluation of the program, which consisted of a sample of 88 participants (just under half had mental illness; L. Raine, personal communication, March 14, 2011) found that in the first year after being housed, there was a **38% reduction in the number of individuals using ambulance services, a 40% decrease in individuals visiting the emergency room, and a 25% reduction in individuals requiring a hospital stay** (Raine & Marcellin, 2009).

The Cost of a Hospital Bed

1 in 4 people who are vulnerably housed or homeless have been hospitalized overnight at least once in the past year (excluding nights spent in the emergency department) (Research Alliance for Canadian Homelessness, Housing, and Health, 2010).

Studies from Ontario concluded that about **40% of current tertiary care psychiatric inpatients with severe and complex needs could instead be served within the community**, if they had the appropriate level of housing and related supports (Koegl, Durbin, & Goering, 2004).

A 2007 report looking at the reasons for inpatient hospitalization found mental illness to be **the most prevalent reason (52%) for hospitalizations among the homeless population**. For the housed population, mental illness was not among the top reasons for hospitalizations - indicating a positive impact of housing the homeless (Canadian Institute for Health Information, 2007).

A psychiatric hospital bed costs between **$330 – 681 per day.**
A hospital acute care bed costs between **$720 – 1115 per day.**

Housing models with the necessary supports reduce capacity pressures on hospital inpatient units. In a study where homeless people with a major mental illness were assigned to either a *Housing First* or 'treatment first' program, **less time was spent in psychiatric hospitals by participants in a *Housing First* group** (Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003). A second *Housing First* study in California showed a 14% decrease in inpatient services for homeless people with serious mental health issues (Gilmer, Stefancic, Ettner, Manning, & Tsemberis, 2010).

Alternate Level of Care

Alternate level of care (ALC) is used to describe hospital patients who no longer require hospitalization but remain in hospital until they can be discharged to a more appropriate level of service (e.g., high support housing). There is substantial consumption of expensive hospital resources due to a lack of appropriate community housing options and resources, particularly high support housing.

Results from an Ontario-based study indicated that **more than 50% of ALC clients are in psychiatric settings**, consuming a significant portion of inpatient resources (Butterill, Lin, Durbin, Lunsky, Urbanoski, & Soberman, 2009).

Additionally, **60% of mental health ALC clients in acute care hospitals stay for more than 90 days** in a single hospitalization. This number rises to 65% in a tertiary care hospital setting (Butteril et al., 2009).

The study suggested that if mental health ALC clients had access to high support housing, this **would result in significant cost savings on the use of hospital beds** (Butterill, Lin, Durbin, Lunsky, Urbanoski, & Soberman, 2009). A second study noted ALC clients to be most significantly impacted by a lack of high support housing units, which would be able to more appropriately and more cost effectively serve their needs (High Support Housing Consortium, 2009).

The Cost of a Visit to the Emergency Room

55% of people who are vulnerably housed or homeless visited the emergency department at least once in the past year (Research Alliance for Canadian Homelessness, Housing, and Health, 2010).

Additional findings from the report *Improving the Health of Canadians 2007-2008* examined the most prevalent reasons for visits to emergency rooms across Canada. The results showed mental illness to be **the most prevalent reason (35%) for emergency room visits among the homeless population**, while mental illness was not among the top five reasons for emergency room visits for the housed population (Canadian Institute for Health Information, 2007). This clearly demonstrates the correlation between homelessness and the use of emergency services for mental health reasons.

The cost of an ambulance is between **$690 – 785 per use.**
The cost of a visit to the emergency room is between **$212 – 820 per day.**

Martinez and Burt (2006) investigated the impacts of permanent, supportive housing for homeless people with psychiatric and substance use disorders. One result of providing housing to this population was a significant reduction in the number of visits to the emergency department. A *Housing First* study in California found **a 32% decrease in emergency services for homeless people with serious mental health issues** (Gilmer et al., 2010).

The Cost of Incarceration

Several studies have looked at the numbers of people living with mental illness in Canadian jails, and the costs to the system. A report by Bland, Newman, Dyck, and Orn (1990) found that inmates of a provincially-run jail in Edmonton, Alberta were 4 to 5 times more likely to have a diagnosis of schizophrenia and 5 times more likely to have had a manic episode than the general population. While numbers vary somewhat depending on whether incarceration is in a provincial or federal facility, overall, **people with serious mental illness are over-represented by a factor of about 5 in Canadian jails** (Gingell, 1991).

The cost of person residing in a jail is between **$143 – 457 per day**.

In Ontario, there are currently 8,395 people in jail, at an average yearly cost of $65,689. This equates to $551,459,155 spent by the province per year (Howlett, 2011, March 24).

In a Canadian federal prison, the cost of incarcerating a woman is roughly $175,000 per year. **Women with mental health issues are more likely to be placed in more isolated prison conditions that can cost more than $250,000 per year.** In addition, many are sole-support parents, often causing both psychological trauma and admittance into costly child welfare systems for their children (Howlett, 2011, March 24).

The *Streets to Homes* program was effective at dramatically reducing pressures on the justice system. Once in housing, the use of police detoxification by program participants was reduced by 75%, the number of arrests was reduced by 56%, and the number of jail admittances was reduced by 68% (City of Toronto, 2009). **A second study, based in Denver, found a 76% decrease in the total number of days spent in incarceration among participants in a *Housing First* program** (Perlman & Parvensky, 2006).

Costs to the Health Care System

At least **$14.3 billion in public expenditures** was spent towards mental health services and supports in Canada in 2007-2008.
(Jacobs et al., 2010)

The largest component of costs to the health care system is pharmaceuticals, followed by hospitalization. In Canada, 7.2% of total government health expenditures go to mental health. Non-profit mental health organizations reported receiving $847.9 million from provincial sources, $18.3 million from municipal sources, and $41 million from Federal sources in 2007-2008 (Jacobs et al., 2010). These numbers are disproportionately low when considered in the context of the prevalence rates of mental illness and the percentage of dollars invested in other areas of health.

Mental illness accounted for 52% of acute care hospitalizations among the homeless in 2005-2006 (Canadian Institute for Health Information, 2007). The number of days spent in hospital by Canadians for reasons related to mental health is 5 times the number of hospital days spent for cancer (Federal Provincial Territorial Advisory Committee on Population Health, 1999).

Costs will continue to climb if nothing changes. For example, in 2010, Alzheimer's disease cost Canada about $22 billion. By 2038, the economic burden of Alzheimer's disease will be $153 billion, and the demand for long-term care will increase tenfold (Alzheimer Society of Canada, 2010).

These numbers only account for one side of the health care equation. Not only do people with mental health issues seek treatment for reasons related to their illness, but they are also at significant risk of experiencing a range of physical health issues. **There is a tri-correlation between housing, mental health, and physical health, as the stress of housing insecurity has been noted to lead to greater mental and physical health issues** (Canadian Mental Health Association, 2009).

Recently, the Health and Housing in Transition (HHiT) study by the Research Alliance for Canadian Homelessness, Housing, and Health (2010) issued initial findings from its longitudinal, multi-city study of people who are homeless or vulnerably housed in Canada. Approximately 1,200 vulnerably housed and homeless single adults are being followed in three cities: Vancouver, Toronto, and Ottawa. The definition for people who were considered "homeless" encompassed both "absolute" and "hidden" homelessness, and people who were considered "vulnerably housed" – who had their own residence, but during the past year had either been homeless or had moved at least twice (and so were considered at risk of homelessness). Researchers have since found that the distinction between these two groups is artificial as people who are considered vulnerably housed had spent almost as much time homeless in the previous year as the homeless group: "instead of two distinct groups, this is one large, severely disadvantaged group that transitions between the two housing states" (Research Alliance for Canadian Homelessness, Housing, and Health, 2010).

The key finding in the initial phase of this study (which runs to 2012), is that **people who are vulnerably housed experience the same risk of serious problems as people who are homeless** including serious physical and mental health problems, problems in accessing health care services, hospitalization, assault, and going hungry. Findings to date from the study group that relate both to people who are homeless or vulnerably housed show:

- More than half (52%) reported a past diagnosis of a mental health problem – most commonly, depression (31%), anxiety (14%), bipolar disorder (13%), schizophrenia (6%), or post-traumatic stress disorder (5%).
- Close to two thirds (61%) have had a traumatic brain injury at some point in their lives.
- One in 3 reported having trouble getting enough to eat – being able to get good quality and nutritious foods was also commonly reported as an issue. Of the 36% of people who have been advised to follow special diets, only two in five (38%) do.
- About 1 in 5 (23%) reported having had unmet mental health care needs. A similar proportion (19%) reported that they did not know where to go to get the mental health care they needed.
- Over half (55%) had visited the emergency department at least once in the past year.
- One quarter had been hospitalized overnight at least once in the past year (excluding nights spent in the emergency department).

Consistent with other recent research, high rates of chronic disease and physical health needs were found among the study group, including diabetes, asthma, and cardiovascular disorders. Over one quarter of the study group also had mobility issues.

Costs to the private sector

When productivity costs are factored in, mental illness and addictions cost Ontario at least **$39 billion a year**.
(Alberta Mental Health Board and the Institute for Health Economics, 2007; Centre for Addiction and Mental Health, 2006; Ministry of Health and Long-Term Care, 2007).

The private sector spends at least $2.1 billion a year on disability claims, drug costs, and employee assistance programs for people with mental illness and addictions. Mental health disability claims have overtaken cardiovascular disease as the fastest growing category of disability costs in Canada (Wilson, Joffe, & Wilkerson, 2000).

Invisible Costs

The numbers above do not reflect the costs for caregivers who carry a significant financial burden, often with little or no support. Family members of people living with mental illness are often forced to take on the costly care of their loved ones, sometimes in less than ideal arrangements, due to a lack of adequate housing options with supports. This study found that caregiver costs is a hidden need.

Rationing and Misdirected Resources

The ultimate question with respect to costing is whether we are spending finite health and housing resources in the most effective ways. For example, other jurisdictions have moved from a segregated, institutionalized model to a system of community-based housing and supports. We can certainly make the claim that Canada is moving in that direction; however, the funding model is still disproportionately institutionally-driven. This means that most of what is spent on mental health is still spent in hospitals and institutions, and despite the numerous reports calling for person-centered funding, funding is still provider-based, leaving those living with mental illness disempowered and dependent on others to direct their care (Jacobs et al., 2010).

43% of long-term psychiatric ALC clients in Ontario (stays of 90 or more days) **were re-admissions within 30 days of a previous hospitalization** (36% of which were also for a mental health related reason).

14% of psychiatric ALC clients in Ontario were **re-admitted to the emergency room within 30 days** after their discharge.

52% of psychiatric ALC clients in Ontario who were discharged **visited an OHIP provider within 30 days.**

This investment in hospital-based services has not resulted in a measurable improvement in mental health; evidence clearly points to a shift to community-based services and supports based on individualized need as the key to recovery, with housing as the foundation.

As others have pointed out (e.g., Pomeroy, 2007), it is also important to note that while the term “cost savings” has been used, this may reflect a true cost savings or it may reflect a cost avoidance in which resources are freed up and can then be used more appropriately. Since most of the emergency system costs are fixed, savings from

reduced utilization and diversion to less costly housing approaches cannot easily be shifted to the housing and supports sector to offset increased costs there. However, the global system will be improved by using resources more appropriately and, over the long run, significant cost savings can be realized.

By the Numbers

Understanding the size of the problem is one of the first steps to solving it. Answering the questions "How many people suffer from mental health problems?" and "How many are inadequately housed?" is not simple.

Estimates of the prevalence rates for mental illness range from **20-26% of the population.** (Health Canada, 2002; World Health Organization, 2001; World Health Organization, 2004)

Between **10% and 25% of seniors** experience mental health disorders. (Cole, McCusker, Ciampi, Windholz, Latimer, & Balzile, 2006)

Over **500,000 Canadians have Alzheimer's disease** or other forms of dementia, and that number is expected to double within 20 years. (Alzheimer Society of Canada, 2010)

Between 15 and 21% of children and youth have at least one mental health issue. (Ministry of Children and Youth Services, 2006)

Estimates from a variety of sources were combined to create a picture of the housing need for people with mental illness in Canada. Although estimates of the prevalence of mental illness in the general population are in the 20-26% range, the prevalence is greater among people who are inadequately housed or homeless. The Centre for Applied Research in Mental Health and Addictions at Simon Fraser University estimates that **the number of people living with serious mental illness who are inadequately housed ranges from 20% to 40%** (Patterson, Somers, McIntosh, Shiell, & Frankish, 2008). Among the homeless population, prevalence rates are greater, with estimates ranging from 30% to 40% (Kirby & Keon, 2006). Recent research suggests that the prevalence of mental health issues among the vulnerably housed and homeless could be even higher than 50% (Research Alliance for Canadian Homelessness, Housing, and Health, 2010).

As noted, the Health and Housing in Transition (HHiT) study followed approximately 1,200 vulnerably housing and homeless adults in three Canadian cities: Ottawa, Toronto, and Vancouver. In both of the groups, **more than half (52%) reported a past diagnosis of a mental health problem while about one in five (23%) reported having unmet mental health care needs** (Research Alliance for Canadian Homelessness, Housing, and Health, 2010). In addition, findings from the initial phase of the study showed that people who are vulnerably housed experience the same risk of serious problems as people who are homeless. Inadequate housing and homelessness are parallel issues – most people who become homeless started off being inadequately housed (The Homeless Hub, 2009).

One of the most frequently utilized estimates of the core housing need of people living with mental illness in Canada comes from the Canada Mortgage and Housing Corporation (2005), which estimates that **27% (140,000) of people with mental illness live in inadequate housing**. Calling it a "hidden emergency," the Research Alliance for Canadian Homelessness, Housing, and Health (2010) estimate that **almost 400,000 people are vulnerably housed**, many of whom have experienced mental health issues. Estimates by the Wellesley Institute (2010) are even higher, stating that **between 450,000 and 900,000 people are precariously housed when considering the prevalence of "hidden homeless."**

Using estimates from multiple sources, Table 6 provides provincial, territorial, and national estimates of prevalence rates of serious mental illness among the homeless population (Kirby & Keon, 2006), core housing need (Canada Mortgage and Housing Corporation, 2005), and people living in inadequate housing (Patterson et al., 2008).

The Housing Need

The Senate Report, *Out of the Shadows*, identified a minimum need for 57,000 affordable housing units for people living with mental illness.

The recommendation from the Senate Report by Kirby and Keon (2006) is based on a goal of lowering the rate of homelessness among people with mental illness from 27% to that of the larger population (15%). **However, Kirby and Keon's estimate of the number of people with mental illness who are inadequately housed does not reflect the hidden number of those who are homeless** – the "hidden homeless" – couch surfing with friends and family. Nor does it necessarily reflect those living with aging parents acting as caregivers.

The budgeting approach outlined above looks at the level of need and asks: "What is the desired level of service increase? What is the cost?" We also considered a number of other methodologies to estimate the need, including using benchmarks and point prevalences, as well as extrapolating need based upon numbers on the waiting lists for municipal housing and supportive housing for people living with mental illness. Not surprisingly, we arrived at a broad range with **an upper end of over 500,000 housing units with supports for people living with mental illness needed for a population the size of Canada** (as seen in Table 6).

We therefore, concluded that given the feasibility around putting this degree of infrastructure into place and taking into account the populations not reflected (e.g., hidden homeless, aging parents who are caregivers) in Kirby and Keon's (2006) recommendation of providing affordable housing to 57,000 people living with mental illness, **100,000 housing units, together with clinical and housing supports, represents the actual minimum of what is required.**

As stressed throughout this report, the call for 100,000 units is recommended to involve a range of housing options contingent upon the individualized needs of the client while incorporating recovery-oriented, flexible supports. A particular problem that must be addressed is the urgent need of 24-hour high support housing options for ALC clients. Currently, in Toronto, high support housing only accounts for 7% of supportive housing units, while extraordinary numbers of high-need clients await housing vacancies to be able to transition out of costly hospital settings (The High Support Housing Consortium, 2009).

We further examined various costing scenarios, including the Mental Health Housing Initiative (MHHI) described in the 2006 Senate Report, which calls for an estimated average annual spending of $224 million over ten years for the development of new affordable housing units and for the provision of rent supplements as part of the Mental Health Transition Fund. A plan for how best to proportion the funds between new capital construction and rent supplement financing is delineated. As well, the housing supports component is addressed as one of the items in the Mental Health Transition Fund. It should be noted that the Senate Report also identified a role in the MHHI for the Canada Mortgage and Housing Corporation to apply some of its reserves to meet the housing needs of people living with mental illness and to have a mandate for providing some support following the 10-year life of the MHHI (Kirby & Keon, 2006).

Shifting the Paradigm

"A home is more than a roof over your head; it is the foundation under your feet."

The numbers are clear. Hospitalizations are costing us money. Emergency room visits are costing us money. ALC beds are costing us money. Incarcerations are costing us money. Uses of the private sector are costing us money.

Housing with supports, too, will cost us money. But significantly less so than the above.

While there can be a wide variation in costing housing and support models, an estimate of **$20-$44 per day** to house a person in supportive housing with low supports is consistent with costing exercises to date and **$82-$115 per day** in supportive housing with high supports. This is about **ten times less** than the cost of institutional and emergency shelters.

A study by Vincent and Morin (2010) estimated that a minimum of 1,200 people living with serious mental illness in Québec would meet the criteria for independent housing accommodation with accompanying community supports. The cost of a rent supplement program to address this would be $4,500,000, and the estimate for the community supports is $3,600,000 annually. This represents an average of $6,750 per year, or $18.50 per day, per person.

Various studies demonstrate that stable housing with appropriate supports improves quality of life and reduces the use of costly emergency, health, and justice services. Although it is difficult to compare findings across jurisdictions due to differences in methodology, client groups, and types of service, overall, studies have found **cost savings including cost avoidance on the order of $1,300 to $34,000 per person annually as a result of providing housing and supports for formerly inadequately housed people**. Cost savings are most significant for the chronically homeless, who are heavy users of the system.

Safe, secure, and affordable housing is the foundation to wellness and belonging; it is a fundamental right that most Canadians take for granted, unless you are living with a mental illness. By virtue of a label – a diagnosis – the most fundamental rights can be stripped from us. Losing one's home is often part of the stripping away of one's personhood. Without a safe and affordable place to call home, as well as appropriate supports, mental illness is often exacerbated, leading to increased hospitalizations, brushes with the criminal justice system and incarcerations, and, of course, homelessness.

Sadly, in a country as well endowed as Canada, incarceration, hospitalization, long waitlists for even the most inadequate housing, and homelessness have become *de rigeur*, often masking the real need for housing and leaving some of the most vulnerable members of our communities in precarious circumstances. **Ensuring we provide adequate housing and supports to people living with mental illness is not only the humane path to follow; it is also the most economically beneficial to Canadian society**.

Table 6. *Range estimates of serious mental illness, homelessness, core housing need, and people inadequately housed across Canada.*

		AB	BC	MB	NL	NB	NT	NS	NU	ON	PEI	QC	SK	YK	CANADA
	Population (Aged 15+)	2,658,835	3,433,885	923,230	427,240	611,745	31,545	767,025	19,470	9,949,480	111,870	6,293,620	780,460	24,655	26,033,060
Prevalence of Serious Mental Illness [2%-5%]	At 2% of the Population	53,200	68,700	18,500	8,600	12,300	640	15,400	390	199,000	2,240	125,900	15,700	500	520,700
	At 5% of the Population	133,000	171,700	46,200	21,400	30,600	1,580	38,400	980	497,500	5,600	314,700	39,100	1,240	1,301,700
People Inadequately Housed [20%-40%] (Patterson et al., 2008)	At 20% of 2% of Population	10,700	13,800	3,700	1,800	2,500	130	3,100	80	39,800	450	25,200	3,200	100	104,200
	At 40% of 2% of Population	21,300	27,500	7,400	3,500	4,900	260	6,200	160	79,600	900	50,400	6,300	200	208,300
	At 20% of 5% of Population	26,600	34,400	9,300	4,300	6,200	320	7,700	200	99,500	1,120	63,000	7,900	250	260,400
	At 40% of 5% of Population	53,200	68,700	18,500	8,600	12,300	640	15,400	390	199,000	2,240	125,900	15,700	500	520,700
People in Core Housing Need [27%] (CMHC)	CMHC estimated 27% of 2% of Population	14,400	18,600	5,000	2,400	3,400	180	4,200	110	53,800	610	34,000	4,300	140	140,600
	CMHC estimated 27% of 5% of Population	35,900	46,400	12,500	5,800	8,300	430	10,400	270	134,400	1,520	85,000	10,600	340	351,500
People who are Homeless [0.58%-1.15%]	Homeless at 0.58% of Population	15,500	20,000	5,400	2,500	3,600	190	4,500	120	57,800	650	36,600	4,600	150	151,000
	Homeless at 1.15% of Population	30,600	39,500	10,700	5,000	7,100	370	8,900	230	114,500	1,290	72,400	9,000	290	299,400
People who are homeless with mental illness [30%-40%] (Kirby & Keon, 2006)	With MI in 30% of 0.58% of Population estimated to be Homeless	4,700	6,000	1,700	800	1,100	60	1,400	40	17,400	200	11,000	1,400	50	45,300
	With MI in 40% of 0.58% of Population estimated to be Homeless	6,200	8,000	2,200	1,000	1,500	80	1,800	50	23,100	260	14,700	1,900	60	60,400
	With MI in 30% of 1.15% of Population estimated to be Homeless	9,200	11,900	3,200	1,500	2,200	110	2,700	70	34,400	390	21,800	2,700	90	89,900
	With MI in 40% of 1.15% of Population estimated to be Homeless	12,300	15,800	4,300	2,000	2,900	150	3,600	90	45,800	520	29,000	3,600	120	119,800

THE ART OF THE POSSIBLE

The hope in this statement reflects the potential of a study that has, in every way, tried to capture the voices and concerns of relevant stakeholders. It also reminds researchers of the commitment that needs to be made to knowledge translation, thereby promoting positive social change.

The sections thus far have contextualized the issue, mapped the current situation in the field of housing and related supports, outlined the challenges faced, and highlighted some innovative strategies that address these challenges. The results of this research also emphasize the need to redefine the basket of support services and underscore innovative practices that have led to the operational redefinition of the basket. Finally, the economic argument underlying the urgent need for investment in housing has been made. This chapter takes the materials from previous sections and seeks to answer the question: **what needs to be done and how can it be done?**

> "When you have a mental illness a lot of times you don't have the energy of the state of mind or whatever to make your voice heard. So I think that one of the reasons that I'm hoping with the MHCC, that that is a way to get our voices a little more unified and heard more."
> -webinar participant

A Need Based Outcome-Oriented Framework

The voices of people living with mental illness and their families resonate throughout this study, and these views are substantiated by the fact that similar concerns are expressed by other stakeholder groups.

Findings reveal that the optimal outcomes in terms of recovery oriented housing and supports for people living with mental illness are as follows:

- Affordable Housing
- Quality Housing
- Housing and Support Options that Work
- Housing and Support Options that Fit

The achievement of these outcomes is contingent on highly specific inputs, synthesized from findings in different sections of the study:

- Investment
- Planning, Partnership, and Coordination
- Localized, need-based, population specific considerations within a framework for a National Mental Health Supportive Housing Strategy
- Application of the Redefined Basket of Services
- Establishment of Service Standards in providing Housing and Related Supports

For the successful implementation of a strategy, it is important to identify up front the key players who need to collaborate. For the National Mental Health Supportive Housing Strategy, the key players are:

- The Mental Health Commission of Canada
- Provinces and Territories
- The Federal Government

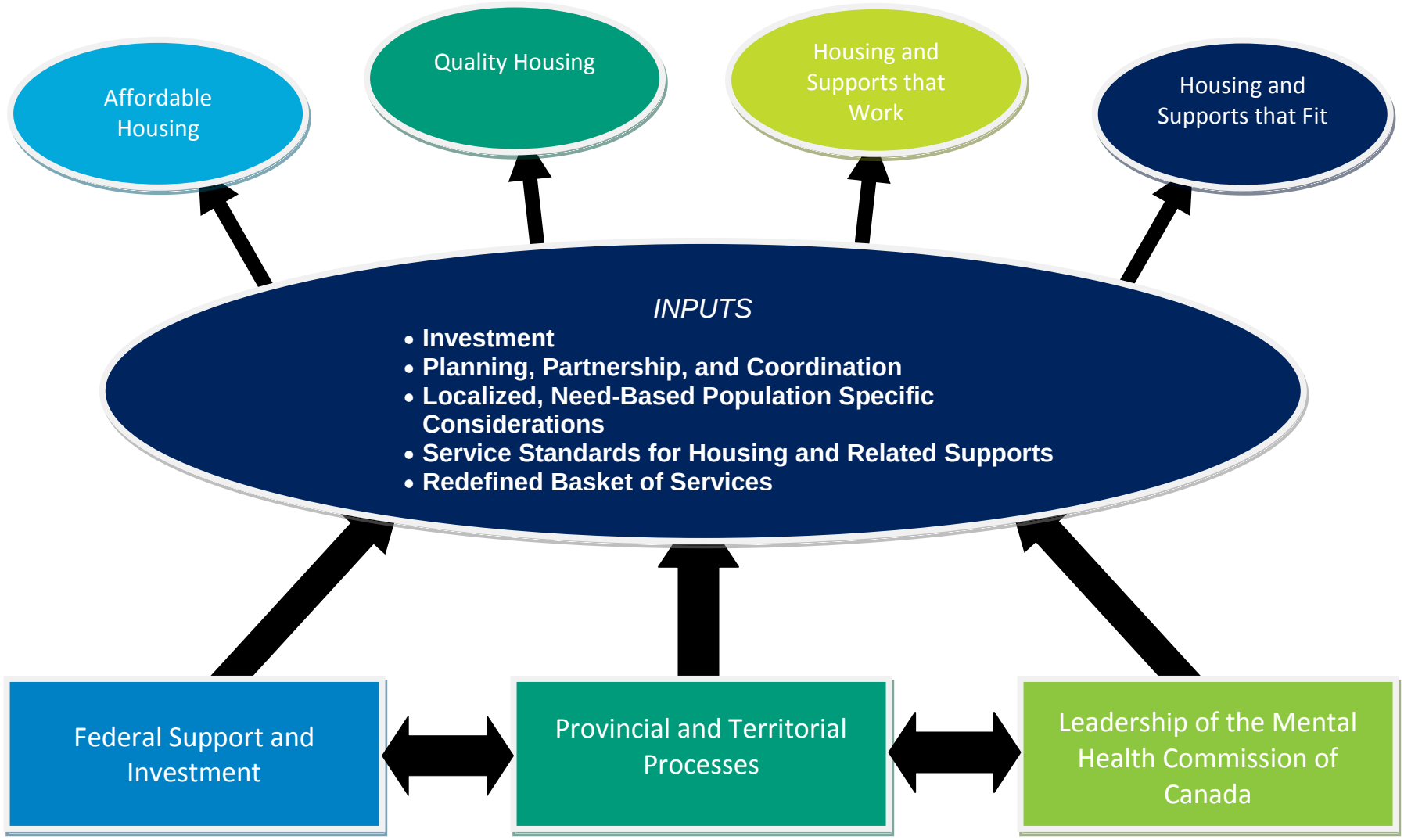
Other collaborators will include municipalities, Aboriginal governments, community organizations, mental health service providers, housing providers, and people living with mental illness.

Of vital importance is a provincial/territorial process, supported by the Federal Government and the Mental Health Commission of Canada.

The suggested framework is in consonance with the Kirby Commission's report, *Out of the Shadows at Last* (Kirby & Keon, 2006), which highlights the need for safe and adequate housing and recommends the establishment of the Mental Health Transition Fund by the Federal Government. This fund includes investment for the following: the Mental Health Housing Initiative, the Basket of Community Services, and the Promotion of Collaborative Care.

The present study confirms the need to expand the scope of the Mental Health Housing Initiative to include the redefined basket of services and the promotion of collaborative care in the context of housing and related supports for people living with mental illness.

Figure 4. *Outcome oriented framework for mental health housing and related supports.*



The following discussion elaborates upon specific elements of the framework and innovations[17] that provide direction with regards to the question: **how to?**

Increasing Affordable Housing Stock

Increased subsidies, rent-geared-to-income, affordable home ownership initiatives, the promotion of a guaranteed annual income, and the provision of portable housing benefits are some of the ways in which housing can be made affordable. **Working closely with government departments to make adequate income supports available to people living with mental illness, along with providing them with budgeting and income management support, is vital for access to affordable housing**.

Out of the Shadows at Last (Kirby & Keon, 2006) calls for a federal investment, of which 60% is allocated to rent subsidies and 40% to the creation of new affordable housing stock, in total providing for 57,000 affordable housing units. Taking into account the populations not reflected (e.g., hidden homeless, aging parents who are caregivers) in the recommendation by Kirby and Keon, we believe that **100,000 housing units represents the minimum required number**.

The renewal of the Homelessness Partnering Strategy (HPS) for another three years by the Federal Government as of November 5, 2010 will also benefit people living with mental illness, as they figure significantly in the homeless population. Through the CMHC, the Federal Government provides contributions to increase the supply of off-reserve affordable housing in partnership with provinces and territories. A similar strategy focused specifically on affordable housing for people living with mental illness is recommended.

[17] Please note that innovations that have already been woven into the body of the report, specifically in sections five and six, are not repeated here but should also serve to inform the reader regarding the art of the possible.

INNOVATIONS

THE PORTABLE HOUSING BENEFIT (MANITOBA)

The office of the Cross Departmental Coordination Initiative (CDCI) was created in 2007 to coordinate activities across provincial departments including Housing and Community Development, Family Services and Consumer Affairs, and Manitoba Health and Healthy Living to better provide housing and supports for seniors and people who are homeless, including people who are homeless with mental health issues. The different provincial departments, through the CDCI pooled their resources to create portable housing subsidies which were then made available across Manitoba. This is an excellent example of how interministerial coordination and commitment led to a fiscal commitment, enabling access to affordable housing. The portable housing benefits are administered through community organizations thereby ensuring that necessary supports are also made available to people in their independent living settings.

MIXED MODEL – HOME OWNERSHIP AND RENTAL OPTIONS (SALMON ARM, BRITISH COLUMBIA)

The Affordable Home Ownership Model
This model is not solely for people with mental illness and addictions, but has benefited these groups. Through an innovative business process initiated by CMHA, the property acquisition arm of B.C. Housing bought 11 two-bedroom apartment units in the picturesque town of Salmon Arm in rural B.C. and provided subsidies to ensure affordable homeownership for qualified buyers. CMHA, on behalf of the province, administers the home ownership program and the waiting list. This is part of the Provincial Housing Strategy, *Housing Matter B.C.*

An effective working collaboration with the local credit union has made a 100% mortgage possible, thus increasing the affordability of housing for people without the capacity to make a down payment. The associated CMHC fee has also been waived. The fact that the housing is not targeted to any specific population group creates a mixed model, facilitating community integration. The housing is affordable in perpetuity, because when home owners are ready to sell they can only sell their unit for what they had paid for it plus the Consumer Price Index.

The Rental Model
Also in Salmon Arm, there are 28 rental apartments just adjacent to the 11 homes. The rental units are subsidized, and operated by CMHA. These units are exclusively dedicated to people with mental illness and addictions. This is a partnership wherein the Interior Health Authority provides onsite clinical support and B.C. Housing has an operating agreement with CMHA to provide property management. All tenants are encouraged to engage with other CMHA programs and services (i.e., clubhouse and peer support). This is a cluster model co-habiting with a mixed model.

The integration of both models in one site is inclusive and recovery oriented, as is the presence of onsite supports. In addition, the fact that the quality of housing in both the owned and rented apartments is on par with what is available in the private market sector contributes to the residents feeling valued as a part of the local community. This is very important, as visibility is very high in small communities such as Salmon Arm, which has a population of around 17,000. Efforts such as these help fight NIMBYism in communities while promoting affordable housing options.

Measures to ensure that Housing Stock is of Good Quality

Maintaining quality housing stock is a constant struggle for housing providers. Across Canada, people with mental health problems rely on private rental stock, social housing, and programs specifically designed for people living with mental illness. In each of these types of housing, most providers struggle to maintain quality standards. Private landlords often house tenants who cannot pay an adequate amount of rent; thus, the rental income does not support maintaining good stock. Social housing has quality problems that have reached crisis proportions across the country. In some cases, housing designed specifically for people living with mental illness has fared better, but the picture across the country is mixed. The mapping done in this study confirms that aging and deteriorated housing stock is a problem in many provinces. This leads to decreased quality of life, increased health risks such as asthma and bed bug infestations, and an overall deterioration of affordable housing stock. Also, the long-term investment for repair and renovation is made much higher.
In some cases, non-profits have tried to counter the deterioration of stock by fundraising and engaging tenants in upkeep of the property; however, these are only partial solutions. **Setting annual targets to repair existing housing stock** as specified in the *Precarious Housing in Canada* report (Wellesley Institute, 2010), as well as **specific investments in maintenance, repair, and upkeep as part of the funding for development of new affordable housing stock, are warranted**.

The report *Housing Vulnerability and Health* (Research Alliance for Canadian Homelessness, Housing, and Health, 2010) also emphasizes high quality housing as one of the three essential components contributing to a healthy place to live, with affordable housing and housing that offers needed supports being the other two components. The other challenge is that good quality housing in safe neighbourhoods is not affordable. Hence, financial and income supports along with quality assurance strategies need to be factored into all planning related to housing and supports for people living with mental illness. For existing housing and support service programs, the inclusion of maintenance, repairs, and upkeep should be included as part of the operational budget and subsequent increases must be allowed to the existing budgets.

Increased Focus on Developing a Range of Recovery Oriented Housing and Support Options Featuring the Redefined Basket of Services

This research project has clearly outlined the need for a range of housing options, from independent scattered models, to cluster models, to 24-hour high support housing, to transitional housing models. Having a range of options available will ensure smooth transition contingent upon the needs of the client. The choice made available to people through the housing range speaks to a recovery orientation. **It is also vital that this range features supports that are flexible and synchronize with the needs of the tenants living with mental illness**.

Limited resources in the housing and mental health sectors have been highlighted as challenges in providing appropriate supports to people living with mental illness. The paucity of resources faced by social housing agencies results in challenges in maintaining their aging housing, paying their staff appropriately, and investing in their organizations (Hulchanski, 2002). This has left few, if any, additional resources that could be used to provide housing support for clients. The lack of adequate housing and supports has resulted in ALC clients in hospitals, increasing costs and resulting in longer wait times for other patients. These challenges have been highlighted in findings from various data sources in the current research project.

Redefinition of the basket of services, to include those aspects that are integral to a recovery oriented focus and that have been reiterated as an absolute necessity by multiple stakeholders, is key to developing responsive supports.

The redefined basket includes ***housing supports*** such as income supports; education and employment supports; supports ensuring food security, housekeeping, meal preparation, on-site workers, outreach workers, and medication management supports; ***peer supports***, both formal and informal; and ***health care supports*** including access to a primary care physician, mental health services, and access to a community nurse.

A housing strategy for people living with mental illness should be comprehensive in that it factors in a holistic investment in both affordable housing stock and related support services. **This calls for coordination within and between government levels and departments, fiscal commitment, and clear standards for the composition of the basket of services and the delineation of responsibilities in the provision of services**. This will avoid duplication, increase cost-efficiency, and promote seamlessness in the supports made available. This also calls for concerted investment to build a strong foundation of evidence with regards to the importance of these support services, which in turn will lead to constant refinement and enhancement of services.

INNOVATIONS

STELLA BURY COMMUNITY SERVICES (ST. JOHN'S, NEWFOUNDLAND AND LABRADOR)

Stella Bury Community Services (SBCS) is the largest NGO housing provider in Newfoundland. SBCS provides affordable housing to low income individuals in St. John's. SBCS owns and operates 17 buildings and provides housing and related services to approximately 80 – 90 tenants (including people with complex mental health needs). SBCS operates using a Housing First approach. Many people who access SBCS housing have a range of mental health needs but this is not a requirement for access to the services.

The organization developed by acquiring several properties (including federal government surplus properties), refurbishing these, and using the equity from its first few homes to buy other private market homes. The organization then received funding to renovate their private market homes to create more affordable housing. SBCS has developed a partnership with St. John's Housing wherein SBCS has become the landlord of properties that St. John's Housing cannot maintain, and also provides support to tenants.

SBCS currently operates three homes: (1) Emanuelle House; (2) Naomi Centre; and (3) Carew Lodge. Emanuelle House is a 16 resident/bed therapeutic residential setting for women and men. Two beds are specifically designated for women on parole. Emanuelle House is the only halfway house in the province for individuals from the federal penitentiary system. Individuals are referred from Correctional Services of Canada. Case management services are offered to clients in consultation with their parole officer. On-site services also include group counseling, life-skills training, active living (e.g., recreational activities), and aftercare services.

The Naomi Centre is a short-term shelter/residence for young women between the ages of 16-30. On-site supports include counseling and assistance with educational and employment needs, life skills instruction and housing.

Carew Lodge offers 12 self-contained units with a shared kitchen on each floor. There are also two transitional housing units available to individuals returning to the community under supervised parole. The transitional units include enhanced supervision and security, as well as 24-hour staff support. On-site services available to all tenants include a community development worker who provides tenants and other clients with assistance regarding education and employment needs and advocacy support with regard to income. Carew Lodge will be the location of a 'one-stop-shop' housing resource centre. This will be the only housing resource centre in the province.

A "COMMUNITY" MODEL: THE PORTLAND HOTEL SOCIETY (VANCOUVER, BRITISH COLUMBIA)

The model created by the Portland Hotel Society (PHS) in the downtown east core of Vancouver is one that creates a sense of community for highly marginalized populations – the poor with severe mental illness and/or addictions. A number of converted hotels in the area provide single room occupancies (SRO) for this population. Units in the area differ in space and privacy, with some having shared bathrooms and others having their own bathrooms. The PHS owns an art gallery that exhibits the work of artists from this community and also runs a café below one of the SRO buildings, which provides training and work opportunities for residents. It also enhances the profile of the community as a 'contributor' to society. For example, a local newspaper, Megaphone, has been offered free space, and residents of the area contribute to articles.

As there is a significant population that does not have access to bank accounts because of lack of identification, the society runs its own bank: Pigeon Park Savings. This allow for disability of welfare cheques to be directly deposited into an account, thus negating exploitation by the privately-run ready cash firms. The society has a harm reduction focus and operates its own safe injection site in the area. Just above the site it operates a detoxification centre funded by the Vancouver Coastal Health Authority. This creates a sense of acceptance, thereby building trust, and there are many who willingly access the detoxification centre. PHS reports that of the three detoxification sites funded by VHA, this is the most successful.

As this model creates and area of high concentration of marginalized population groups, detractors of the model criticize it to be akin to "warehousing." However according to Mark Townsend, Executive Director of Portland Hotel Society, such a model provides the sense of community much needed for those facing severe and multiple marginalization, who are likely to feel lonely, isolated, and unwanted in scattered models.

Phoenix Residential Society (Regina, Saskatchewan) featured in Section Four and Houselink (Toronto, Ontario) featured in Section Six are also examples of innovations that illustrate the range of housing and related supports that focus on a social determinants of health framework to recovery.

Development of Programs that Enable Bed Flow

A study by the Health Systems Research and Consulting Unit of the Centre for Addiction and Mental Health reports that psychiatric ALC days and long-stay days (i.e., days exceeding three months for a single hospitalization) consume a significant portion of inpatient resources, accounting for 51% of all ALC/long-stay days in Ontario (Butterill et al. , 2009). The data from the present study, including the mapping of the provinces and territories, survey data, and reference group consultations clearly indicate that linkages between hospitals and service providers are crucial to facilitating discharge from hospital and appropriate placement into a safe, supportive housing environment.

Partnerships and planning are necessary to address the issue of bed flow. All successful programs that aid discharge and ease bed pressures have a very strong partnership factor ingrained in the model.

INNOVATIONS

ST. HELEN'S (VANCOUVER, BRITISH COLUMBIA)

St. Helen's is an innovative multi-purpose SRO style, supportive model, offered by Coast Mental Health, Vancouver. St. Helen's offers 86 rooms in a multi-storey building with some common community space. It operates from a harm reduction, low barrier, strength-based approach and thereby successfully houses extremely marginalized populations.

The third floor of St. Helen's is dedicated to a much needed service innovation – temporary housing for homeless individuals with severe mental illness and addictions who are on the waiting list of the Burnaby Mental Health and Addictions Centre. Since homelessness is a cofounder when it comes to accessing health services, it is ensured that those on the hospital's waiting list are housed until intervention can be provided or more stable housing is acquired. This ensures that the clients are not lost to the system by virtue of their homelessness. This is a partnership between Coastal Mental Health and the Burnaby Centre, through which 22 clients are housed. Once the clients are housed, the staff of Burnaby provide clinical supports, which sometimes negate the need for hospitalization. At other times, clients are transferred to the hospital for clinical management of their symptoms once a hospital bed becomes available. In the interim, tenant support staff of Coastal Mental Health also work with these clients to help them secure long-term housing.

Another floor of the St. Helen's SRO has five beds allocated to the clients of the community transition team of St. Paul's Hospital. Clients are discharged from the hospital into this three-month transitional housing arrangement, in which they are provided with step-down clinical staff support one or two times a week. The clients are then supported to find and move into long-term housing. This enables bed flow as well as supports people in transitioning into independent living arrangements. Also at St. Helen's, there is a five-bed youth transitional program in partnership with Broadway Youth Services, Covenant House, and local psychiatrists.

The Lower Union Street Project (Kingston, Ontario) featured in Section Four and the Post Discharge Transition Program – Hamilton House (Calgary, Alberta) also featured in Section Four are additional examples of innovations that illustrate partnerships which enable discharge.

Conversion of Existing Custodial Housing Stock to Recovery Oriented Stock

The need to move to recovery oriented models is a theme that has resonated with multiple stakeholders. Survey data clearly show us that people living with mental illness reported the highest satisfaction when they lived in their own homes or in apartments dedicated to people with mental health issues. Hence, it is imperative to look at converting existing housing stock to reflect recovery oriented choices. This issue has also been stressed by international key informants. In a landscape where housing stock is limited, it becomes important to think creatively and increase the housing options available through innovative approaches to the conversion of existing stock.

Across the country, models that do not reflect best practices can be found. Typically, these are versions of board and care homes, often large in size. Models like these are custodial if they fail to provide adequate privacy and if they have a one-size-fits-all approach to care. In many cases, the home receives a per diem payment to provide meals, laundry services, and so on. These services must be provided according to the rules of the funding, whether or not a client needs them. Individual support planning is curtailed and lengths of stay are often very long. In many cases, clients are required to eat and take medications at specified times, much like an inpatient ward. Putting in place individualized recovery strategies is very much an uphill battle.

A Related Innovation in Moving from Collective Care to Independent Living Models

The deinstitutionalization process moved clients from hospital settings into community settings. Many models that emerged during this phase were collective care models characterized by group living arrangements in group homes and residential care facilities. Recovery orientation in mental health spurred the movement towards independent living and provision of the relevant opportunities and supports. However, this movement has always been riddled by problems like conversion of existing stock, inadequate independent housing stock, negligible rent supplements, and other funding dilemmas. There have been various innovations that have tried to address these challenges at some level in the different provinces. A case in point is Saskatchewan, which has been cognizant of this need and has been involved in the conversion of group home stock to independent housing stock over the past 20 years.

INNOVATIONS

WAKAMOW PLACE (MOOSE JAW, SASKATCHEWAN)

Through an innovative strategy, three funding pots were integrated to provide the resources to establish this independent living arrangement at Moose Jaw, which facilitated movement away from a group home to a supervised apartment living model. This model, which has been acclaimed as a best practice, is based on a strong partnership between the Moose Jaw Non-Profit Housing Corporation, the Saskatchewan Housing Corporation, the City of Moose Jaw, the Moose Jaw Housing Authority, Five Hills Health Region, the Mental Health Resource Centre and the Kinsmen Foundation.

Through the strategic planning of supports enabled by the partnerships, this 16 unit complex, with four bachelor and 12 one-bedroom suites, accommodates tenants at three levels of care/independence. Tenants can move up and down through these levels of care and the services will follow them. The Kinsmen Foundation provided furnishing to all the apartments.

The building has a recreational area, as well as a vocational centre that provides supported employment opportunities to clients. Groups are conducted on a regular basis and focus on topics such as life skills. In addition, income-management services, education groups, meal programs, and help with medication are provided at no extra cost to residents. The basic rent is $500 for any unit.

Individualized staff support is provided through Thunder Creek Rehabilitation. There is access to the Mental Health Resource Centre. The Health Authority plays a crucial role in this partnership through a very engaged leadership. There are Health Region staff who work at the venue, and psychiatrists and community nurses visit Wakamow Place on a regular basis. Workers of the Health Region are cross-trained in mental health and addictions, and hence a single staff person assigned to a client is able to deal with both issues. There is a strong recovery focus, and clients are encouraged to move out into the community with supports following them.

Developing Housing and Support Options Specific to the Needs of Sub-Populations

Current housing and support options fall short of providing adequate services to sub-populations such as those with concurrent disorders and dual diagnoses, as well as youths and transitional-aged youths, the aging population, culturally diverse populations, and the Aboriginal population. The reasons for this include lack of understanding of the specific needs and tailoring of supports to address needs, lack of sufficient investment into housing and support needs of the populations, lack of investment in training of staff to deal with these population groups, rigid admission criteria that exclude certain sub-populations, the dearth of low-barrier housing options, and a lack of foresight in planning exercises that do not factor in the long-term impacts of not responding to the needs of specific population groups. Related political, social, cultural, and economic implications are also ignored.

There is additional research warranted into the needs of specific sub-populations to make effective and responsive recommendations. While a national project such as this can succeed in highlighting issues and possible strategies, a concerted plan of action requires in-depth study of those specific sub-populations where research is scarce.

INNOVATIONS

BOLIVAR COURT – FRASERSIDE COMMUNITY SERVICES (SURREY, BRITISH COLUMBIA)

Fraserside is a community organization that provides supported housing programs for people living with mental illness and addictions in Coquitlam and Surrey and an emergency short-stay shelter in Burnaby.

Bolivar Court, operated by Fraserside, provides safe, supported, affordable housing to residents experiencing a mental illness and, most often, a concurrent substance use problem. Residents are between the ages of 19 and 65.

An extremely low barrier housing approach is necessary for the residents, due to the previous absence of housing or threat of housing loss; ongoing instability with housing resulting in constant moving from place to place; lack of social and familial support networks; and in many cases, restrictive access to alternative housing in the community.

The program employs a harm reduction approach, is resident-oriented, and encourages active participation in day-to-day activities through personal choice. The length of stay in the program is determined on an individual basis. The housing is based on a tenancy agreement and is not a program. The housing is located in a recently-renovated motel and in the event of hospitalization or other absences, the accommodation will be retained until the resident returns. It is home to 17 tenants who are supported by staff of Fraser health Authority and Fraserside Community Services. There is a nurse specializing in concurrent disorders who is at Bolivar Court three days a week. The nurse functions as a case manager for all 17 residents. In addition, there are four staff available five days a week, with reduced staffing over the weekend between 9 a.m. and 6 p.m. A doctor, a concurrent disorders therapist, and an addictions specialist also provide services at Bolivar Court. Though every apartment is complete with bathroom and kitchen, there are also common kitchen facilities, communal spaces, and an onsite gym to enhance the sense of community. Informal approaches to support like knocking on the door and helping with medication are also employed if needed.

There is a strong network with other organizations, and many organizations like Employment Options visit Bolivar Court and provide services in-house. The partnership with the Fraser Health Authority assists in the referral process as well as providing easier access to detoxification and worker services. This arrangement has significantly reduced hospitalization. To combat NIMBYism, a strong partnership with the police has been built over the years.

Section Four outlines other innovations that address the needs of specific sub-populations.

Developing a Rural Housing and Support Strategy within the Context of a National Supportive Housing Framework

There are specific challenges that impact rural communities at a much greater level than they impact urban communities. Rural communities face the challenge of limited stock in a limited geographic area, as well as limitations in funding and other resources including services. Staffing and staff retention, inadequate outreach supports, and problems in accessing services due to transportation further confound the issue at hand. The political will to invest in these communities often poses additional challenges.

At this point, innovations have become key to addressing these challenges. However, as stakeholders were quick to point out during the visits to rural communities, the fact that they are managing with 'little' through innovative mechanisms should not facilitate a counterproductive argument, as the need is tremendous, and those pieces that innovations manage to address in the context of an under-resourced environment are just the "tip of the iceberg."

A rural/remote housing strategy should factor in the investment required into housing stock in rural communities, the supports required to assist the aging population, a human resource plan that ensures adequate staffing, staff training and staff retention, and most importantly, partnership and coordination at multiple levels in operationalizing the framework. Specific provincial and ministerial investments are required as part of the strategy.

INNOVATIONS

THE INTEGRATED RANGE OF SERVICE PARTNERSHIP MODEL (BRANDON, MANITOBA)

The housing and supports offered in Brandon are the perfect example of seamless integration between Health, Family Services and Consumer Affairs (FSCA), Manitoba Housing, and community supports and services, in a close knit community where flexibility and reciprocity are core values enhancing service delivery.

The Manitoba Portable Housing Benefit (PHB) is delivered innovatively here. People have to be on EIA (Employment Insurance Assistance) to access PHB. A successful partnership with FSCA enabled the assistance rate to be raised, offering a portable subsidy of up to $200 that is carried by the client. CMHA, which administers a number of the PHBs, delivers the damage deposit immediately to ensure that the apartment is not lost, and later gets it reimbursed through EIA. CMHA has also established good relationships with landlords who are assured of support and hence are open to taking people living with mental illness. The Central Intake Committee for the PHB comprises the Brandon Regional Health Authority, Manitoba Housing, CMHA, and FSCA. This enables immediate placement in either social housing or CMHA housing. This avoids delay in terms of a prolonged application process to the housing provider. There are also instances when there is flexibility in administering the PHB model – where clients out of personal preference use the PHB to rent a house and live together with support through the Brandon Regional Health Authority.

A range of housing options, including transitional units, approved and licensed homes, scattered apartments, cluster apartments, and group homes are accessible to clients, though the stock is short of demand. Varying degrees of support services are available in these different models. The emergency shelter run by CMHA is not a dormitory-style shelter, but is comprised of individual units. This negates the need for 24-hour on-site staff and is cost effective as well as recovery oriented, in that units are more like apartments than dorms.

Employment supports are provided by the EIA department through ‘job connection workers.’ CMHA also hires tenants as cleaners in all of its buildings. In addition, the regional health authority provides employment support through employment development counselors.

The Brandon Regional Health Authority operates acute care beds, group homes, and runs a crisis service centre that enables discharge and transitional care until clients are ready to move into the community. They also employ an eviction prevention strategy by working to stabilize a destabilized client by housing him/her temporarily in the crisis centre. A mobile crisis unit providing outreach to remote areas also operates from this centre.

The Health Authority has cultivated effective partnerships with Manitoba Housing, FSCA, and community service providers. From specialist services to proctor services, a range of services are offered through the Regional Health Authority and their partnerships. It is an ‘extended team’ model.

The proctor model is a unique model in which community members are trained and hired as casual support workers. As proctors are from their home communities, they are able to serve clients in rural/remote areas, reach out to them, and support them in their home settings. This avoids dislocation and provides for the maintenance of hosing of clients in their home communities. 20-25% of the proctors are people with lived experience, which indicates a trend towards a peer support model.

INNOVATIONS

EFFECTIVE COMMUNITY PARTNERSHIPS IN AN UNDER RESOURCED ENVIRONMENT: SHARE AND CMHA (PRINCE ALBERT, SASKATCHEWAN)

There are limited services and housing options available for people with mental illness and addictions in many rural areas. Funding is a constant challenge. In such situations, community organizations diversify their services to address unmet needs, and also collaborate for maximum efficiency and reach. The individual services of SHARE and CMHA, as well as their partnership in Prince Albert, are one such example.

SHARE converted Molson's brewery into a vocational centre in 1988. It provides sheltered employment to clients with mental health and addictions. Lawn cutting, snow removal, signage, litter picking, moving jobs, and collating mail-outs are some of the jobs undertaken. Funding is received partially through the health authority and partially through charging for services. Clients can earn up to $250/month. As homelessness was a major issue in the area, and there was inadequate housing, SHARE expanded its services and now runs a group home through the Approved Home Funding. The SHARE vocational program maintains this building, resulting in some cost savings.

CMHA is involved in health promotion an education and community support service in Prince Albert. They have recently taken on the role of supported hosing provider and are nearing completion of an apartment building with eight independent units: six one-bedroom and two two-bedroom units. The tenants will have access to CMHA's drop-in centre, the vocational program, and a support worker, and will also be attached to a community mental health nurse. In an environment where most of the housing available for clients with mental illness and addictions is through Approved Homes, this is a step towards independent living. The rent is affordable at $550/month.

The partnership between CMHA and SHARE makes services of both organizations available to each other's clients. CMHA clients may access the sheltered employment at SHARE if they don't work well in the vocational programming offered by CMHA. The tenants of SHARE can avail themselves of the day programming at CMHA, including the drop in centre, the vocational programming and the lunch program. Both organizations jointly advocate for service and supports to the province and the health authorities.

Section Four outlines another innovation that addresses rural/remote challenges, in which Eden Health Care Services works with multiple health authorities to provide services to many parts of rural/remote Manitoba.

The Foundational Pillars of the Framework

The achievement of outcomes has been elaborated upon in this section. This has also led to an elaboration of the inputs needed to operationalize these outcomes, such as partnerships, the redefined basket of services, and localized and population-specific considerations.

Two elements are fundamental to the successful attainment of the desired outcomes. They are:

1. Planning, Partnership and Coordination
2. Establishment of Service Standards

Opening Doors through Planning, Partnership, and Coordination

Routine assessment and continuous planning based on need levels should be a fundamental aspect of the National Supportive Housing Strategy. At present, planning for housing and related supports are relatively lacking in comparison to other health care planning (e.g. , Cancer Care Ontario, where planning seeks to ensure that people

get cancer treatment within a reasonable time period). Sectoral responsiveness to the housing and support needs of people living with mental illness is not on a par with the responsiveness to other health needs.

There are initiatives from multiple provinces in which such planning and assessment has been undertaken and implemented. For example, Housing Matters BC (Government of British Columbia, 2006), the Provincial Housing Strategy in British Columbia, focuses on providing supportive housing to vulnerable populations. In Ontario, there have been similar attempts through Making It Happen (Government of Ontario, 1999) and other initiatives such as the present Toronto Central Local Health Integrated Network initiative which looks at current capacity in terms of housing and supports against required capacity as a planning tool for the geographic area. The provincial policy framework informing mental health planning in Québec is the Plan d'Action en Santé Mentale 2005-2010 (Government of Québec, 2005). This policy profiles a recovery orientation, highlights the importance of partnerships, and encourages the fluid integration of health and social services aimed at supporting users of services and their natural supports.

As the issue at hand spans multiple ministries and multiple players, the importance of partnership and coordination is integral to the process of providing optimal housing and related supports to people living with mental illness. Survey data, site visits, and consultations with international key informants and reference group members have provided concrete evidence of the need for partnership and coordination.

Examples of partnerships and coordination have been found at multiple levels and are a distinctive feature of almost all the innovations featured throughout this report.

The housing strategy should be informed by the development of a partnership and coordination model which outlines the multiple levels of partnership, the coordination within and among levels of partnership, and the operational aspects of the partnerships that translate into specific program outcomes.

These players will include government departments (e.g. , ministries in charge of housing, income assistance, and disability), regional health authorities, non-profit and for profit housing providers, mental health service organizations, peer and family organizations, and community based service organizations.

While provincial partnership and processes are crucial, federal-provincial partnerships and coordination are a key element of successful planning and implementation of appropriate and affordable housing options across provinces and territories in Canada.

A case in point is the $32 million dollar federal-provincial investment in Nova Scotia was announced by the Ministry of Community Services in October 2010. This investment will provide safe, affordable housing for more than 6,000 families, seniors, and person with disabilities. Of this investment, $21 million is for housing renovations and repairs.

INNOVATIONS

THE CROSS DEPARMENTAL COORDINATION INITIATIVES DIVISION (MANITOBA)

The Cross Departmental Coordination Initiatives (CDCI) office was created in 2007 to coordinate activities across provincial departments (including Housing and Community Development, Family Services and Consumer Affairs, and Manitoba Health and Healthy Living) to better provide housing and supports for seniors, people who are homeless, and people who are homeless and have mental illness issues. The office works with regional health authorities and communities to improve policy coordination, integrate service provision, improve collaboration, and coordinate strategies.

The CDCI liaises with provincial government departments, regional health authorities, housing authorities, and community-based organizations and research initiatives. The CDCI is seen to have played an integral role in the creation of the Portable Housing Benefit for people with mental health issues. This benefit, combined with attached housing support services delivered by mental health agencies, has already had positive impacts. Factors that facilitated the creation of the CDCI included:

- Consensus across government, health providers, housing providers, and other community agencies that meaningful collaboration was needed to address housing and homelessness issues
- Increasing advocacy and pressure in public forums
- Strong commitment at the ministerial level to housing and homelessness issues: the Minister responsible for housing at the time was committed to learning about better practices in housing (such as Housing First), ensuring that people weren't being discharged from hospitals into homelessness, and developing a long-term strategy to address housing and homelessness issues.

The CDCI has also played a funding and supportive role in the development of the Community Wellness Initiative, which provides supports to people with mental health issues living in social housing units in Manitoba. This was another example of CDCI facilitating coordination across multiple provincial departments, including the Department of Family Services and Housing, the Department of Health and Healthy Living, and the Manitoba Housing and Renewal Corporation. The CDCI is also able to facilitate rapid problem solving; for example, when people were finding that the Portable Housing Benefit wasn't sufficient to cover the damage deposits when people were signing leases, CDCI was able to bring this issue forward to the Department of Family Services and Housing and generate the funding solution required.

INNOVATIONS

THE SUPPORTIVE LIVING COMMUNITY PARTNERSHIP (NEWFOUNDLAND & LABRADOR)

This interdepartmental government initiative was introduced in 2009. The initiative attempts to overcome two major problems that the non-profit sector was experiencing: (1) having to fit their requests into the parameters of multiple government funding programs, which often meant that non-profit organizations were compromising on what they really wanted to do, and (2) a number of good ideas/projects had capital money but lacked operational funds and thus, couldn't get off the ground.

The program was developed by provincial government departments (Department of Justice, Human Resources, Labour and Employment, Newfoundland and Labrador Housing, Department of Education, and Regional Health Authorities). In an effort to better support non-profit organizations, the departments decided to pool money and put a single request in to the Cabinet. The request was approved and one of the regional directors has been seconded to implement the initiative, including managing the funds.

The Supportive Living Community Partnership is tasked with developing programs, assessing need, and responding to the need of communities by supporting a range of supportive housing/supportive living options. This allows non-profit, community-based groups to work closely with government while receiving funds to facilitate supportive living. The definition of supportive housing (in this initiative) is: a range of services and supports which promote housing stability for individuals that present with complex needs. These services include: eviction prevention, supporting community access, linking those to community services, budget management, and life skills development. Supports must be provided in a community-level, broad-based perspective, and not at the individual level (e.g. , only to those requiring a high level of individual support). The program place is restricted from funding those programs that require a home-support component (e.g. , 24-hour a day one-on-one support).

The overall goal of the initiative is funding community groups that will develop models of providing services and staff to individuals who do not require a high level of support. The program can fund a range of services, depending upon the needs of the community. The focus is on individuals who are in and out of institutions, health care, and emergency shelters. It is not focused on supporting congregate living, but seeks to develop scattered-site housing in accordance with a Housing First model; however, funding is available for clustered on-site services, scattered-sites housing, or more flexible community services and supports. All funding goes to non-profit, community-based organizations. Some examples of funding provided by the supportive Living Community Partnership include; support for the creation of a Housing Resource Centre through Stella Burry Community Services; sponsorship of a conference on working with individuals with complex needs (held in St. John's in October 2009); creating a full-time position to support capacity building within the system; and enabling on-site support services to be offered in transitional housing for youth (at Choices for Youth).

The hope is that, through this program, more scattered units and outreach services will be developed. The amount of funding provided by the Supportive Living Community Partnership depends on the target population; a general assessment tool is utilized by the program to determine funding. This process was implemented to allow for flexibility in program development and to ensure that funding can meet the needs of the community.

INNOVATIONS

CLÉ EN MAIN PROGRAM (QUÉBEC CITY, QUÉBEC)

Clé en main secures housing for independent living for persons living with severe mental illness and/or co-occurring disorders in Québec City as well as in some more rural areas.

Clé en main provides a unique response to the housing needs of persons living with mental illness. It acts as a system leader and catalyst to create and maintain cross-sectoral mechanisms that effectively connect the housing provider sector, the mental health support sector, and tenants with mental illness.

Persons living with serious mental health problems are housed with the coordination support of Clé en main. Tenants are provided with access to individual apartments from a variety of housing providers, as well as community mental health supports delivered from one of a variety of mental health service agencies.

The key innovation of Clé en main is its proactive role in developing mechanisms for cross-sectoral integration. Clé en main provides the leadership and the operational means to connect the resources from the housing sector with those from the health sector, resulting in a tri-partite protocol agreement between the client/tenant, the housing provider, and the community support sector. This model is highly applicable to different regions (i.e., urban and rural) and also different marginalized and vulnerable populations (e.g. dual diagnosis).

"La vie en logement au Coeur du développement de la citoyenneté et du rétablissement."
(Housing is at the heart of recovery and citizenship)
-Clé en main program flyer, Clé en main: le rétablissement par le logement autonome

The Establishment of Service Standards in Providing Housing and Related Supports

Accountability is a vital aspect of a framework that applies a recovery oriented lens, and emphasizes the need for developing housing and supports that work and fit the needs of the clientele it services. Service standards are crucial to promoting this accountability and ensuring consistency in the quality of services provided nationwide.

Survey data consistently reported gaps in services available at the agency and regional levels, inadequate staff training and skill levels, issues related to unresponsive and insensitive landlords, and lack of ability ot meet the needs of specific sub-populations.

This results in inconsistency in the quality of services and the range of services made available to people living with mental illness in their respective housing contexts. Two seemingly similar housing programs may differ considerably in their recovery orientation and quality of services rendered due to a lack of service standardization. This greatly impacts rural/remote communities where staff training and retention are significant issues.

The establishment of service standards is integral to the success of a National Supportive Housing Strategy that functions from a social determinants of health framework, with a focus on recovery and optimal functioning. At a minimum, the service standards should include:

1. The redefined basket of services: this includes housing support, peer support, and health and mental health support, with baseline requirements for each of these categories.
2. Training: this should be comprised of overall training requirements, and specific training requirements based on role, geography, and populations served. Training standards should include refresher training options and evaluations at baseline and follow-up. The development of training curricula and a training agenda should be part of the strategy.

3. Landlords: service standards need to be established in terms of the inclusion and exclusion criteria when working with landlords in the private market as well as in the social housing context. A training curriculum and consultation support are minimum requirements in working with landlords.
4. An evaluation mechanism: should be created to allow for continuous improvement and performance review of housing and support services. The evaluation mechanism should include both process and outcome evaluation.

An example from the international arena is the training curriculum developed by the Corporation for Supportive Housing in the United States. This training series, with 11 curricula, provides best practices and guidance on supportive housing development, operation, and services. This curriculum is available at the U.S. Department of Housing and Urban Development's Homelessness Resource Centre.

A useful guide to benchmarks is The Housing Stability Benchmarking Study by the Community Support and Research Unit (Centre for Addiction and Mental Health, 2003). This clearly outlines benchmarks and recommended practices for improving housing and related supports for people living with mental illness, with a focus on ensuring housing stability. This study was followed by The Housing Stability Validity Study (Centre for Addiction and Mental Health, 2005), which validated the Housing Stability Model and the benchmark evaluation procedure developed in Toronto, Ontario through application to two other local housing systems in Canada: Ottawa, Ontario and Halifax, Nova Scotia.

INNOVATIONS

EVALUATION FRAMEWORK TO MAINTAIN PROGRAM FIDELITY AND QUALITY (QUÉBEC)

Community organizations are often challenged to implement evaluation mechanisms that enable them to ensure quality and maintain fidelity to evidence-based practices. Le Mûrier, which manages a large spectrum of housing and support service programs for different target populations, chose to invest in developing and implementing an evaluation framework in order to achieve continuous improvement. They hired a consultant for the development of the initial instrument and have continued to tailor it to meet their changing needs.

The evaluation instrument is comprised of 12 assessment grids that rate processes and procedures for client support and services. The instrument is completed by each program team every three years. The results are analyzed and enable the establishment or organizational improvement goals. Action plans are written and implemented in the following two years. This ongoing quality assurance process enables the organization to stay attuned to clients' needs, organizational assets and challenges, and environmental realities. The organization has fine-tuned and tailored the instrument over the years and continues to do so. The instrument and the process benefit the orientation and training of all staff.

The Art of the Possible stressed the importance of a recovery orientation and a social determinants of health framework in all the initiatives that need to be undertaken to improve housing and related supports for people living with mental illness. It is imperative that governments and policy makers embark on this exercise equipped with this lens so that investments are focused and reflective of best practice.

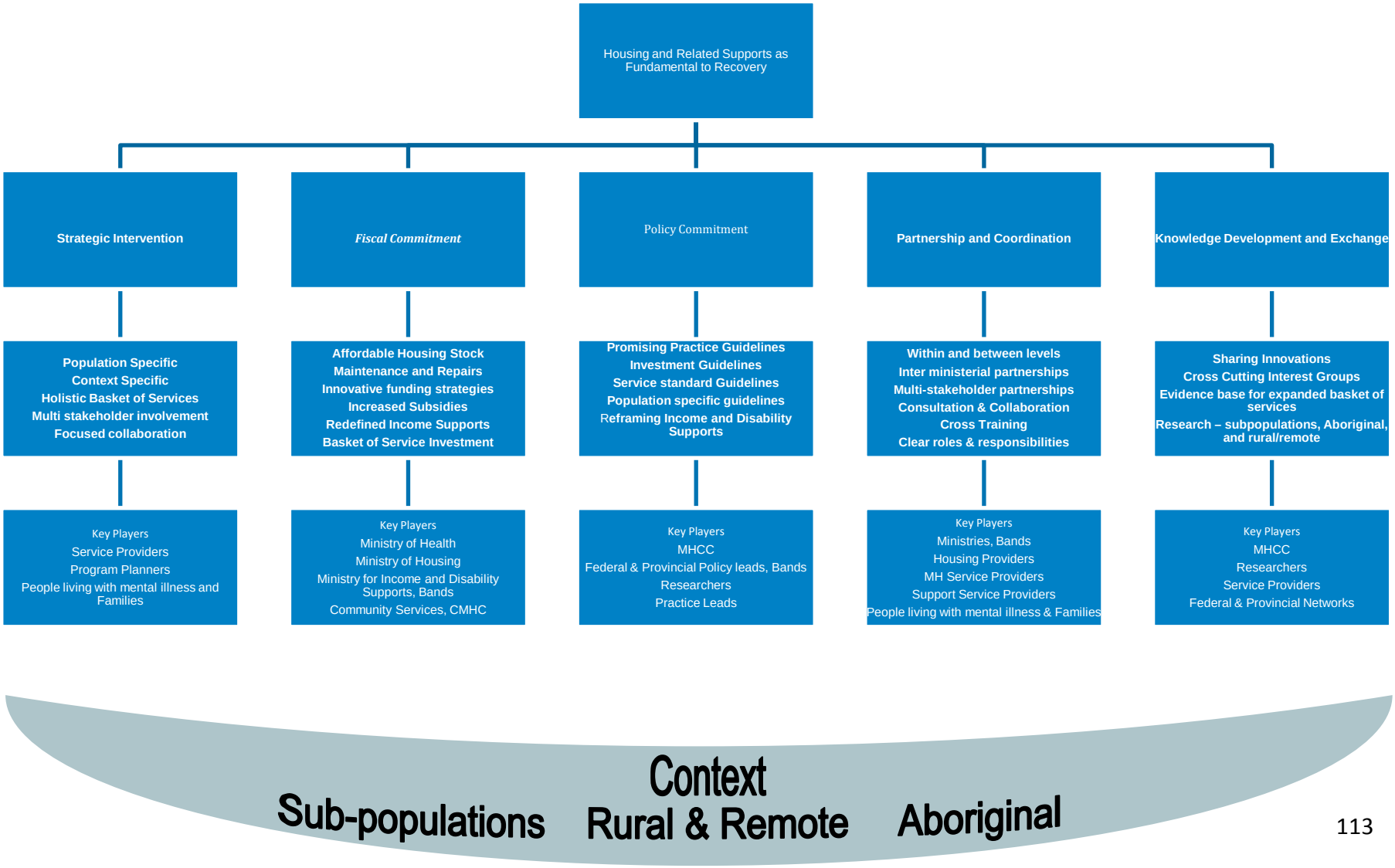
The next page features a guideline for actualizing the outcome-oriented framework for a National Supportive Housing Strategy.

Project Limitations in Populations Investigated

There are a number of populations that experience unique housing and related support challenges that were beyond the scope of this project. We acknowledge that populations such as those with acquired brain injuries, concurrent disorders, dual diagnoses, forensic backgrounds, and the again population are important to consider in the development of a national supportive housing strategy. The Mental Health Commission of Canada has taken a

lead role in identifying how to improve the mental health system for some of these populations. Of its advisory committees, which conduct research projects in eight different fields, one is focused on the needs of seniors with mental illnesses or mental health problems and a second is focused on people with involvement in the legal system that also have mental illnesses or mental health problems. Further research is required into the unique needs and challenges of these and other populations as they relate to housing and supports.

Figure 5. *Guideline for Operationalizing the Outcome of Oriented Framework for a National Supportive Housing Strategy*



TAKING ACTION

Perhaps the best starting point for action in Canada is Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada. Issued by the Standing Senate Committee on Social Affairs, Science and Technology (Kirby & Keon, 2006), this report stressed the importance of housing and set national targets. Out of the Shadows at Last is also frank about the housing impacts that have resulted from Canada's underdeveloped mental health system:

> "The result has been that far too many people living with mental illness have ended up in prisons and homeless shelters — indeed, prisons and shelters have become the asylums of the 21st century."
>
> – Kirby and Keon (2006)

We can add to this the thousands of people across the country who remain in hospitals or live in insecure housing and in models that do not meet best practice standards. Out of the Shadows at last proposed to address these issues through a national Mental Health Housing Initiative (MHHI). A ten-year plan would see the creation of housing units through the development of new housing and by establishing rental subsidies. The plan was truly national, with participation by provinces and territories as well as service providers seen as important components.

The MHHI is an ambitious plan that addresses the scale of action needed to solve the housing issue. The present report confirms that we have the foundation in place to build the MHHI and that we have a clear rationale for doing so from the perspective of the health system. Poor housing is bad for people's health and is bad for already strained health budgets. We know that by working together, we can invest in people and give them the tools to live productive and fulfilling lives.

Out of the Shadows at last (Kirby & Keon, 2006) makes a critical distinction between a 'federal' and a 'national' strategy. A federal strategy focuses on the actions of the federal government. While this is vital, it cannot work in isolation. A truly national strategy sees all of the actors – including governments at all levels, service providers, people living with mental illness and their families, and others – working together under a common framework. Thinking this way, we can see the tremendous resources and experience that can be brought to bear to solve the housing problem.

But how do we get going? The good news, of course, is that we are moving forward on many fronts already. In many provinces and territories, mental health strategies are in place or being reformulated, and most of these have housing as a feature. As well, the Mental Health Commission of Canada is soon to issue a national mental health strategy. The voice of persons living with mental illness is crystal clear – "a home, a job, a friend" – and new housing models such as rent subsidies are bringing greater cost flexibility and feasibility.

A National Process

We need to start or enhance a series of key processes to get housing solutions implemented. Using a national approach, as defined above, we can identify regional, provincial/territorial, and federal initiatives that can work together. The challenge is to recognize that we are trying to influence a series on ongoing processes. Many jurisdictions have housing strategies, poverty reduction strategies, and other relevant initiatives. This makes the challenge one of how to influence current actions and to shape new ones, rather than starting from scratch. We will suggest a few ideas below and some process ideas for moving forward.

PROVINCIAL/TERRITORIAL LEVEL

At the centre of any action plan will be a strong sense of what is needed in each province and territory. How many housing units and what type of housing will address people's needs? We have seen in Section Seven how we can estimate need, but each jurisdiction has a unique context with its own challenges. In preparing this report, we

heard repeatedly of the need to bring players together to develop a unified approach. Given this, a fundamental step is to create (if this has not been done) provincial and territorial targets.

Creating targets has several implications:

- A point of leadership is needed with the province/territory and the process needs to be sanctioned, ideally by government.
- The right players. The members of the advisory groups that helped to guide the current study are a starting point. Players should include government, social housing providers, people living with mental illness and their families, and specialized mental health housing providers, people living with mental illness and their families, and specialized mental health housing providers.[18]
- Reviewing the existing resources. This report offers detailed material on each province and territory, but a critical review is needed. The four focal points defined in Section Eights above (affordability, quality, support and fit) are categories that can form the basis of a review. For example, many jurisdictions still use custodial board and care homes. These are examples of a problem with support – they are not recovery focused. In other cases, rural and remote housing options are a key issue.
- Identifying the number and type of units needed.
- Putting the spotlight on partnerships. People from all across Canada have repeatedly mentioned the need to get key players together and build partnerships.

We can see that targets will include revamping or modifying some existing programs, defining new net housing resources, and developing new levels of cooperation and partnership. Targets alone, however, are not enough. Each jurisdiction needs an action plan that defines the steps needed to reach the targets.

FEDERAL LEVEL

The Mental Health Commission of Canada has initiated two national housing projects: this one and At Home/Chez Soi. These projects have created a national focus on housing for people living with mental illness and brought together a wide range of players including the federal government, national professional bodies, and the national level of peer run and family organizations. Action at the federal level will include:

- National Leadership. The Mental Health Commission is ideally suited to coordinate the federal dimension of a mental health housing initiative.
- National targets. This report has provided an estimate of the national need, but a more detailed picture will emerge when provincial targets are rolled up.
- Cross-cutting interest groups. To address and overcome challenges in the area of housing and related supports for people living with mental illness, key players need to be open to ongoing discussions with other individuals from across Canada. During the process of this study, five issues of interest across Canada emerged which include:
  1. Housing and supports in rural and remote areas
  2. Facilitating movement from custodial to non-custodial models
  3. Challenges specific to sub-populations – youth, the elderly, people with addiction issues
  4. Creative funding and partnership models
  5. Housing and supports for Aboriginal populations

  People across the country have expressed interest in working together to find solutions. The Commission is ideally suited to host this function.
- Sharing what we have learned. In addition to cross-cutting groups, it is essential to have a national exchange of ideas. This report developed a base of innovative practices that will be posted electronically on the Commission's website. It will create easy access to information on these approaches, and people will be able to add new resources.
- Make housing a part of the social movement for mental health.

[18] Note that in some cases the estimate of need will include federal input; for example, elements of Aboriginal populations and the military.

Building on Success

This is an ideal way to pose the challenge in housing: building on success. We have these ingredients in place:

- A rich base of experience and knowledge
- An infrastructure of housing providers that can move quickly to meet new goals
- A dynamic national environment of mental health reform
- A national focal point: the Mental Health Commission of Canada
- A growing understanding of the social determinants of health

Next Steps

1. Canvass members of the provincial advisory committees to form the basis for groups that will set provincial/territorial targets
2. Use the Mental Health Commission of Canada's provincial and territorial reference group to promote the concept of provincial targets
3. Involve appropriate federal departments in discussions of Aboriginal issues and funding issues for a national strategy
4. Launch, under MHCC auspices, national cross-cutting interest groups
5. Implement a communication strategy with the base of providers and other stakeholders; this is underway
6. Brand the effort so it will stand out and become a rallying point for reform

Key Recommendations to the Mental Health Commission of Canada

- The Federal Government continue to collaborate with provincial and territorial governments to address affordable, mental health housing with supports in Canada
- The MHCC should work with the reference groups set up through this project, regional health authorities, and provincial and territorial governments to use the findings in this report to develop plans to increase the supply of mental health housing and supports across the country, with a minimum goal of developing and funding 100,000 supportive housing units and related supports over the next 10 years.
- The MHCC, provincial and federal governments, and community partners develop plans to ensure that constituents in the At Home/Chez Soi projects continue to access Housing First individualized housing and recovery oriented support when the research phase expires and that the MHCC and its partners develop a knowledge to action strategy to build on the learnings of the At Home/Chez Soi project.
- The MHCC work with federal, provincial, and territorial governments to ensure that current and future mental health strategies developed in partnership with First Nations, Inuit, and Métis include actions to improve the supply and quality of housing and supports.
- The MHCC should convene a working group to develop a plan to ensure the recommendations in the report by the Task Force on Social Financing[37] are used to make mental health housing and supports a priority for social enterprise investment with foundations, pension funds, and government.