Turning the Key

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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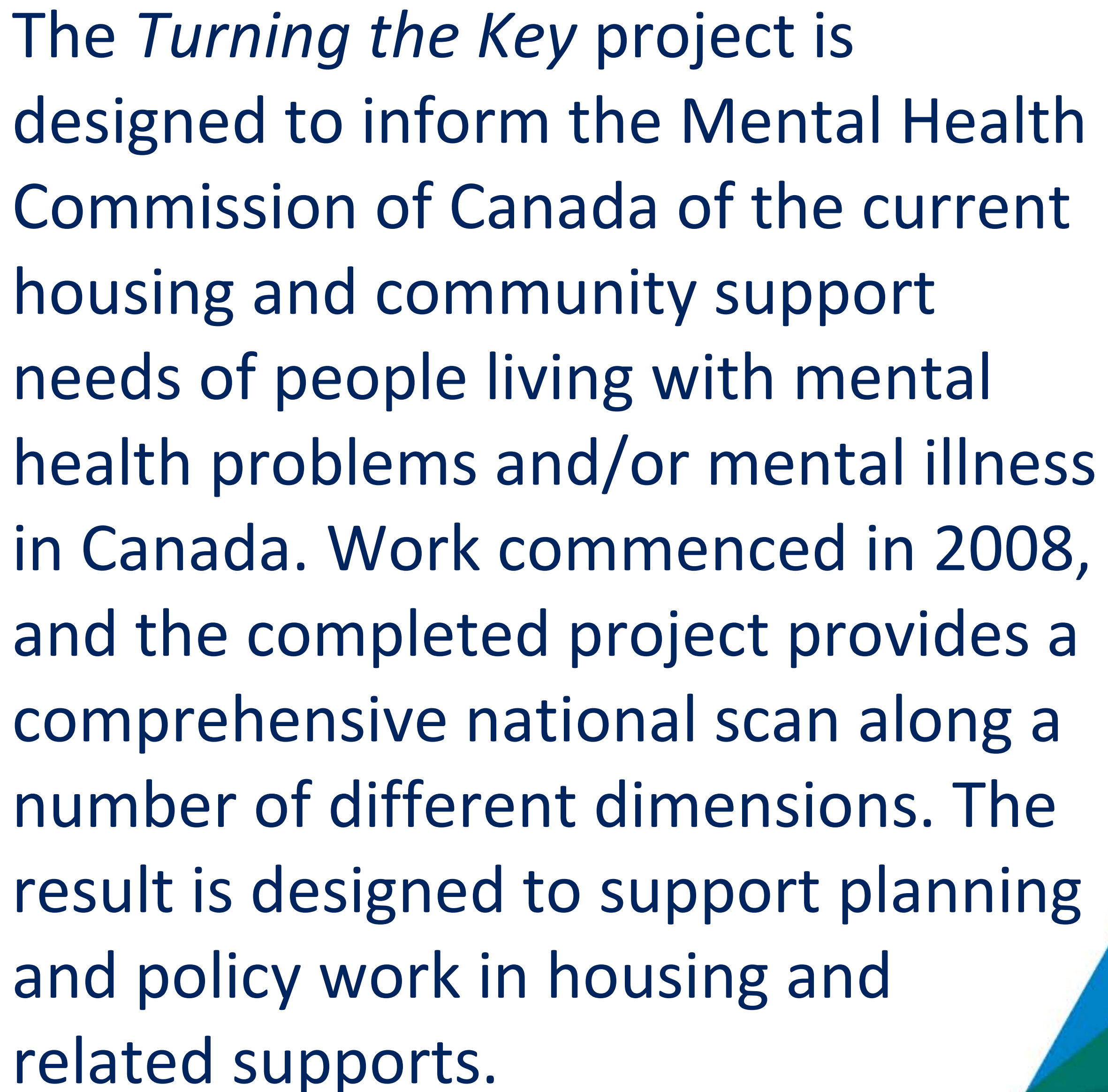

The *Turning the Key* project is designed to inform the Mental Health Commission of Canada of the current housing and community support needs of people living with mental health problems and/or mental illness in Canada. Work commenced in 2008, and the completed project provides a comprehensive national scan along a number of different dimensions. The result is designed to support planning and policy work in housing and related supports.

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Project Purpose

The *Turning the Key* project is designed to inform the Mental Health Commission of Canada of the current housing and community support needs of people living with mental health problems and/or mental illness in Canada. Work commenced in 2008, and the completed project provides a comprehensive national scan along a number of different dimensions. The result is designed to support planning and policy work in housing and related supports.

What Was Involved

Multiple approaches to gathering information were employed, many of them designed to reach out to various stakeholder groups in all provinces and territories. These methods included: (1) development of provincial/territorial and national reference groups; (2) interviews with key system stakeholders; (3) hosting of webinar consultations; (4) development and distribution of surveys 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; (5) creation of provincial and territorial 'maps' of the existing housing and related supports, structural organization of housing and supports, key policy initiatives, promising practices, challenges, and trends; (6) comprehensive literature search and review; (7) site visits; and (8) interviews with international key informants. Input from people living with mental health problems and/or mental illness was a key activity in shaping this report.

Who Was Involved

This project was carried out by researchers at the Community Support and Research Unit of the Centre for Addiction and Mental Health and the Canadian Council on Social Development. Other partners included the National Network for Mental Health, as well as researchers at Ryerson University and the University of Ottawa. This project has been made possible through funding from the Mental Health Commission of Canada. The work of the Mental Health Commission of Canada is supported by a grant from Health Canada.

DEFINITIONS

Dedicated Housing

Housing funded 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 sources originate from municipal, provincial, and/or federal governments, although there are some instances where dedicated housing is funded via private sources. There are two broad categories of dedicated housing: housing with supports and residential care options.

Supported Housing

A form of housing with supports (dedicated housing) in which there is a delinking of support from the housing in which the person lives (i.e., if the person moves, the supports follow them).

Supportive Housing

Conversely, in supportive housing, at least some component of support is linked to the housing in which the person lives.

Non-Dedicated Housing

Refers to housing options funded via government sources that are not dedicated to people living with mental illness. In general, the goal of all such initiatives is to provide housing options where the housing 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 for people with mental illness, the reality is that people with mental illness often live in these options.

Custodial Housing

Typically refers to a board and care model in which a private operator provides a fixed basket of services including meals, laundry, and housekeeping. In most cases, but not all, rooms are shared and privacy limited. Most custodial models date from the phase of deinstitutionalization when longer term clients were seen as needing to be taken care of, rather than as dynamic individuals interacting with their environments and supports in a process of recovery.

WHAT WE FOUND

Introduction

Housing is a potent catalyst for recovery. This has been well documented in previous literature as well as in the findings of this project. Secure housing means affordability, the right support, 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.' When the elements are positively aligned, a home is a foundation, a base, and a key component of our personal lives.

Not everyone with mental illness is equally affected by housing challenges. Mental illness affects millions of Canadians and many of these people live and work in the community and are not in need of special housing supports. As we would expect, the crisis is most severe for people with more serious levels of disability. It is vital to realize that this is not a simple case of cause and effect; the inherent nature of the illness does not determine the level of support needed. People, who cannot work at some time in their life, or on a continuous basis, and as a result rely on social assistance, have a high risk of ending up homeless or poorly housed. When this happens a new factor is introduced that independently worsens mental health. People who could progress towards recovery and more independence in fact become more ill and disabled.

Our research tells two stories. One is of the many Canadians with mental illness who are unable to acquire adequate housing, and the tremendously detrimental effect this has on their physical and mental health. We also see the dramatic moral and financial costs to people and their family members as well as financial pressures on the health care system itself. The second story tells us that this does not need to be the case. Canada has a rich foundation of innovative programs and practical experience that point to the solution and show that we can do it. Across the country there are examples of innovation by governments, agencies, and people affected by mental illness themselves. This is what is so exciting - in Canada we have the right ingredients to properly house people and provide recovery-oriented supports. We also know that by doing this, we will save money through the reduced use of expensive institutional and emergency services[1,2,3,4,5,6].

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.

People can't find homes

People with serious mental illness often live in poverty and are put at increased risk of homelessness or of living in inadequate housing[7]. Across Canada, we found people stuck on waiting lists, in hospitals, in inadequate housing, in shelters, or on the streets. The impact on people clearly shows that housing is a health issue, and that these adverse living situations have a devastating impact on people's ability to move forward in their recovery.

The United Nations declared that homelessness and inadequate housing a "national emergency" following the 2007 review from the UN "Special Rapporteur" on the Right to Adequate Housing in Canada, which declared that it had a "deep and devastating impact" on the lives of Canadians[9].

When good housing is not available shelters become a reality for people living with mental illness. For example, in the territories, we found a very high use of the shelter system. In Yellowknife, 936 people (5% of the city's population) stayed in a shelter in 2008, with shelter beds being used a total of 67,340 times[8]. One factor that plays a role in this is the increasing percentage of Aboriginal persons migrating from reserves to other communities that are not equipped to deal with the culture-specific challenges that this poses. Low vacancy rates also affect

shelter usage; this is the case in Brandon, Manitoba where portable housing benefits for people living with mental illness are of limited use as the vacancy rate is often as low as 0.1%.

As the prevalence of mental health problems is exponentially higher among the homeless population compared to the general population[10], shelters become a last resort option for many people living with mental illness who are homeless. Among the homeless population, estimates of mental illness range from 30% to 40%, with new research suggesting it could be even higher than 50%[11,12].

Without a range of housing and related support options, people living with mental illness are also vulnerable to being stuck in arrangements that are mismatched to their needs. One place where this occurs is with people in hospital (often referred to as alternate level of care, or ALC patients) who have nowhere suitable to be discharged. ALC patients are in hospital when they could be living in the community, a dilemma arising from a lack of appropriate housing and support options. The costs of this are high – someone who does not need the level of support a hospital provides occupies an expensive bed. Results from an Ontario-based study indicate that more than 50% of ALC patients are in psychiatric settings, consuming a significant portion of inpatient resources[5]. Additionally, 60% of mental health ALC patients in acute care hospitals stay for more than 90 days in a single hospitalization. This number rises to 65% in tertiary or specialized hospital settings.

Alternate level of care (ALC) is used to describe patients who no longer require hospitalization but remain in hospital until discharge to a more appropriate level of service (e.g., high support housing).

While some people remain in limbo in hospitals, others living in the community are stuck on long waiting lists for the kind of housing that will allow them to remain in the community. From survey respondents and webinar participants, we heard numerous stories of these long waits for adequate housing options. These stories are only a small fraction of the widespread problem. In May 2011, The Ontario Non-Profit Housing Association (ONPHA) reported that there are 152,077 households on waiting lists across the province for affordable housing, an increase of 7.4% in one year[13]. The Coordinated Access for Supportive Housing System in Toronto reports that the wait list for supportive housing in Toronto has grown to 4510 from 700 in 2009.

The ALC issue was widely mentioned across the country by people who contributed to this report, and in many provinces and territories as an important priority.

Like poverty, homelessness is an adverse part of the journey for so many living with mental illness[15]. The lack of housing options and adequate supports, and uncoordinated intersecting service systems place too many people at risk of homelessness. 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[1†]. We found that there are only 25,367 housing units dedicated to people living with mental illness available in Canada. Contrasting this figure with the 2008 Annual Report by the Ontario Auditor General in which it was estimated that this one province needs another 23,000 supportive housing units[19] for people living with mental illness, we see the need for investment in housing and supports across Canada.

Using Ontario estimates, the Wellesley Institute suggests extrapolating this to a national level as a rough measure of need, equating to roughly **3.4 million households** on waitlists for adequate housing in Canada[14].

[†] The results are composite figures generated from data from several reports[12,16,17,18].

Rents have increased in Canada every year since 1992 while household incomes have not kept pace.[20]

People can't afford the cost of housing

14.3% of Canadians report having a disability, and many rely on social assistance benefits[21]. Compared to other OECD nations, Canada offers very low levels of assistance. When it comes to public spending on disability-related issues, Canada ranks 27th of 29 countries surveyed[22]. In looking across 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. As a result, people who rely on disability income to support themselves have become increasingly poor since the mid 1990s.

The Organization for Economic Cooperation and Development (OECD) is a group of 34 countries that work together on economic and social issues. Currently, it is working in the area of disability policy to develop approaches that will fully include people with disabilities, recognizing their many strengths.

A stable and sufficient income is needed to afford the cost of housing. Many people who are receiving disability income benefits want to work and evidence from the OECD shows that they can work if the proper circumstances are in place. A lack of employment or under-employment leads to poverty and in this sense inclusion in the labour force is one important way of addressing poverty. The stigma and discrimination faced by people with mental illness and the assumption that they are not capable of work reduces the chances of obtaining and sustaining employment[23]. Many Canadians with mental illness also report that they face disincentives to obtaining employment. Securing work may lead to the loss of benefits and potentially place people in harsher conditions than those they faced as recipients of social assistance, including the risk of losing their housing. In addition, the incapacity-focused income assistance systems pressure individuals to prove their inability to work in order to qualify for assistance, creating a major deterrent to disclosing what capacities they do have.

For people with mental illness on social assistance finding affordable housing is difficult or impossible. Many Canadians are paying the majority of their income on housing, with some spending more than 80%[24]. This creates an imminent risk of becoming homeless and the inability to meet basic needs, such as food, clothing, and medication[9]. In a U.S. study, it was found that people with mental illness were also spending **up to 80%** of their income on rent, and that poverty was the major issue in their lives[24].

Disability income programs across Canada provide incomes that are below the poverty line and fail to keep up with the cost of living and inhibit the transition to employment. As a result, few people with significant mental health challenges can access affordable housing[25].

"Working makes a huge difference in life… but if you work full-time, you make less than when you are on disability and work part-time."

– webinar participant

People are living in dire conditions

Poor housing conditions damage health. Housing options are curtailed both by insufficiency in the range of available options and because options are often far from optimal in terms of factors such as safety and accessibility. We found that people are living in harmful housing situations due to the deterioration of the buildings, inadequate amounts of space, dampness, infestations, and other factors that greatly affect personal health. This was voiced as a major concern by contributors to the project, and the decrease in housing options and lack of affordable housing were noted as primary reasons for the situation.

In the regional webinars, participants living with mental illness noted that lack of housing stock and options can give rise to what they called 'slum-type' living situations, including some where social services make rent payments directly to landlords without adequate consideration for the living conditions.

The study's mapping process confirmed that aging and deteriorated housing stock is a problem in many provinces. Many housing providers, who are leaders in innovative housing and supports, said that it was a constant struggle to find the funds for maintenance and upkeep. The mapping process showed that while options in securing capital funding for housing stock development exist, there are few opportunities to secure new, annualized funding to support tenants, subsidize rental costs, and sustain operational costs. Deteriorating stock was also a significant concern expressed by housing and service providers during one-to-one conversations across the different provinces.

In his 2007 report to the United Nations Human Rights Council, the Special Rapporteur on the Right to Adequate Housing declared that "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"[9].

The problem is intensified within the Aboriginal population. We found dire living conditions among both Aboriginal persons living on- and off-reserve. The rate of housing need among Aboriginal persons on-reserve is twice that of the non-Aboriginal population in Canada[26]. Additional challenges and imminent concerns include infrastructure problems (e.g., inadequate water and sewage systems) and overcrowding. These challenges have been identified for many years but progress has been very slow leaving entire communities in poor living conditions for decades.

By neglecting the deterioration of existing housing stock, we are allowing people to live in unsafe and unsanitary housing conditions, compromising both their health and quality of life, and putting in place another barrier to recovery.

People aren't getting the help they need

People living with mental illness have the ability to thrive in the community and move towards recovery. Bricks and mortar are part of the solution, but without adequate supports recovery will not succeed. Across Canada, we found people who were not getting the support they needed, at times preventing them from accessing even the basic necessities of life. Many survey respondents who live with mental illness told us they had faced or were currently facing the challenge of finding a place to live that has the supports they need to stay in the home.

This was an even greater concern among the family members of people with a mental illness; nearly half reported that their family members had faced this problem.
Canadians living with mental illness also told us about the difficulties they face in navigating the mental health and housing systems. People reported they were unable to access the services they need for many reasons, including:

- Supports not being portable whereby moving can result in a loss of support
- Eligibility restrictions on services (e.g., exclusion due to physical health problems or involvement with the law)
- Distance and location of services
- Full caseloads among clinicians

"Our mental illnesses strike each of us very differently."
– webinar participant

We also heard about major issues particular to Canada's Aboriginal communities including racism, lack of understanding of cultural differences, and lack of trust, as barriers to providing needed supports to the Aboriginal population. A lack of culturally specific programming and failure to provide an environment of cultural safety were byproducts of these barriers.
Intermittent periods of distress may be a naturally occurring part of a mental health issue, or may be provoked by environmental conditions. A number of studies demonstrate the role and impact of good housing and related supports in reducing crises. A lack of these necessary supports can create a greater need for hospitalization, increased use of emergency services, and may also lead to higher rates of incarceration. These, in turn, can result in the termination of disability income benefits, eviction, and eventually homelessness[6].
The consequences of living in inadequate housing without the necessary supports are demonstrated in findings from the Health and Housing in Transition study[11] wherein participants who were homeless or vulnerably housed experienced an array of health-related problems:

- More than half (52%) of the participants reported a past diagnosis of a mental health problem – most commonly, depression (31%), anxiety (14%), bipolar disorder (13%), schizophrenia (6%), and post-traumatic stress disorder (5%).
- Close to two-thirds (61%) have had a traumatic brain injury at some point in their lives.
- One in three reported having trouble getting enough to eat – being able to get good quality and nutritious foods was also commonly reported as an issue. Of these, 36% of people were advised to follow special diets, but only two in five (38%) did.
- About one in five (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).

"There's a rotating door effect. Every time you get a little better, you lose support and it drags you back down."
– webinar participant

People find the housing and mental health systems uncoordinated

A lack of coordination and integration exists between housing and other support services. This causes gaps in service for people living with mental illness and leads to the creation and maintenance of less than optimal living arrangements. Gaps between multiple levels of government, within government departments and ministries, between housing providers and mental health service providers, between service providers and landlords, are a few examples that adversely affect the ability to secure adequate housing.
Our study found that coordination between key stakeholders including funders, policy makers, and housing and service providers was a critical challenge in developing an efficient and effective housing and support system for people with mental illness.

Several issues pertaining to the lack of collaboration emerged from discussions with provincial and territorial reference group members and informants:

> "I didn't get help for a long time because with psychiatry they said I had to stop taking drugs before getting any help and substance abuse programs said I had to deal with the mental illness [first]. After an attempted suicide, I was referred to psychiatry for concomitant problems. I started looking for help in 1993 and I only found it in 2005."
> – webinar participant

- Instability in leadership (e.g., cabinet shuffles and interdepartmental/interministerial changes, municipal policy changes) creates confusion at the service delivery level.
- An absence of mechanisms in place to coordinate service delivery in health and social services presents challenges to putting in place housing and supports.

The need for integration and collaboration was not limited to the government sector. Housing providers, mental health service providers, and hospital respondents participating in the surveys were all in agreement that the integration of mental health and housing services was one of the top issues to be addressed. Without coordinated housing and mental health services, people living with mental illness have even fewer housing options and face greater challenges to living autonomously.

We also heard directly from people living with mental illness on this issue. The existing disconnect between programs and services creates a heightened risk of losing housing. Being hospitalized or getting a job can lead to the severing of disability income, and if changes then occur (e.g., discharge from hospital or job loss) uncoordinated systems can cause severe delays in re-acquiring needed assistance. This can lead to financial strain and the threat of eviction; a lack of collaboration can lead a person living with mental illness to homelessness.

At present, planning for housing and related supports is lacking in comparison to other areas of health. In other areas, planning is geared towards ensuring people receive treatment in a reasonable period of time. There is, for example, the routine monitoring of wait times for surgery or other treatments, and major efforts to improve them. Despite the direct health implications of poor housing and homelessness we do not have the same level of monitoring and action. The absence of housing strategies, the level of demand for housing and supports at the front-line level, and the inadequate levels of resources promote a 'crisis reaction' approach to planning rather than a proactive one. Having comprehensive and reliable data available to make accurate assessments of the housing and related support needs for people living with mental illness is a systemic gap that needs to be urgently addressed.

Providing housing and supports is complex and spans multiple sectors. It requires strategic planning and ongoing monitoring. But most of all, it requires the recognition that housing is a health issue.

We are wasting money and lives

Throughout interviews with key informants, national reference groups, and reviews of the literature, we found countless references to inefficient allocations of funding and resources. Two issues arise from this misdirected action: a substantial waste of money, and the waste of human lives.

Many ALC clients who manage to get discharged into the community wind up back in the hospital in less than a month's time.

The Financial Costs of Misdirected Action

The majority of what is spent in mental health is spent in hospitals and on formal treatment of illness. Although numerous reports have called for person-centered funding, funding is still provider-based, often leaving those with mental illness disempowered and dependent on others to direct their care[27]. It is important to realize that a reasonable investment in hospital-based services has been found to be necessary in most developed countries, and that although our current investment is large in terms of its percentage of mental health budgets, it is not large when compared to levels of unmet and untreated illness. It is also true that a proportion of hospital spending goes to supporting people who live in the community. But the fact remains that hospitals themselves report a high level of inpatient bed use that is unnecessary – the people involved could live in the community if the resources were available. It is this fact that points to the more fundamental issue in how the money is spent.

The *Housing First* approach, in which the provision of housing is provided as the first step to recovery, has been shown to be effective in reducing hospitalizations, visits to the emergency room, incarcerations, and shelter use post-housing[3, 29, 30].

The real issue is not only geographic – hospital or community. It is the imbalanced focus on illness treatment, wherever it occurs. Treatment is needed of course, and by international standards Canadians do well. But we do not do well in the areas identified by many people living with mental illness: a home, a job, a friend. What is clear is that the evidence points to the central importance of community supports based on individualized need as the key to recovery, with housing as the primary foundation. It is also the foundation that can get people who do not need inpatient care out of hospital and open the beds to those who do.

It is inefficient to neglect the need for housing with supports in individual recovery. In Ontario, 43% of long-term psychiatric ALC patients (stays of 90 or more days) were actually re-admissions within 30 days of a previous hospitalization[5]. During the hospital stay, clinicians may have dealt with symptoms, but patients aren't provided with the appropriate support mechanisms to live successfully in the community. Instead, we are paying for people to receive expensive hospital care that they do not actually need. In addition to the amount of healthcare funding that is spent, 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[31].

Not getting support in the most cost-efficient way leads to the wasteful use of much more expensive resources:

- **A psychiatric hospital bed costs between $330–681 per day.**
- **A hospital acute care bed costs between $720–1115 per day.**
- **The cost of an ambulance is between $690–785 per use.**
- **The cost of a visit to the emergency room is between $212–820.**
- **The cost of a person residing in a jail is $143-457 per day.**

People living with mental illness become dependent on the health care system in part due to the lack of available housing units with adequate supports. Inadequately housed people living with mental illness re-circulate through a range of health and justice system services such as emergency rooms, psychiatric hospitals, general hospitals, emergency shelters, domestic violence shelters, foster care, detoxification centres, and jails.

The costs of emergency and institutional shelters are about ten times more than the cost of housing with supports. We are gravely misusing already limited funds.

The Human Costs of Misdirected Action

As we have indicated, there is a correlation between housing, mental health, and physical health[31]. People who are inadequately housed or homeless are living in situations of poverty, and poor people in Canada experience 95% more ulcers, 63% more chronic conditions, and 33% more circulatory conditions than do the richest fifth of Canadians[32]. Chronic health conditions like arthritis (33%), hepatitis B (30%), asthma (23%), chronic obstructive pulmonary disease (18%), diabetes (8%), and heart disease (8%) are common among people who do not have adequate housing or are homeless[11]. This research also found that 28% have trouble walking, have experienced limb loss, or have other mobility issues, and that 38% have experienced physical abuse in the past year.

In a 2002 review of the homelessness crisis in Canada, it was noted that "one of the most vivid illustrations of the extent to which homelessness is a problem can be seen in how quickly homeless people die"[33].

There is a strong relationship between housing quality and perceived health: the better the dwelling, the better the health status[35].

Among the homeless population, the risks are even greater[34]. A four-year study of 9,000 homeless people in Toronto demonstrated that the average lifespan was 46 years. The mortality rate for 18 to 24 year-old homeless men was more than eight times that in the housed population[33]. In addition, men who are homeless or vulnerably housed are **twice as likely** as the general population to commit suicide; women are **six times** more likely to commit suicide[11].

If we don't deal with housing we are exacerbating mental health issues, creating physical health issues, and shortening life spans - **we are costing people their lives**.

PEOPLE ARE TRYING TO INITIATE CHANGE

The evidence thus far has displayed a dire picture of the inadequate living conditions of many Canadians with mental illness. It is, unfortunately, an accurate picture for too many people. However, there are signs of hope, of possibility, and of promise to improve the lives of those who are inadequately housed. Across Canada, people are taking action to initiate change. We found people developing creative partnerships, working to improve housing conditions through intelligent planning, improving community integration, improving access in rural communities, acknowledging the unique needs of subpopulations, taking on the challenge of bed flow, and recognizing the power of peer support.

During our site visits across Canada and during the mapping process, we identified a wealth of innovations from which we can learn. The following examples are a sampling of the creative and innovative practices we found. These examples demonstrate that the solution to the housing issue is within our grasp.

The Portland Hotel Society in Vancouver, British Columbia

The Portland Hotel Society created a community model for highly marginalized populations – people with severe mental illness and/or addictions who are living in poverty. A number of converted hotels provide single room occupancies (SROs) for this population. Businesses are encouraged to establish themselves in the area, by providing free space or space at a nominal rent in the buildings.

- An art gallery exhibits the work of artists from this community
- A café provides training and work opportunities for residents
- The program features a harm reduction focus and operates its own safe injection site in the area
- A bank allows for the direct deposit of disability or welfare cheques
- A detoxification centre funded by the Vancouver Coastal Health Authority is available

This encourages community integration and job opportunities for residents and enhances the profile of the community as a contributor to society.

CMHA in Nanaimo, British Columbia

After the closure of a nearby psychiatric facility, many people with mental illness and addiction faced the risk of homelessness or inadequate housing in Nanaimo. Through a partnership between CMHA and the Vancouver Island Health Authority, the challenge of integrating these individuals back into the community was met by the provision of the only low barrier, long-term housing option in Nanaimo. It is a 19-unit SRO model converted from a former hotel.

- Income assistance services from the Ministry of Housing and Social Assistance are provided on-site
- Vancouver Island Health Authority provides on-site mental health and addiction services
- CMHA has homeless outreach workers who also operate out of this office space
- An Assertive Community Treatment team provides an integrated psychosocial approach to working with clients

This program meets the challenge of coordination by bringing together a range of services that are easily accessible to a community. Effective partnerships, and the fact that a marginalized, high-need group is supported in retaining existing housing, enhances their quality of life and ability to recover.

St. Helen's in Vancouver, British Columbia

St. Helen's is a multi-purpose SRO style supportive housing model offered by Coast Mental Health in Vancouver. It offers 86 rooms and operates from a harm reduction, low barrier, and strengths-based approach. It successfully houses extremely marginalized people.

- One floor is dedicated to temporary housing for individuals with severe mental illness and addictions who are on the waiting list of the Burnaby Mental Health and Addictions Centre. Through a partnership with the Centre, people are housed until treatment can be provided. Clinical supports are provided, which can prevent the need for hospitalization. At other times, clients are transferred to the hospital once a hospital bed becomes available.
- Another floor of St. Helen's allocates beds to clients of the Community Transition Team of St. Paul's Hospital. Clients are discharged from the hospital into this three-month transitional housing arrangement where they are provided with step down clinical support. Clients are then helped to find and move into long-term housing. This enables bed flow and supports people in transitioning into independent living arrangements.

St. Helen's works to prevent homelessness for those who are awaiting hospitalization as well as those who no longer require hospitalization; it is a promising innovation to address the needs of ALC patients.

Potential Place in Calgary, Alberta

Potential Place Society is a strengths-based clubhouse model with two apartment buildings. Peers live adjacent to each other and contribute to the supportive environment that is crucial to recovery. The sense of community and ownership is enhanced by the fact that all members of Potential Place are the landlords, and the tenants act as their own property managers of the apartments. Members in the housing assume complete responsibility for building maintenance and general upkeep of the property.

Tenants are members of two local community associations; this has helped address NIMBY issues.

Partnerships with Calgary Police and Alberta Health Services prevent escalating situations.

Alberta Works and CMHA renovated the two buildings and members in the housing take responsibility for building maintenance.

Calgary Housing assists the project by providing rent assistance on a case-by-case basis.

Independence is key with peer support playing a central role. Clubhouse program supports are also available.

The focus of Potential Place Society is to contribute to the rehabilitation of people suffering from a mental illness by creating a supportive and restorative environment. Individuals who have been marginalized by the impact of having a mental illness help each other to attain or regain their self-esteem, confidence, and the skills necessary to lead productive and satisfying lives.

The Cross Departmental 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) in order to better provide housing and supports for seniors, people who are homeless, and people who are homeless with mental health issues. The office works with regional health authorities and communities to improve policy coordination, integrate service provision, improve collaboration, and coordinate strategies.

Factors that facilitated the creation of the CDCI included:

Increasing advocacy and pressure in public forums.

Consensus across government, health providers, housing providers, and other community agencies that meaningful collaboration was needed to address housing and homelessness issues.

Strong commitment at the ministerial level to housing and homelessness issues. The minister responsible for housing at the time was committed to three things: learning about better practices in housing (e.g., *Housing First*); ensuring people weren't being discharged onto the streets; and developing a long-term strategy to address housing and homelessness issues.

The Portable Housing Benefit in Manitoba, was created through the CDCI by coordinating different provincial departments in pooling resources to provide housing subsidies. 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.

The CDCI liaises within provincial government departments, with regional health authorities, with housing authorities, with community-based organizations, and with research initiatives. The CDCI has played an integral role in the creation of well-planned initiatives as well as facilitating rapid problem solving when coordination issues are brought to light.

NAVNET in St. John's, Newfoundland and Labrador

NAVNET is an innovative collaboration which coordinates seven government departments and two community organizations in order to improve system approaches in supporting people with multiple and complex needs living in St. John's, Newfoundland and Labrador. NAVNET engages in a wide variety of activities aimed at coordinating the response to individuals with complex needs.
Some of these activities include:

- Developing an information sharing protocol in line with privacy legislation to facilitate the sharing of relevant information.
- Completion of an analysis to determine the costs associated with providing support to clients who use multiple government and community services.
- A client identification project which allows NAVNET to quantify the number of individuals in St. John's who meet NAVNET's definition of having 'complex needs.'
- Exploring ways to facilitate the development of housing system capacity that will address gaps and meet the needs of prospective NAVNET clients.

NAVNET addresses the issue of a lack of collaboration between ministries; in turn, this has the potential to improve services on the ground level through a top-down method.

At Home/Chez Soi Project

At Home/Chez Soi is a multi-year research and demonstration project funded by the Mental Health Commission of Canada (MHCC). Drawing from knowledge generated from the *Housing First* approach, the aim of this project is to explore ways to help homeless people who have mental health issues. The project will generate strong evidence and information to guide policy and program approaches to ending homelessness in Canada
At Home/Chez Soi has been implemented in five cities across Canada (Vancouver, Winnipeg, Toronto, Montreal, and Moncton). Each site has an additional focus unique to their site:

- **Moncton** the fit of services with smaller urban and rural communities
- **Montreal** study of a range of housing options and a unique vocational intervention
- **Toronto** ethno-cultural diversity including new, non-English speaking immigrants
- **Winnipeg** the urban Aboriginal population
- **Vancouver** people who are also experiencing problematic substance use as well as a unique congregate setting

A total of 2,285 participants will be randomized into two groups, one group will receive housing and supports and the other group will receive the services commonly available in their city. Both groups will be followed over a two-year period to compare a number of outcomes, including: housing stability, health, substance use, community functioning, quality of life, and service use.

Transitional Rehabilitation Housing Project in Ottawa and Toronto, Ontario

The Transitional Rehabilitation Housing Project (TRHP), with sites initially funded in Ottawa and Toronto, provides transitional housing and recovery-oriented supports for people with mental illness in the criminal justice system. This population experiences a wide range of difficulties in finding and keeping housing.

The Ottawa TRHP includes two components for people being discharged from the forensic inpatient units at the Royal Ottawa Health Care Group: a four-bedroom transitional home ("Grove") and six satellite apartments. Both components include ongoing case management and housing support.

A teaching apartment that serves as an opportunity to assess participants, as well as a chance for participants to prepare their move from Grove to their own apartment.

Support from on-site workers including: day-to-day support, life skills, wellness promotion, negotiating living independently, and living with others.

A range of partners and resources working together to allow for a number of strategies to be used to help support residents (e.g. brief hospital stays).

Tenants in the satellite apartments can continue to access the on-site rehabilitation supports at Grove on an ongoing or transitional basis.

In Toronto, a partnership exists 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 where they receive case management and housing support from TRHP staff. The housing stock includes one-bedroom and two-bedroom apartments.

No limits to participants' length of stay in the program (although average is 18-22 months).

Support and education from on-site workers including: activities of daily living; housing rights; orientation to community services; and medication, mental health, and recovery.

Gradual transitions are built into the program – from hospital to TRHP apartment building to community living.

Creation of peer support position to work with clients on a one-to-one basis. The peer support worker is a former client of the TRHP program.

All of the organizations involved with the TRHP programs agree that while the program is still relatively new, it has had a major impact on discharge rates and bed flow.

What Innovation Shows Us

The innovations above are only a small sample of many initiatives aimed at improving housing and support systems for people living with mental illness. These promising practices provide services that are in short supply and utilize creative approaches to overcome problems in partnership, planning, and coordination. They demonstrate that the provision of housing and supports works for physical and mental health, and if equipped with the right tools, people can change their lives.

We save money by spending smart

When people need help they will use the supports and services available to them. All too often this means emergency rooms, shelters, or housing that is not meeting their need for safety, affordability, and support. A well known example is "Million-Dollar Murray," a homeless man with serious mental health issues and alcohol dependence from Reno, Nevada[36]. The story became well known when Malcolm Gladwell published a detailed description in the *New Yorker* magazine. Because the right services were not provided, the cost to the system mounted to an estimated $100,000 per year over a ten year period.

With our rich foundation of knowledge, we know that the provision of housing and supports works in recovery. This, in turn, reduces the reliance on costly alternatives such as hospital beds, emergency rooms, ambulances, shelters, and jails. We found many examples of reductions in usage throughout the literature, and through discussions with key informants and reference group members. A Toronto-based program, *Streets to Homes*, noted a 40% decrease in individuals with mental illness visiting the emergency room, upon the provision of housing[2]. An example from a Denver-based study found a 76% decrease in total number of days spent in incarceration through participation in a *Housing First* program[6]. These findings are only two of the many studies that demonstrate reductions in hospital stays, incarceration, use of emergency services, and use of the shelter system following the provision of housing.

The cost of housing a person in supportive housing is about **ten times less** than the cost of institutional and emergency shelters[12].

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. Supportive housing will cost significantly less than these. We have the ability to save money by directing resources down a more efficient path. Investments in housing with supports are effective and improve the quality of life for people living with mental illness.

"When I finally moved to my apartment it was tremendous for my recovery."
– webinar participant

WHAT NEEDS TO BE DONE?

The voices of people living with mental illness and their families are loud and clear in this study, and their concerns are substantiated by the fact that they are shared by other stakeholder groups. The 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 Supports that Work	Housing and Supports that Fit

Synthesized from findings in this study, achieving these outcomes is contingent on the following tailored and highly specific inputs:

- **investment; planning, partnership, and coordination;**
- **localized, need-based, population specific considerations within the framework of a national mental health supportive housing strategy;**
- **provision of the supports needed by people living with mental illness; and**
- **establishment of service standards in providing housing and related supports.**

We need affordable housing stock

Perhaps the best starting point for action in Canada is the Senate Report, *Out of the Shadows at Last*[12]. This report stressed the importance of housing and set out a ten-year plan that would see the creation of a minimum of 56,500 housing units, either through the development of new housing or by putting in place rental subsidies. Taking into account the populations not reflected in the Senate Report's recommendation (e.g., hidden homeless, aging parents who are caregivers), we believe that 100,000 supportive housing units for people living with mental illness represents the actual minimum that is required.

Making adequate income supports available for housing (e.g., through increased subsidies, rent-geared-to-income options, affordable home ownership initiatives, and portable housing benefits) is key to achieving this target. What we do have in place is a foundation of innovative agencies, programs, and models which have the experience needed to meet the challenge. With some exceptions we don't need to invent new solutions, we need to scale up what we have. Some communities have special challenges.

We determined that the creation of **100,000 supportive housing units over a ten year period represents the minimum of what is required**.

Many rural and remote communities for example face the challenge of working with limited stock spread across a large geographic area, and limitations in funding and other resources including treatment services. Because of this, rural/remote housing solutions may be different.

We need good quality housing stock

In some cases, non-profit organizations have tried to counter the deterioration of stock by fundraising and engaging tenants in upkeep of the property; however, these are only partial solutions.

The experience of living in poor housing was repeatedly discussed by people living with mental illness. In addition, we heard about the constant struggle of housing providers to maintain quality housing and found that aging and deteriorating housing stock is a growing problem in many provinces. Setting annual targets to repair existing housing stock as specified in the *Precarious Housing in Canada* report[14], is needed.

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 seen as an important part of their operational budget and subsequent increases must be allowed to existing budgets.

We need housing and support options that work and fit

A range of housing and support options will ensure that smooth transitions, contingent upon the needs of the client, are feasible.

People living with mental illness have varying levels of need. There is a need for a range of housing and support options, from independent scattered models, to cluster models, to 24-hour high support housing, to transitional housing models. It is also vital that this range features supports that are flexible and synchronize with the needs of the tenants living with mental illness.

A key trend in housing development is clear. Over time it has been recognized that most people can live with less support than was previously thought. More independent settings, in which people are tenants or owners, rather than clients, are now common and usually referred to as supported housing. Recognizing the capacities of people with mental illness has been a steep learning curve for many professionals. With recognition have come new models that focus on enabling people to live independently.

Housing First strategies have emerged as a highly effective way of providing enabling support. Some older programs created (and still create) a list of conditions that must to be met to get into housing, often quite long lists. *Housing First* models recognize that housing itself is the key to moving forward with recovery and community integration. The At Home/Chez Soi project now being carried out under the auspices of the Mental Health Commission of Canada is using this approach.

In addition to the excellent programs we have across the country, we face a major challenge with other models. Many housing and support models that now exist do not reflect best practices. Typically these are versions of board and care homes, which are custodial in nature. They often fail to provide adequate privacy and 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. A fundamental shift needs to occur.

Putting in place individualized recovery strategies is an uphill battle but also a necessary one to promote independence and improve the quality of life of people living with mental illness.

As we have seen, housing is more than bricks and mortar. Recovery-oriented supports are integral to people living with mental illness. Traditionally, the basket of support services seen as necessary consisted largely of formal mental health services. This study, however, found that people living with mental illness value supports differently and identify the critical importance of factors beyond mental health services, such as help from peers, and help with employment, income, and education.

The basket of services desired by people living with mental illness includes:

Housing Supports
e.g., income supports, education and employment supports, supports ensuring food security, housekeeping, and meal preparation

Health Care Supports
e.g., access to a primary care, mental health services, medication management supports, and access to a community nurse

Peer Supports
both formally through peer organizations and informally through social networks

Current housing and support options often fall short of providing services that fit the needs for sub-populations (e.g., people with dual diagnoses, concurrent disorders, people who have experienced trauma, Aboriginal persons, youth, people from ethnoracial and ethnocultural groups, and the aged population). This is due to a lack of understanding of specific needs and the tailoring of supports to address these needs. A lack of training for staff to deal with these population groups, rigid admission criteria that exclude certain sub-populations, the shortage of low-barrier housing options, and a lack of foresight in planning are other key issues. While a national project such as this highlights the issues and possible strategies, a concerted plan of action requires in-depth study of those specific sub-populations where research is scarce.

We need planning, partnership, and coordination

There are initiatives across Canada where planning and assessment for housing and related supports have been undertaken. For example, *Housing Matters BC* is the provincial housing strategy in British Columbia. It focuses on providing supportive housing to vulnerable populations. In Ontario, there have been similar attempts through *Making It Happen* and other initiatives. The provincial policy framework informing mental health planning in Québec is the *Plan d'Action en Santé Mentale 2005-2010*, which profiles a recovery orientation, highlights the importance of partnership, and the fluid integration of health and social services aimed at supporting users of services and their natural supports. Many jurisdictions have housing strategies, poverty reduction strategies, and other relevant initiatives already in place, and given this, the challenge is how to influence current actions and to shape new ones, as opposed to starting from scratch.

A national mental health supportive housing strategy should be informed by the development of a partnership and coordination model which outlines multiple levels of partnership, the coordination within and between partners, and the operational aspects of the partnerships which 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, community based service organizations, and people living with mental illness and their families. It must also include routine assessment and continuous planning based on need levels.

Action is needed on the federal and provincial/territorial fronts. At the centre of any action plan will be a strong working sense of what is needed in each province and territory. In preparing this study, we heard repeatedly of the need to bring the players together to develop a unified approach. Given this, a fundamental step is to create provincial and territorial targets. Targets alone, however, are not enough. Each jurisdiction needs an action plan that defines the steps needed to reach the targets.

Provincial/Territorial Level	National Level
▪ A **point of leadership** is needed within the province/territory and the process needs to be sanctioned 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. ▪ **Reviewing the existing resources**: this report offers detailed material on each province and territory, but a critical review is needed. The four focal points (affordability, quality, support, and fit) are categories that can form the basis of a review. ▪ **Identifying the number and type of units needed**. ▪ Putting the spotlight on **partnerships**: people from all across Canada emphasized the need to get the players together and build partnerships.	▪ **National leadership**: the Mental Health Commission of Canada is ideally suited to coordinate the national dimension of a mental health housing initiative. This will mean bringing together the key players. ▪ **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. ▪ **Sharing what we have learned**: in addition to cross-cutting groups, it is essential to have a national exchange of ideas. This report identified a base of innovative practices across Canada that will be posted online on the MHCC's website. It will create easy access to new approaches and allow people to add new ones. ▪ **Make housing a part of the social movement for mental health.**

RECOMMENDATIONS TO THE MENTAL HEALTH COMMISSION OF CANADA

- **T**he 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.

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